

Department of Management and Engineering  
Division of Political Science

Master Thesis in International and European Relations

# **Impacts of Living and Working Conditions on the Health of Immigrants**

*A Comparative Study on Asylum-Seekers in  
Germany and the Netherlands*

By  
Shima Haji Modiri  
19841022-9762

Supervised by  
Jörgen Ödalen, Ph.D.  
Senior Lecturer in Political Theory  
Linköping University

ISRN-Number  
LIU-IEI-FIL-A--15/02100--SE

2015-09-02



**Linköpings universitet**

*Abstract:*

During the last several decades, many people, fleeing from disasters or political threats, have applied for asylum in the European countries. Council Directive 2003/9/EC, laying down minimum standards for the reception of asylum-seekers, as well as several other directives, have been developed in the EU in order to ensure fair treatment of the asylum-seekers in all the European countries. However, there are huge differences in the national asylum laws of countries and consequently, the way they treat the asylum-seekers. In this research, the national asylum laws of Germany and the Netherlands are studied and compared, showing that though following the Council Directive, fair or equal treatment of asylum-seekers cannot be guaranteed. In the Netherlands asylum-seekers are granted with a great extent of benefits while in Germany, they are greatly discriminated against. Based on the Social Determinants of Health Model, developed by Dahlgren and Whitehead in 1991, the hypothesis is that the asylum seekers in the Netherlands enjoy better health status than the ones in Germany, because based on the Dutch asylum laws, they have better living and working conditions. In order to confirm or negate this hypothesis, a meta-study of available literature on the health status of asylum-seekers has been done. However, the hypothesis could not be confirmed/negated due to extreme lack of availability of data in this area.

By discussing the relationship between life conditions and health of individuals, reviewing current legal instruments regulating asylum in the EU and analyzing the available data on the health status of asylum-seekers, this paper draws the attention to the importance of data and research on these topics and the need for development of practices for collection of such information. Availability of such information can affect future decision and policy makings regarding asylum-seekers and their health and might result in comprehensive reformations in the current national or international legal instruments.

*Key words: Asylum-seekers, Health, Germany, the Netherlands, National Laws, EU, Council Directive 2003/9/EC, AsylbLG, AsylVfG, SGB, Alienes Act 2000, COA, RVA, RVB, Living and Working Conditions, Education, Employment, Food, Health Care Access, Housing, Human Rights*

## **Acknowledgements**

I would like to express my deepest gratitude to my supervisor, Dr Jörgen Ödalen, for sharing his knowledge with me and supervising this research. His constant support, encouragements and of course, his magnificent skills in research and passion for teaching made this dissertation possible.

I would also like to thank Dr Per Jansson, the director of “International and European Relations” Master’s Program at Linköping University as well as all the other Professors at this program who provided us with high quality studies and supported us frequently in every aspect of our lives.

Furthermore, I would like to express my greatest appreciation to Mr Bernd Mesovic, the chief executive officer at Pro Asyl Germany, for providing me with the most necessary information to complete this dissertation. In addition, thanks to Europe Direct with their clear and useful suggestions.

And in the end, a special thanks to my wonderful husband, my loving parents and generous sisters who have always believed in me and have been there for me through every step in life. Words cannot express how grateful I am to have you.

## Table of Contents

|          |  |           |
|----------|--|-----------|
| <b>1</b> | <b>Introduction .....</b>  | <b>1</b>  |
| 1.1      | EU and Asylum-Seekers .....  | 1         |
| 1.1.1    | Impacts of Asylum-Seekers on the Host Societies in the EU.....                           | 2         |
| 1.1.2    | Health: A Major Factor Influencing Impacts of Asylum-Seekers on the Host Societies ..... | 3         |
| 1.2      | Focus and the Purpose of this Study.....   | 4         |
| 1.3      | Research Questions .....   | 6         |
| <b>2</b> | <b>Research Design and Methodology.....</b>  | <b>7</b>  |
| 2.1      | Structure and Method .....   | 7         |
| 2.1.1    | Analysis A.....  | 7         |
| 2.1.2    | Analysis B.....  | 7         |
| 2.2      | Deductive Reasoning.....   | 8         |
| 2.3      | Positivist/Post-Positivist Approach .....  | 9         |
| 2.4      | Selection of Factors and Cases .....   | 10        |
| 2.5      | Intervening Factors.....   | 11        |
| <b>3</b> | <b>Effects of Living and Working Conditions on the Health of Individuals .....</b>       | <b>14</b> |
| 3.1      | Education.....   | 14        |
| 3.2      | Employment .....   | 15        |
| 3.3      | Food.....  | 16        |
| 3.4      | Health Care Access .....   | 17        |
| 3.5      | Housing .....  | 18        |
| <b>4</b> | <b>Review of the Legal Instruments: Specifying the Independent Variable .....</b>        | <b>20</b> |
| 4.1      | Legal Instruments on Education.....  | 23        |
| 4.1.1    | EU .....   | 23        |
| 4.1.2    | Germany.....   | 25        |
| 4.1.3    | The Netherlands .....  | 26        |
| 4.2      | Legal Instruments on Employment .....  | 28        |
| 4.2.1    | EU .....   | 28        |
| 4.2.2    | Germany.....   | 29        |
| 4.2.3    | The Netherlands .....  | 31        |
| 4.3      | Legal Instruments on Food and Water .....  | 33        |
| 4.3.1    | EU .....   | 34        |
| 4.3.2    | Germany.....   | 35        |
| 4.3.3    | The Netherlands .....  | 36        |
| 4.4      | Legal Instruments on Health Care Access.....   | 38        |
| 4.4.1    | EU .....   | 39        |
| 4.4.2    | Germany.....   | 40        |
| 4.4.3    | The Netherlands .....  | 42        |
| 4.5      | Legal Instruments on Housing .....   | 46        |
| 4.5.1    | EU .....   | 47        |
| 4.5.2    | Germany.....   | 49        |

|          |   |           |
|----------|---|-----------|
| 4.5.3    | The Netherlands .....   | 49        |
| 4.6      | Actual Implementation of the Laws .....   | 51        |
| 4.7      | Conclusion of the Chapter .....   | 51        |
| <b>5</b> | <b>Health Status of Asylum-Seekers: The Dependent Variable .....</b>                                    | <b>53</b> |
| 5.1      | Availability of Data .....  | 54        |
| 5.2      | Study of the Literature.....  | 57        |
| 5.2.1    | Certain Infectious and Parasitic Diseases (A00-B99) .....   | 59        |
| 5.2.2    | Mental and Behavioral Disorders (F00-F99) .....   | 60        |
| 5.2.3    | Diseases of Respiratory System (J00-J99) .....  | 62        |
| 5.2.4    | Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99) ..... | 62        |
| 5.2.5    | Factors Influencing Health Status and Contact with Health Services (Z00-Z99) .....                      | 63        |
| 5.3      | Results .....   | 63        |
| 5.4      | Discussions.....  | 65        |
| <b>6</b> | <b>Summary, Conclusions and Recommendations .....</b>   | <b>69</b> |
| <b>7</b> | <b>References .....</b>   | <b>76</b> |
| <b>8</b> | <b>Appendix .....</b>   | <b>85</b> |

## Table of Figures

|   |    |
|---|----|
| Figure 1: Social Model of Health (Dahlgren & Whitehead 1991, p.5).....                                | 4  |
| Figure 2: Deductive Reasoning (Trochim & Donnelly 2008).....  | 8  |
| Figure 3: Health Expenditure Per Capita (US \$ 24/04/2014) (The World Bank 2014).....                 | 12 |
| Figure 4: Design and Methodology of the Research.....   | 13 |
| Figure 5 : Education for Asylum-Seekers in Council Directive 2003/9/EC .....                          | 24 |
| Figure 6 : Access to Education or Training.....   | 27 |
| Figure 7 : Employment for Asylum- Seekers in Council Directive 2003/9/EC.....                         | 29 |
| Figure 8 : The Right to Work and Access to Fair Working Conditions.....                               | 32 |
| Figure 9 : Material Reception Conditions in Council Directive 2003/9/EC .....                         | 34 |
| Figure 10 : Monthly Cash Benefits for Asylum-Seekers and National Citizens in Germany (EMN 2013)..... | 35 |
| Figure 11 : Access to Adequate Food .....   | 37 |
| Figure 12: Health Care Access for Asylum-Seekers in Council Directive 2003/9/EC.....                  | 39 |

|   |    |
|---|----|
| Figure 13: Health Care Access for Asylum-Seekers in AsylbLG 1993.....   | 41 |
| Figure 14: Access to Health Care and Treatment for Adult Asylum-Seekers According to<br>Applicable National Legislation (Collantes 2009) .....                        | 42 |
| Figure 15: Health Care Access for Asylum-Seekers in RVA .....   | 43 |
| Figure 16: Health Care Access for Asylum-Seekers in RVB .....   | 43 |
| Figure 17: Access to Health Care and Treatment for Adult Asylum-Seekers According to<br>Applicable National Legislation (Collantes 2009) .....                        | 44 |
| Figure 18: Access with No Restrictions.....   | 44 |
| Figure 19: Housing for Asylum- Seekers in Council Directive 2003/9/EC.....  | 48 |
| Figure 20 : The Right to Adequate Housing .....   | 50 |
| Figure 21: Conditions for Asylum-Seekers in DE and NL .....   | 52 |
| Figure 22: Diagnoses Based on Gender, ICD 10, Most Frequent Diseases, Years 2001-2008,<br>(All Diagnoses N=20.752, Women n=8.763 Men n=11.989) (Jung 2011, p.49)..... | 58 |
| Figure 23: Data on Tuberculosis among Asylum-Seekers in DE and NL .....   | 64 |
| Figure 24: Data on Mental Disorders among Asylum-Seekers in DE and NL .....   | 64 |
| Figure 25: Data on PTSD among Asylum-Seekers in DE and NL .....   | 64 |
| Figure 26: Data on Headaches among Asylum-Seekers in DE and NL.....   | 65 |

## List of Abbreviations

|         |  |
|---------|--|
| AsylbLG | Asylum-Seekers Benefit Act                                   |
| AsylVfG | Asylum Procedure Act   |
| BAMF    | Federal Office for Migration and Refugees                    |
| BVerfG  | The Federal Constitutional Court                             |
| CDU     | Christian Democratic Union of Germany                        |
| CEAS    | Common European Asylum System                                |
| CHS     | Community Health Services                                    |
| COA     | Act of the Central Reception Organization for Asylum-Seekers |
| CRC     | Convention on the Right of the Child                         |
| DE      | Germany  |
| DESA    | Department of Economic and Social Affairs                    |
| EC      | European Commission  |
| ECRE    | European Council on Refugees and Exiles                      |
| EFA     | Education For All  |
| EMCONET | Employment Conditions Knowledge Network                      |
| EMN     | European Migration Network                                   |
| EU      | European Union   |
| FDP     | Free Democratic Party  |
| GDP     | Gross Domestic Product                                       |
| HIV     | Human Immunodeficiency Virus                                 |
| HUMA    | Health for Undocumented Migrants and Asylum-Seekers          |
| ICD     | International Classification of Diseases                     |
| ILO     | International Labor Organization                             |
| IOM     | International Organization for Migration                     |
| MedLine | Medical Literature Analysis and Retrieval System Online      |

Impacts of Living and Working Conditions on the Health of Immigrants  
*A Comparative Study on Asylum-Seekers in Germany and the Netherlands*

|        |  |
|--------|--|
| NCBI   | National Center for Biotechnology Information                    |
| NL     | Netherlands  |
| NLM    | National Library of Medicine                                     |
| OECD   | Organization for Economic Co-operation and Development           |
| PMC    | PubMed Central   |
| PTSD   | Post Traumatic Stress Disorder                                   |
| PubMed | Public/Published MedLine   |
| RVA    | Regulation on Provisions to Asylum-Seekers                       |
| RVB    | Scheme Benefits in Certain Categories of Aliens                  |
| SGB    | Book of Social Code  |
| SPD    | Social Democratic Party of Germany                               |
| UAF    | Refugee Students Association                                     |
| UN     | United Nations   |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNHCR  | United Nations High Commissioner for Refugees                    |
| USA    | United States of America   |
| WHO    | World Health Organization  |

# 1 Introduction

Asylum is a fundamental right. All the EU countries have a shared responsibility in receiving asylum-seekers in a dignified manner, ensuring that they are treated fairly (European Commission 2015). When it comes to regulations on living and working conditions for asylum-seekers, directives have been developed by the EU to set minimum standards for the national asylum legislations to ensure fair treatment of the asylum-seekers. Even though these minimum standards are considered, there are still huge differences in the way asylum-seekers are treated based on each country's national laws. In Germany for the first 4 years, asylum-seekers are greatly discriminated while in the Netherlands less signs of discrimination can be found. Via a combination of qualitative and quantitative research based on a meta-study of the existing literature and information on the health status of asylum-seekers, this research intends to investigate how different national legal instruments on living and working conditions for asylum-seekers in Germany and the Netherlands can affect their health conditions.

Such studies are of great importance since they inform future decision-makings concerning living and working conditions for specific types of migrants. However, there is a great lack of data in this field, right now.

In this introductory chapter, the background and situation, shaping the research questions, are presented.

## 1.1 EU and Asylum-Seekers

Asylum is a fundamental right. This right has been recognized and for the last several years efforts have been made to make asylum situations humane. Article 14 of the *Universal Declaration of Human Rights 1948* recognizes the right of persons to seek asylum in other countries when in danger of persecution. This recognition was followed by *the United Nations Convention on the Status of Refugees*, adopted in 1951 in Geneva, which plays the most important role in asylum protection till today. At the beginning, this convention was limited to people fleeing from the events before January 1951 within Europe but later an amendment in the form of a protocol in the year 1967 removed the limitations from the convention and gave it universal coverage (UNHCR 1951, p.2).

Being granted with this fundamental right as human beings, every year, thousands apply for asylum in the EU countries. The number of asylum applications in the whole EU varies every year. The highest numbers were in 2001 with 425 thousand cases, in 2013 with 435 thousand cases and in 2014 with 626 thousand cases. The lowest number was 200 000 cases in 2006 (EC 2013b) (EC & Eurostat 2015a).

The number of asylum-seekers and their relative importance (the number of applicants in relation with the population of the host country) differ among the EU countries. Some countries have a larger share of the asylum applications, showing that these countries are preferred by asylum-seekers due to the probability of being granted with protection and the benefits connected to the protection status, as well as some other factors like the language of the country (EC & Eurostat 2013).

Such imbalances in the share of each country from asylum-seekers have made EU to work on creating a Common European Asylum System (CEAS) based on the *Geneva Convention* and international instruments since 1999. The recently agreed on new rules which aim at setting common standards to ensure equal treatment of asylum-seekers in a fair system are: *The revised Asylum Procedures Directive, The revised Reception Conditions Directive, The revised Qualification Directive, The revised Dublin Regulation and The revised EURODAC Regulation* (EC 2013b). There is a higher chance for the host countries to receive a fair share of asylum-seekers if the asylum-seekers are treated in any country, equally and fairly.

EU has been setting minimum standards for treatment of asylum-seekers via various measures and directives. However, these minimum standards do not mean or guarantee equal standards and in different countries, the asylum-seekers are treated very differently based on the countries' national laws. At this point, one might ask what possible incentives would the host countries have in order to give asylum-seekers more rights and entitlements than the minimum rights which are set by the international agreements. The following section can serve as a potential answer to such question.

### **1.1.1 Impacts of Asylum-Seekers on the Host Societies in the EU**

Asylum-seekers' needs must be met and their rights must be granted by the host countries, not only because the countries have to follow the human rights laws but also because asylum-seekers can have significant influences on their countries. In the study "Impact of Immigration on Europe's Societies", done by European Migration Network (EMN), the

impacts of immigration on the economies, culture and political structures of nine European countries are studied (European Migration Network 2006, p.7). The purpose of such study is to provide information for political areas concerning migration. Based on this study, it becomes apparent that immigrants, either directly or indirectly, have a significant impact on the mentioned areas in the host countries.

Keeping the results of the EMN study in mind and also considering asylum as one of the different types of immigration, including around 300 thousand people every year (EC 2013b) in the EU, the importance of taking care of the asylum-seekers and the extent of their impacts on the host countries become clear. The better the conditions for this great number of asylum-seekers are, the more desirable impacts they will have on the host countries. And here is a potential encouraging answer for the states to the question of why to give more entitlements to the asylum-seekers than the minimum.

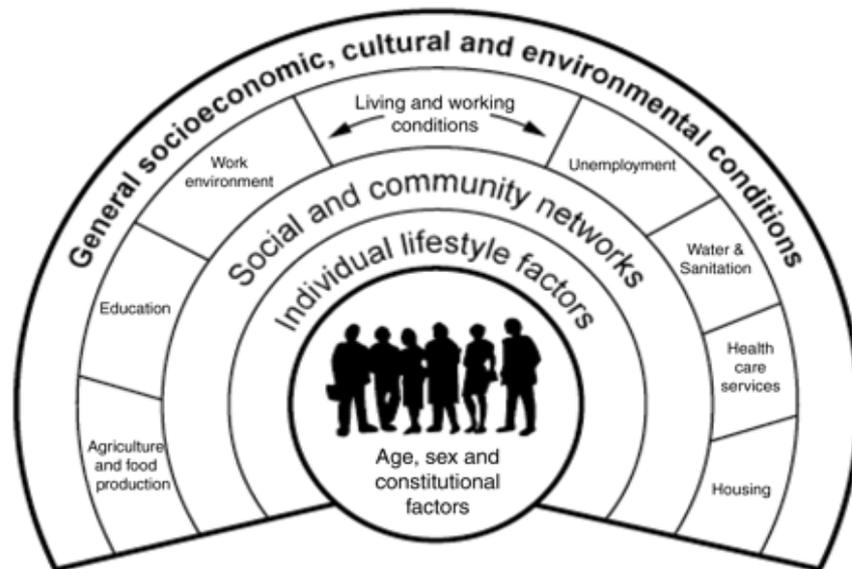
Having mentioned briefly the importance of sufficient care and the consequences on the host country, this topic will not be discussed further in this research. The main focus here will be on one of the most important factors that can affect the influences of asylum-seekers on shaping the economy, politics and culture of the receiving states, health, which is introduced in the following part.

### **1.1.2 Health: A Major Factor Influencing Impacts of Asylum-Seekers on the Host Societies**

Health as a human right was articulated at international level in the *Constitution of the World Health Organization of 1946* for the first time and then in Article 25 of the *Universal Declaration of Human Rights 1948*. Since then, it has been included in several treaties among EU member states, for example, at Article 12 of the *International Covenant on Economic, Social and Cultural Rights of 1966* (Benedict 2010, p.6).

Health is asylum-seekers' human right and also according to the International Organization for Migration, one of the most important factors, which enables immigrants to sustainably contribute to the social and economic development of their host country, is improved standard of health; physical and mental wellbeing (IOM 2013). Thus, not only health is immigrants' right, but also asylum-seekers, as one of the most vulnerable groups among immigrants, are severely affected by this factor, which consequently influences their performance and impacts on the EU host countries.

Health status of individuals depends on several conditions, surrounding them and their lives. Dahlgren & Whitehead (1991) investigated various factors influencing the health of a population and created the “Model of Determinants of Health”, which can be seen in Figure 1.



**Figure 1: Social Model of Health**  
(Dahlgren & Whitehead 1991, p.5)

This model shows what individual, social, general economic and environmental factors combine together and influence health of individuals and consequently affect their communities. Asylum-seekers, as a part of the host countries’ population, are among the most vulnerable subjects to these conditions.

In this study, the focus will be on the living and working conditions layer of social determinants of health; access to education, employment, food/water, health care services and housing. These conditions differ from country to country for asylum-seekers because they are shaped with the national laws and regulations.

## **1.2 Focus and the Purpose of this Study**

The target countries for this research are Germany and the Netherlands. National laws concerning living and working conditions for asylum-seekers in these two countries are sometimes at the opposite ends of the spectrum. For example, when it comes to health care services, one gives almost all kinds of access to health care services and one gives access just in emergency cases. As asylum-seekers make a great number of the population in both countries, a lot of attention must be paid to their situations and well-being, not only for the

sake of the benefits for the countries but also to ensure that the asylum-seekers are granted their human rights.

This study investigates the EU level and national legal instruments in Germany and the Netherlands, which are effective in shaping the living and working conditions for asylum-seekers and intends to find out how these differing laws influence the well-being and health of the asylum-seekers.

In Chapter 2, the research design and methodological framework are introduced. In chapter 3, the effects of living and working conditions on the health of individuals are briefly discussed. In chapter 4, the most effective legal instruments shaping the conditions for asylum-seekers will be introduced and possible interpretations are discussed. In Chapter 5, via information gathered from the meta-study of existing researches and literature, health status of asylum-seekers in the two countries will be compared and discussed. Afterwards, in chapter 6, conclusions and recommendations based on the findings of the research will be presented.

This research is of great importance since comprehensive research on the policies, laws and regulations influencing health of migrants and consequently the impact of immigrants on the countries are missing. The capacities for comparative research in this area are promising (European Migration Network 2006, p.5).

The report by Collantes and HUMA (2009) is one significant work done in this area. Based on the observations carried out in their report, they claim the necessity for new policies and policy changes concerning immigrants. They make recommendations to the European institutions and also address national, regional and local authorities (Collantes 2009, p.181).

There are a number of studies done comparing the laws in different countries but not so much has been done to find out how these laws influence the health in real life situation. The purpose of this study is to fill in this existing gap with the aim to serve as a source of recommendations for future law-makings regarding living and working conditions for migrants. Having recognized the importance, focus and purpose of this research, the research questions will now be introduced.

### **1.3 Research Questions**

According to Dahlgren and Whitehead (1991), some factors influencing an individual's health such as social environment and socio-economic conditions, including food, education, housing, employment and access to health care services, are modifiable. As a result, any policies, laws, programs or ideas that have the potential to change these modifiable factors, reducing the negative influences and increasing the positive influences on the health, are very important and must be treated with great attention and knowledge.

In this study, the focus will be on finding the impacts of different legal instruments, concerning living and working conditions for asylum-seekers in the two countries on their health status.

Thus, the research questions can be formed as:

- What are the existing legal instruments on education, employment, food, health care access and housing (living and working conditions) for asylum-seekers in Germany and the Netherlands?
- How are these conditions affecting the health status of asylum-seekers?

It is important to recognize how these differing laws, frameworks or regulations influence the health of the immigrants since the findings will contribute to the recommendations addressed to the politicians, the civil societies, the health professionals, the immigrants and in general any power that plays a role in creating new policies and laws in their future decision-makings regarding immigrants and their entitlements.

In the following chapter, the design of the research and the methodological framework are presented.

## **2 Research Design and Methodology**

Research method is concerned with the collection of data and research design ensures that the collected data enables answering questions as unambiguously as possible (de Vaus 2001, p.9). The overall strategy or the research design of this thesis is based on the method of focused-structured comparison, working with the “most similar” cases. The method is structured because the research objectives guide data collection, systematic comparison and accumulation of findings. It is focused because it deals with a few specific empirical aspects (George & Bennett 2005, p.67).

### **2.1 Structure and Method**

The research consists of two sets of case study analyses, called Analysis A and Analysis B. Analysis A is carried out in order to provide Analysis B with the needed data and variables, introduced in the following part.

#### **2.1.1 Analysis A**

The objective of Analysis A is to review and compare the legal instruments on education, employment, food, health care access and housing for asylum-seekers in the Netherlands and Germany. The objective is simply “... to describe, explain, interpret, and/or understand a single case as an end in itself rather than as a vehicle for developing broader theoretical generalizations” (Levy 2008, p.4), therefore to carry out an idiographic case study.

Based on the objective, data is gathered, comparison is made and findings are accumulated. According to George & Bennett (2005, p.75), such study can contribute to theory testing or heuristic purposes. In the course of this research, findings out of this analysis serve as the independent variables used in the next part, Analysis B.

#### **2.1.2 Analysis B**

The objective of Analysis B is to find the impacts of independent variable, different types of living and working conditions (attained in Analysis A), on the dependent variable, health status of asylum-seekers.

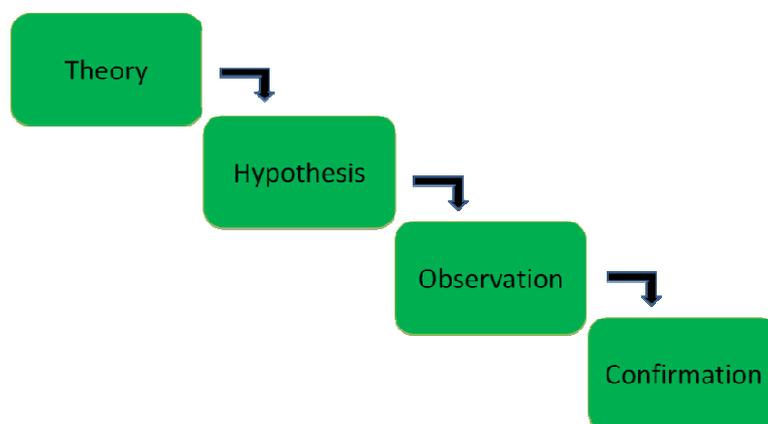
The objective here is to do a hypothesis testing case study. Based on the Social Model of Health (Dahlgren & Whitehead 1991), it is expected that the dependent variable (health)

changes whenever the independent variable (education, employment, food, health care access and housing) is changed. Thus, the hypothesis is that the better the living and working conditions, the better the health. Or in other words, the asylum-seekers in the country with better living and working conditions enjoy better health status.

Since access to absolutely accurate registered data on the health of asylum-seekers is not possible, the data will be gathered by a meta-study of existing literature and then the hypothesis will be tested by measuring relationships between the variables (Maxwell & Mittapalli 2008).

## 2.2 Deductive Reasoning

As mentioned previously, from the Social Determinants of Health Model, suggested by Dahlgren and Whitehead (1991), several theories can be drawn. The *theory* that is focused on in this study is that, the living and working conditions affect the health status of individuals. Narrowing down the theory, a hypothesis is suggested. The *hypothesis* is that the asylum-seekers in the Netherlands enjoy a better health status than the asylum-seekers in Germany because they have better living and working conditions.



**Figure 2: Deductive Reasoning**  
(Trochim & Donnelly 2008)

A deductive method of reasoning is being used in this study, as shown in Figure 2. The hypothesis is suggested and based on that, *observations* through case studies will be done. The results from the case studies and observations will *confirm* (or not) the hypothesis and the original theory that the research started with (Trochim & Donnelly 2008). Thus, the research is a theory-testing one and the result will serve as a resource for future policy makings.

### **2.3 Positivist/Post-Positivist Approach**

Positivist approach in research means that the knowledge is gained from positive verification of observable experience and experimental testing or scientific methods are the best way of attaining this knowledge. Positivists claim that there is an objective reality which people can know of and symbols can explain and describe this objective reality (Cohen & Crabtree 2006).

Positivism has been subject to several criticisms. According to Max Horkheimer, the German philosopher and sociologist working in critical theory, positivism can be criticized for two reasons. First criticism is that positivism underestimates human social actions. Social facts are a product of socially and historically mediated human interactions and consciousness and they do not just exist on their own. Positivism falsely represents social reality as existing objectively and the role of social ideas are ignored. His second criticism on positivism is that positivism is conservative and supports status quo rather than posing challenges to the social reality (Fagan 2005).

Criticisms as such have led to the development of post positivist theories. While positivism claims that the observer and the observed object are independent from each other, the post positivist approaches hold the belief that the knowledge, background and values of the observer can influence what is being observed. Based on post positivism, human knowledge is based on opinions, thus, possible biases must be recognized. Post positivists just like positivists believe that a reality exists but they additionally believe that this reality can be known only probabilistically and imperfectly (Robson 2002, p.624).

In this research using the cases, linkages between causes (independent variables: living and working conditions) and effects (dependent variables: health status of asylum-seekers) are discovered (della Porta & Keating 2008, p.13), keeping in mind the fact that some phenomena might not be governed by causal laws but by probabilistic ones (della Porta & Keating 2008, p.24). Though the base for the research is positivist, normative values must be taken into consideration, as well, which makes the approach of the research more post positivist.

According to H eritier , a positivist approach would start with a theory, “which then generates hypotheses which are then subjected to the test of hard facts and only accepted if they survive the ordeal” (H eritier 2008) and this is the way this research is being carried out, following a hypothetic-deductive method of reasoning. Not only the causal linkages and the deductive

reasoning, but also the use of ‘hard’ methods such as concrete evidence and rules and regularities (della Porta & Keating 2008, p.26) point at the positivist approach of the research. With a post positivist touch, values and norms can also be considered at the course of the research.

## **2.4 Selection of Factors and Cases**

As mentioned earlier, the study is carried out based on the method of structured-focused comparison working with “most similar” cases i.e. “...cases that are comparable in all respects except for the independent variable, whose variance may account for the cases having different outcomes on the dependent variable (George & Bennett 2005, p.81). Other intervening factors that might have an effect on the results shall be recognized and isolated.

Among the several types of immigrants, asylum-seekers will be addressed here, since most of them not only suffer from barriers like no access to health insurance, social exclusion, direct and indirect discrimination, like other types of immigrants, (Rechel et al. 2011, pp.5–6) but also due to the hardships they have been through, they are a very fragile group of the society.

The chosen factors, asylum-seekers and their living and working conditions, will be investigated in the two countries of the Netherlands and Germany. Germany and the Netherlands have been chosen due to their great percentage of immigrants and high standards of living. The GDP per capita in these two countries are higher than the European Union average, showing high standards of living and material well-being of their population (EC 2013a), making them very attractive destinations for migrants. According to the United Nations report “Trends in International Migrant Stock”, 11.9% of German population and 11.7% of the population in the Netherlands are immigrants (UN/DESA 2013), including huge numbers of asylum-seekers.

When it comes to food, housing, education and employment laws for asylum-seekers in these countries, there are some differences in the legislations and the extent of access the asylum-seekers have to them. Notably, when it comes to health care access for the asylum-seekers, there are huge differences in the laws of the chosen countries. In Netherlands, asylum-seekers have access to free health care with very few exceptions (Collantes 2009, p.15). Many European countries provide this type of immigrants with access to health care like the Netherlands. But there are two remarkable exceptions; Germany and Sweden (Collantes 2009, p.178). In

Germany, asylum-seekers are seriously discriminated based on legislations, during the first four years of their stay (Collantes 2009, p.14).

Thus, Analysis B is designed based on the fact that a variation in the variable of living and working conditions exists. An application method of the most similar systems design is carried out here, meaning that the variables in these two countries are the same except one single independent variable, living and working conditions, which is hypothesized to change the outcome (Anckar 2008).

In order to make sure that the attained results show the effect of independent variable (living conditions) on the dependent variable (health status), other potentially intervening factors that might affect the outcome must be isolated. The most important factors to be isolated would be factors such as differing characteristics of the asylum-seeker populations (fixed factors) (Dahlgren & Whitehead 1991) and health expenditure of each country. In the following section, these topics are discussed briefly.

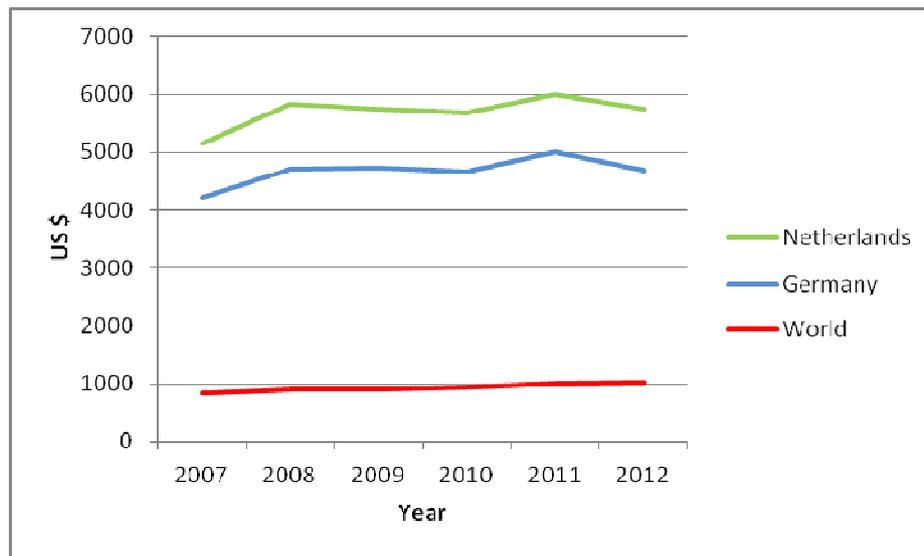
## **2.5 Intervening Factors**

For this research, living and working conditions (education, employment, food, access to health care services and housing) among the determinants of health are chosen to be studied. There are other layers of determinants of health, introduced by Dahlgren & Whitehead (1991), such as social networks, individual lifestyle and constitutional factors, as well, as we saw in the theoretical model earlier. Thus, the determinants of health other than the living and working conditions can act as intervening factors, imposing unexpected outcomes to the research. Due to this fact, the intervening factors must be recognized and isolated.

### *Health Expenditure*

“Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation” (The World Bank 2014).

Health expenditure is one of the most important factors that must be considered as an intervening factor since it can affect the outcomes of Analysis B. Based on the data from the World Bank, the health expenditures in Germany and Netherlands are as shown in Figure 3.



**Figure 3: Health Expenditure Per Capita (US \$ 24/04/2014)**  
(The World Bank 2014)

Based on Figure 3, the health expenditures in both countries are high, ranking both countries among the top 10 (OECD Health Division 2013) (WHO Department of Health Statistics and Informatics 2013). Thus, health care expenditure will not play a major role in affecting the outcomes of the comparison done in Analysis B.

### *Origin, Gender and Age*

The countries of origin of asylum-seekers are important because people coming from different countries have different health status levels. Thus, this factor must be considered when studying the effects of different living and working conditions on health status.

Gender should also be considered as an important intervening factor since gender differences affect the prevalence of health problems. They also influence the course of diseases. Health problems in men and women vary according to socio-economic status, as well. It means that gender is strongly intertwined as risk factor with socio-economic status, ethnicity, and age (Lagro-Janssen et al. 2008).

Apart from these mentioned factors, there are several other intervening factors such as the education level of the individuals, marital status and their social networks that can influence health status. In order to make sure that the results attained from Analysis B are caused by the independent variables attained in Analysis A, any possible intervening factor must be taken

into account and considered before making conclusions. This topic will be further discussed in the final chapter.

Figure 4 summarizes what has been discussed in this chapter.

| <b>Research Design and Methodology</b> |  |   |
|--|--|---|
| <b>Deductive Reasoning</b>             | <i>Theory</i>                              | Living and working conditions affect health status.   |
|  | <i>Hypothesis</i>                          | Asylum-seekers in the Netherlands enjoy better health status than the ones in Germany due to better living and working conditions.  |
|  | <i>Observation</i>                         | Structured-focused comparison (most similar cases design)<br><br>Analysis A: The objective is to conduct an idiographic case study:<br>Gathering and comparing the legal instruments shaping living and working conditions for asylum-seekers in Germany and the Netherlands<br><br>Analysis B: The objective is to conduct a hypothesis-testing case study:<br>Different entitlements attained in Analysis A (independent variable/cause)<br><br><div style="text-align: center;">↓ Affect</div><br>Health of asylum-seekers (dependent variable/effect) |
|  | <i>Confirmation (or not) of Hypothesis</i> |   |

**Figure 4: Design and Methodology of the Research**

Chapter 4 is dedicated to Analysis A, reviewing the legal instruments determining living and working conditions for asylum-seekers in Germany and the Netherlands. But before that, in the following chapter, chapter 3, the importance of living and working conditions and their influences on health status of individuals will be briefly discussed.

### **3 Effects of Living and Working Conditions on the Health of Individuals**

According to WHO constitution, health is a state of complete mental, physical and social well-being. Health is not just the absence of disease or infirmity (World Health Organization 1948). Health is determined by several factors including personal behaviors and habits, genetics, access to health care and the external environment such as housing and the quality of water (Hernandez & Blazer 2006, p.25). There are several layers of these factors, introduced by Dahlgren & Whitehead (1991), seen in Figure 1. The layers of the factors that are not fixed factors are shaped by social, political and economic forces. It is important to take into consideration that migration can exacerbate the effects of these factors on health (Davis et al. 2006, p.5).

There are several types of migrants including asylum-seekers, students, undocumented migrants and displaced people (Mladovski 2007) and these migrants face various challenges not only in the access to health care but also other social services. The lower their socioeconomic position, the more problems they face. Thus, asylum-seekers with their unstable status are among those who are more fragile to the social determinants of health and the unequal distribution of the determinants (Davis et al. 2006, p.6).

The social determinants that this research will focus on will be the ones that Whitehead and Dahlgren (1991) name as living and working conditions. These conditions include education, employment (employment conditions and unemployment), Food and water, health care access and housing.

At this part of the research, links between the named determinants of health (living and working conditions) and health will be briefly introduced. After recognizing the relation of these factors with health status, in the following chapter, the legal instruments regulating these conditions for asylum-seekers in the EU, Germany and the Netherlands will be reviewed.

#### **3.1 Education**

To assess education two standards are normally used. These standards are the number of years of completed schooling and the attained credentials. There is extensive literature on the relationship between education and its effects on health. For example, there are studies that

show the infants of mothers with higher education are less likely to die before their first birthday. The quality of education can also affect health, but it is not easy to assess that, accurately (Hernandez & Blazer 2006, p.27).

The results from the majority of the literature suggest that education level is related to health status. The higher levels of education are associated with better health status (Hernandez & Blazer 2006). There are several causal pathways that have been suggested through which the relation between the higher levels of schooling and improved health might be explained. A person with higher level of education enjoys improved health status because this person has gained the knowledge and skills that promote health, by for example adapting healthier habits and behavior. Or a person with higher education is healthier because this person's health literacy is more expanded and s/he is able to navigate the health care system. Or a person with higher levels of education enjoys mental health because of the higher status and prestige and the sense of mastery and control s/he gains through the attained education. It is not clear which pathway is the most important to improve health but all the pathways suggest that the higher the level of education is, the better the health status (Hernandez & Blazer 2006, p.28).

Thus, it can be concluded that the better the quality of education, the more the years of schooling and the more credentials attained, the better the health status. Asylum-seekers as one of the most vulnerable members of the society are also affected by this determinant of health, education. In the upcoming parts of the research, the extent of access to education for asylum-seekers in the selected countries will be discussed.

### **3.2 Employment**

Employment and working conditions are among the most important factors forming a person's social position and health status. Employment affects health not only through the employee-employer relations but also by giving the ability to the worker to provide food, housing and transportation. There are complex pathways for the relation between the employment/working conditions and health status.

There is extensive amount of literature on the relationship between employment/working conditions and the health status. An important work done in this area is called The Employment Conditions Knowledge Network (EMCONET). This study develops models to clarify how unemployment, threat of becoming unemployed, different types of jobs and

conditions can affect a person's health. Via this study pathways by which employment and working conditions affect the health of workers and their families have been identified (WHO 2014). According to this study unemployment and bad working conditions result in physical and mental illnesses (Benach et al. 2007). Pharr et al. (2012) suggest that unemployment, either voluntary or involuntary, has significant impacts on a person's mental health. There are studies that show effects of psychosocial working conditions on both mental and physical health. For example, the study by Elovainio et al. (2006) shows that job strain, effort-reward imbalance and organizational injustice are all associated with incident coronary heart disease. According to Stansfeld & Candy (2006), factors such as job strain, effort-reward imbalances, highly demanding jobs and low work social support cause mental health problems.

As a result, better working conditions result in better physical and mental health while unemployment and bad working conditions have negative effects on the health of individuals. Having recognized that, legal instruments which shape the employment conditions for asylum-seekers and affect their health status, consequently, will be discussed in the following chapter.

### **3.3 Food**

Food and adequate food are among the most important factors affecting individuals' health. Specifically women have special dietary needs due to reproduction. If women in their child bearing age do not have access to adequate food, life threatening complications during delivery or pregnancy can occur. Also, malnutrition during pregnancy can cause the death of children or long lasting consequences such as chronic illnesses, weak immune systems, mental and physical problems and weak reproductive health (United Nations High Commissioner for Refugees 2010, p.15-16).

The right to food does not mean just right to minimum amount of proteins, calories and specific nutrients. The right to food means the right to all nutrition that a person needs to live an active and a healthy life (United Nations High Commissioner for Refugees 2010, p.2).

Adequate food means that the food satisfies individual's dietary needs based on factors such as their age, health conditions, sex, living conditions and occupation. For instance, food that is energy dense but not nutritious which leads to diseases and obesity is not an adequate food.

Or if a child's food does not include nutrition needed for mental and physical development, then this food is not adequate. According to United Nations High Commissioner for Refugees, food should be safe for human to use and it must be free from substances, such as contaminants, pesticides, veterinary drugs or hormones. Additionally, adequate food must be culturally acceptable (United Nations High Commissioner for Refugees 2010, p.3). For instance, if the meat is not "Halal", then this food is not adequate for Muslims.

We should keep in mind that human rights are interdependent meaning that if one right is violated, the enjoyments of all the other rights are impaired. If the right to adequate food is violated, then, the right to health, education or life are also violated. The right to adequate food is a component of not only the right to food but also the right to health (United Nations High Commissioner for Refugees 2010, pp.5–6). For example, if a child with malnutrition does not receive adequate food, but receives health care services or vice versa, his/her human rights are violated.

### **3.4 Health Care Access**

Access to some medical services can improve health status of a whole population. Such services include contraceptive services, immunization and antibiotic treatments. Observations of health status and mortality rates have proved these measures effective. If the access to these services for some groups of society is restricted, inequality in health and excessive illnesses among them will take place. There is considerable evidence that in Europe, some groups have very restricted access to health services (Whitehead & Dahlgren 1992, p.38). Apart from access to these essential services, access to other health care services can lead to better health and quality of life, as well.

Access to health care services for migrants depends on their legal status. Undocumented migrants and asylum-seekers have the least access to adequate care. Additionally, the accessibility and quality of health services depend also on other factors such as gender, culture, financial status and geographical factors. For example, beliefs about health and illness might prevent migrants from using the health services. Health literacy meaning awareness of entitlements and availability of services plays an important role in the use of services, as well. This is especially true for the migrants regardless of their legal status or socio-economic background. When the access to the health care services is restricted, life quality decreases and the illnesses exacerbate. For instance, in the case of tuberculosis, HIV and Malaria,

multidrug-resistant illnesses can develop, if health care services are not received (Davis et al. 2006, p.11).

### **3.5 Housing**

Access to adequate housing is interrelated to the enjoyment of other human rights such as the right to health, the right to work, the right to education, vote, privacy and social security. For instance, based on the location of living, a person's ability of earning can be seriously impaired, or schools reject children whose settlements have no official status, or homeless people cannot vote and enjoy health care services. Inadequate housing has serious consequences for health, for example, if a housing has no safe drinking water and sanitation, the residents might become very ill (United Nations 2009, p.9).

A home perceived as safe and adequate can provide the residents with major physical and mental benefits. When a safe home is provided, senses of safety from outside world, identity and attachment in the individuals, alone or as a part of the family, develop. When external factors intrude and remove these feelings of safety, intimacy and control, mental and social function of the home reduces (Relph 1976). Inadequate housing can be caused by factors such as mould growth, indoor air pollution, inefficiency of heating system, lack of hygiene and sanitation as well as crowding and noise exposure (Evans 2003). These factors can result in not only mental health problems but also in physical ones.

Also housing can affect health through the education, ethnic composition and socioeconomic characteristics of the community in the neighborhood. Large number of studies show that sense of trust and collective efficacy in the neighborhood community promotes or impedes social interactions (Altgeld 2004) and consequently mental well being of residents.

Immediate housing environment affects health through the quality of design. For example, poorly planned areas usually lack public services, playgrounds, parks and walking areas which can result in obesity, loss of ability to socialize and problems in cognitive development in children. Such areas are planned somehow that people need to use individual transportations which leads to increased pollution and noise exposure, endangering most vulnerable people like children and elderly (Cohen et al. 2003).

Housing characteristics can affect a person's health through physical, mental, or social mechanisms and all the dimensions are linked to each other. As Bonnefoy (2007, p.415)

suggests, if the ministries of health and ministries of environment and social affairs intend to provide individuals with proper and adequate housing, it is necessary that they consider that

- “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,
- Housing is the conjunction of the dwelling, the home, the immediate environment, and the community,
- The role of public health is to provide the circumstances under which people can be healthy”.

Having discussed the relationship between living and working conditions and the health status of individuals, in the next chapter, legal instruments regulating these conditions for asylum-seekers will be introduced and interpreted.

## **4 Review of the Legal Instruments: Specifying the Independent Variable**

The purpose of this chapter is to review the legal instruments on health care access, housing, food, education and employment for asylum-seekers in the two countries of Germany and the Netherlands. The legal instruments on each topic will be introduced separately at EU level and national level and it will be discussed how these entitlements and conditions shaped by the laws can affect the health status of asylum-seekers.

The right to health is recognized in the national constitutions of Hungary, Italy, Belgium, the Netherlands, Portugal and Spain. National legislations in Italy (*Articles 34 and 35 of legislative Decree no. 286, 1998*) and Spain (*Article 1 of General Health Law 14, 1986*) also clarify the entitlements of migrants to health care access. But in the other EU countries, less clarification on the entitlements of migrants has resulted in very different services to be offered (Benedict 2010, p.7).

As a result of such confusing situations, since 1999, the EU has been working on setting a Common European Asylum System (CEAS), introducing directives to the member states with specific goals to be achieved, in order to build a fair system. The *Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum applicants* aims to ensure that the applicants have a dignified standard of living and that comparable living conditions are afforded to them in all member states. When analyzing the regulations on the living and working conditions for asylum-seekers at EU level, we refer to this directive and at the national level we refer to the national laws of the countries. An introduction to each of these legal instruments follows.

### *Legal Instruments at EU Level: Council Directive 2003/9/EC*

At a special meeting in Tampere on 15 and 16 of October 1999, the Council of European Union agreed to establish a Common European Asylum System based on the application of *Geneva Convention* supplemented by the *New York Protocol 31 January 1967* (points 13 and 14 of the conclusions of the Tampere European Council). This agreement led to the adoption of *Council Directive 2003/9/EC*, which ensures respect for human dignity and promotes application of Articles 1 to 18 of *Charter of Fundamental Rights of the European Union* (Council of European Union 2003).

*Council Directive 2003/9/EC* has entered into the force on 6<sup>th</sup> of February 2003, laying down minimum standards for the reception of asylum-seekers. The purpose of this directive is to ensure that the asylum-seekers have a comparable dignified standard of living in all the EU member states (Official Website of European Union), which will consequently result in limiting the secondary movement of asylum-seekers affected by different reception conditions (Council of European Union 2003). According to this directive, based on the nature of minimum standards, states have the power to introduce or maintain more favorable provisions.

The directive applies to all nationals of third countries and stateless persons who ask for asylum at the territory or border of the member states, who must be immediately informed about their rights, benefits as well as their obligations.

### *Legal Instruments in Germany: AsylbL, AsylVfG and SGB*

In Germany, the right to asylum is recognized and regulated based on *Asylum Procedure Act/Asylverfahrensgesetz*, abbreviated *AsylVfG*. Alongside with that, the rights, entitlements and obligations for asylum-seekers are covered in *Asylum-seekers Benefit Act/Asylbewerberleistungsgesetz*, abbreviated *AsylbLG* (Federal Republic of Germany 1993). This Act has entered into force on 1<sup>st</sup> of November 1993.

At the early 1990s, great number of Yugoslavian civil war refugees fled to Germany as well as other types of asylum-seekers from other countries. The German government had to take an action regarding the massive number of immigration to the country. Thus, in December 1992, after an asylum debate, the German governing parties CDU/CSU, SPD and FDP decided on the creation of *Asylum-Seekers Benefit Act (AsylbLG)* (Bundesamt für Migration und Flüchtlinge 2011). The aim of the government by taking this measure was to prevent the abuse of the right to asylum and limit the incentive for the asylum-seekers to go to Germany just due to the high level of standards (Bundesverfassungsgericht 2012, para.121).

In §1 of *AsylbLG*, all the beneficiaries which are the different types of asylum-seekers are named. Then in §2 Subparagraph 1, it is stated that these beneficiaries, for a period of 48 months, will benefit from § 3 to §7 of *AsylbLG* and after the 48 months, the Twelfth *Book of the Social Code/Sozialgesetzbuch (SGB)* will be applied to them only if they have not manipulated the duration of the residence. The paragraphs applied during the first 4 years are: §3 basic services, §4 sickness, pregnancy and birth, § 5 job opportunities, § 6 other services

and § 7 income and assets. The Twelfth *Book of the Social Code (SGB: Sozialgesetzbuch XII)*, which be applied to them after 48 months just like German citizens is titled “Social Help”.

### *Legal Instruments in the Netherlands: Aliens Act 2000, COA, RVA and RVB*

The *Netherlands Aliens Act (2000)* has entered into force on April 2001. The purpose of this act is to regulate admission of aliens in to the Netherlands. Based on this act, the rules are clearer and the procedures are shorter which result in faster decisions on applications for residence permit while maintaining high standards (The Ministry of Justice 2004, p.3)

According to the Article 11 §2 Subparagraph B of *Aliens Act 2000*, an asylum-seeker (a type of alien) is granted entitlements to facilities, benefits in kind and social security benefits if s/he is residing in this country lawfully and her/his entitlements are granted by the *Act of the Central Reception Organization for Asylum-Seekers (COA)* (The Netherlands 1999).

*The act of 19 May 1994 laying down rules for the establishment of an independent administrative body in charge of the material and immaterial reception of asylum-seekers* puts COA in the position of taking care of asylum-seekers (D’Ancona 1994). COA is responsible for asylum benefits, which are further elaborated in two ministerial regulations: *the Regulation on Provisions to Asylum-Seekers/Regeling Verstrekkingen Asielzoekers en Andere Categorieen Vreemdelingen (RVA)* and *Scheme Benefits in Certain Categories of Aliens/Regeling Verstrekkingen Bepaalde Categorieen Vreemdelingen (RVB)*.

This chapter will be dedicated to responding the first research question:

- What are the existing legal instruments on the education, employment, food, health care access and housing (living and working conditions) for asylum-seekers in Germany and the Netherlands?

The objective of this section is to carry out an idiographic case study by going through the laws and providing good descriptions which will be used in subsequent analysis (George & Bennett 2005, p.75).

For each topic, the legal instruments on international, EU and national levels will be discussed.

## **4.1 Legal Instruments on Education**

Education is a powerful tool for economically and socially marginalized adults and children to lift themselves out of poverty and participate fully as citizens. Education is a fundamental human right and important for the exercise of other human rights. It promotes individual freedom and empowerment and yields important development benefits (UNESCO 2014).

According to the *Universal Declaration of Human Rights of 1948*, everyone has a right to education. Elementary education shall be compulsory and free.

Article 28 of the *Convention on the Rights of the Child (CRC)*, effective since 1990, recognizes the child's right to education without discrimination and schools must be accessible to all children.

United Nations and UNESCO, through their normative instruments, lay down international legal obligations for the right to education. “These instruments promote and develop the right of every person to enjoy access to education of good quality, without discrimination or exclusion. These instruments bear witness to the great importance that Member States and the international community attach to normative action for realizing the right to education. It is for governments to fulfill their obligations both legal and political in regard to providing education for all of good quality and to implement and monitor more effectively education strategies” (UNESCO 2014). Education for All (EFA) is, for instance, a global movement guided by UNESCO which contains six internationally agreed goals. These goals focus on assuring access to quality education for all, including children in difficult situations.

Despite all the efforts done by the United Nations and UNESCO, all the treaties and declarations, there are still many children that have no access to education or quality education, among which there are asylum-seekers and undocumented migrants.

In the following parts, the laws for asylum-seekers regarding their access to education in EU, Germany and the Netherlands will be reviewed.

### **4.1.1 EU**

Article 10 and Article 12 of the *Council Directive 2003/9/EC* refer to education of minors and vocational training for adults, as shown in Figure 5.

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum Seekers  |
|-----------------------------|--|
| Chapter II                  | General Provisions and Reception Conditions  |
| Chapter II Article 10       | Schooling and Education of Minors  |
| Chapter II Article 10 § 1   | Access to education for asylum minors and continuation at the secondary level                                  |
| Chapter II Article 10 § 2   | Delay in access maximum three months, or one year when other ways of access are offered                        |
| Chapter II Article 10 § 3   | Where access to the education system is not possible, the Member State may offer other education arrangements. |
| Chapter II Article 12       | Vocational Training  |
|                             | Member States may allow asylum seekers access to vocational training   |

**Figure 5 : Education for Asylum-Seekers in  
 Council Directive 2003/9/EC**

The Council Directive obliges the States to give access to education to the minor asylum-seekers and sets time limits for delay in this access. It also gives guidelines for vocational training and other types of educational arrangements. However, the use of the word “may” makes the use of the guidelines very optional. For complete text of the Articles, see appendix.

The main concern with this provision is that it gives permission to the Member States to educate the children of asylum-seekers and minor asylum-seekers separate from the mainstream education system. According to the directive, education can also be provided in the accommodation centers and this means removal of children from mainstream education. This way of educating asylum children “... may be regarded as a form of ‘segregation’ that could lead to stigmatization of these minors and impair or at least delay their integration” (Da Lomba 2004, p.242).

According to the directive, the access to the education might be delayed up to three months and up to one year if specific education is provided. This regulation might be helpful for the children who need specific help to enter the State education system but on the other hand it might result in separation and isolation of asylum children from the mainstream education (Cholewinski 2004, pp.17).

Apart from the provisions for the access of asylum minors to education, the Directive also addresses access to vocational training in Article 12. But the provision is very disappointing since “...it contains no firm State obligation and is drafted in permissive terms” (Cholewinski 2004, p.20)

#### **4.1.2 Germany**

As explained earlier, the asylum-seekers in Germany, during the first four years, enjoy the benefits offered by *AsylbLG* § 3 to § 7. Education or vocational training are not mentioned in any of the *AsylbLG* sections. However §6 of *AsylbLG* mentions that

*"Other benefits may be granted in particular when they are necessary in individual cases indispensable for securing the livelihoods and health, offered to meet special needs of children or to meet an administrative duty to cooperate."*

If we consider education as necessary to meet particular needs of children, then, they can be granted with provisions for access to education. The minors can apply for access to education and in case of a rejection, a complaint can be filed (Voigt & Hügel 2011, p.10).

Education and training for asylum-seekers in Germany are regulated in part by federal laws and partly by state laws. While the constitution identifies the right to equal opportunity to education for foreign children, individual states interpret the access to education differently. A comparative look at different states is helpful in providing an image of how the access to education for asylum-seekers works. Pelzer et al.(2003) have done such comparative study, results of which are briefly presented here.

According to Pelzer et al. (2003), the state of Berlin has already agreed on the access to educational package for children and adolescents in the context of § 6 *Asylum-Seekers Benefits Act (AsylbLG)*, as binding. In Rhineland-Palatinate, Saarland and Thuringia, the compulsory education of refugee children and adolescents is dependent on their status. A compulsory education is not accepted at an uncertain status such as toleration. In other states such as Saxony and North Rhine-Westphalia, there is a right or entitlement to attend school. In Bavaria, Berlin, Brandenburg, Bremen, Hamburg, Hessen, Lower Saxony and Schleswig-Holstein education for all children is compulsory. In Bremen, asylum-seekers are excluded from access to education as long as they are in the reception centers. In Lower Saxony, education for children without legal residence status is compulsory but they often do not go to school due to fear of being investigated at school.

In practice, the asylum procedure can take up to several years. When it is possible for the minors to attend mainstream education finally, they are already too old to be included in

mainstream schools. Also, attainment of qualifications is not mentioned anywhere in the laws. Thus, students finish secondary or high school but get no qualifications in the end.

Neither compulsory education law nor schools guarantee places for asylum students. Other factors such as the offer of incentives, individual decisions, regional openness or spatial conditions play an important role in the attendance of asylum-seekers in the education (Pelzer et al. 2003).

#### **4.1.3 The Netherlands**

*Compulsory Education Act (1969)* lays down rules for obligatory attendance at school. In the Netherlands, all children, regardless of immigration status, from the age of five must attend full time school for 9 years or till the end of the school year when they turn 16 (including asylum-seekers whose appeal rights have been exhausted). A primary school is linked to each asylum-seekers' centre, but parents can choose a school for their children, as well.

For adult asylum-seekers, the access to education is limited to activities with a focus on integration into Dutch society, including vocational, language and cultural lesson (van Gelder 2003, p.4) offered by COA.

Adults who would like to have an education at university can get help from the Refugee-Students Association UAF. The UAF helps asylum-seekers by providing information, advice and guidance, finding work and providing financial support. But in order to receive this help the asylum-seekers must satisfy some conditions such as being fluent in Dutch (UAF 2014).

### *Conclusion*

There are several international agreements that recognize the right of everyone to education. There have been efforts to make education accessible to all, especially to the children. Asylum children are not excluded from these rights, either.

*EU Council Directive 2003/9/EC* sets some standards for the access of asylum-seekers to education but some ambiguities exist that make the minimum standards not clear. The way each country handles the access of asylum-seekers to education still varies widely.

| Education and Training |        |                      |
|------------------------|--------|----------------------|
|                        | Minors | Adults               |
| Minimum Standards      | √      |                      |
| Asylum Seekers in DE   | √      | Only in a few Länder |
| Asylum Seekers in NL   | √      | √                    |
| National Citizens      | √      | √                    |

**Figure 6 : Access to Education or Training**

Figure 6 shows that national citizens have access to education and vocational training with no specific restrictions. *Council Directive 2003/9/EC*, setting minimum standards for reception of asylum-seekers in the EU, mentions that the minor asylum-seekers must have access to education. It leaves the states free to choose how this access will be and also does not oblige the states to provide adult asylum-seekers with education and training opportunities.

As a result, Germany provides minors with access to education but mostly keeping them separate from mainstream education system. Every Land handles this situation in their own way but very few of them provide adults with education or training. In the Netherlands, not only the children but also adults have access to education but in order to get help they must fulfill some conditions.

Taking all the described situations into account, one might interpret that the Council Directive, with its minimum standards, cannot harmonize and guarantee equal access to education in the asylum systems, leaving so much space for the states to choose the extent of access. It can also be interpreted that in the Netherlands minor and adult asylum-seekers enjoy more access to the education and training than the ones in the Germany.

## **4.2 Legal Instruments on Employment**

According to the *Universal Declaration of Human Rights (1948)*, everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.

The *International Covenant on Economic, Social and Cultural Rights (1966)* recognizes the right to work, as well, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right. According to this covenant the steps to be taken for the full realization of this right “include technical and vocational guidance and training programs, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual”.

*ILO Employment Policy Convention (1964)* is one of the international instruments which aims at ensuring that “there is work for all who are available for and seeking work; such work is as productive as possible; there is freedom of choice of employment and the fullest possible opportunity for each worker to qualify for, and to use his skills and endowments in, a job for which he is well suited, irrespective of race, color, sex, religion, political opinion, national extraction or social origin”.

The entitlements to employment and the employment conditions are one of the effective social determinants of health. The laws and regulations on employment for asylum-seekers in the EU, Germany and the Netherlands are introduced in the following parts.

### **4.2.1 EU**

Article 11 of the *Council directive 2003/9/EC* is concerned with setting minimum standards for Employment of asylum-seekers. States have the power to introduce or maintain more favorable provisions. Figure 7 shows this article briefly. For the complete text of the Articles, see appendix.

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum-Seekers   |
|-----------------------------|---|
| Chapter II                  | General Provisions and Reception Conditions   |
| Chapter II Article 11       | Employment  |
| Chapter II Article 11 §1    | A period of time during which an applicant shall not have access to the labour market, decided by the States                                      |
| Chapter II Article 11 §2    | Member States shall decide the conditions for granting access to the labour market for the applicant if the waiting is already more than one year |
| Chapter II Article 11 §3    | Access to the labour market during appeals procedures   |
| Chapter II Article 11 §4    | Priority to EU citizens, nationals of States and to legally resident third-country nationals  |

**Figure 7 : Employment for Asylum- Seekers in  
 Council Directive 2003/9/EC**

The idea of setting a period of time after which the asylum-seekers can access the labor market has been supported widely. It is important that asylum-seekers can look for employment as soon as possible. The right to work is very important to protect asylum applicants against social exclusion, to facilitate their integration and to promote their self-sufficiency. Additional conditions created by the States on asylum-seekers' access to employment might include conditions such as work permit requirements, limitation of the right to work to specific economic sectors and severe time restrictions. Such conditions hinder the access to employment in practice. Some restrictions also encourage underground employment, which makes asylum-seekers vulnerable to exploitation (ECRE 2009, p.10).

Thus, the conditions that are set by Member States on the employment of asylum-seekers can delay and restrict the access and ECRE (2009) suggests that "... the European Commission should step up its efforts to monitor the impact of additional conditions imposed by Member States and hold them accountable for any breach in their obligations concerning access to employment".

#### **4.2.2 Germany**

§ 5 of *AsylbLG* is concerned with the conditions of job opportunities for asylum-seekers in Germany. According to that, asylum-seekers are provided with hourly job opportunities which are paid 1.05 Euros an hour. The employment does not cover pension and health insurance. If the asylum-seeker who is capable of working does not cooperate in getting a job, s/he will not be entitled to benefits, any more. For complete text of the law, see appendix.

The jobs that have a salary of 1.05 Euros are for example, childcare and cleaning / tidying of the Kindergarten, telephone service, interpreting services, office ancillary activities, cleaning hallways and stairwells, cleaning the kitchen area and of community and living rooms,

cleaning of sanitary areas (toilets and showers), cleaning the outdoor area and painting (Classen 1999).

Contrary to the first impression that one has from § 5 of *AsylbLG*, this article does not mean that all asylum-seekers must be provided with an employment service. It means that as many job opportunities as possible must be created for them (Classen 1999).

In practice, social services offer (to save on budget) often no job opportunities when beneficiaries are willing to work. Since the social welfare offices are obliged to create appropriate agencies and job opportunities for the beneficiaries, the beneficiaries can attempt to make a claim to an appropriate body liable for an increase of their pocket money (Classen 1999).

In Baden-Württemberg, Saarland, Bremen and Hamburg, there are opportunities especially in mini-jobs in restaurants, newspaper delivery and cleaning. In Hessen, refugees receive a stamp in their paper, which allows them to work 20 hours a week without the need to get a work permit. In Schleswig-Holstein seasonal work in agriculture, tourism and in grocery stores is possible. In Thuringia, Saxony-Anhalt, Brandenburg and Berlin, there is almost no chance for work. In Mecklenburg-Vorpommern, it can take up to 2 years till a work permit procedure is done (Pelzer et al. 2003).

Refugees can work without applying for a work permit for 1-2 EUR / hour. This form of community service is readily accepted in some regions, such as Bremen, Brandenburg, Thuringia, in Berlin, Baden-Württemberg and Saarland and Hessen.

§ 61 of *Asylum Procedure Act (AsylVfG)* mentions employment of asylum-seekers in Germany, as well. According to that, as long as an asylum-seeker is living in a reception center, s/he is not allowed to be employed. It also states that an asylum applicant who has lawfully resided in the Federal territory for a year may take up an employment.

The refugees consider the prohibition of work and also shared accommodations as an attack on their personal dignity. Their exclusion from work and life in German society has shown to cause mental and physical illnesses over time (Classen 2009, p.2).

### **4.2.3 The Netherlands**

As mentioned earlier, *the act of 19 May 1994 laying down rules for the establishment of an independent administrative body in charge of the material and immaterial reception of asylum-seekers* makes COA responsible for taking care of asylum-seekers in the Netherlands.

According to COA, asylum-seekers may work a maximum of 24 weeks with pay in the Netherlands. Any income is deducted from their clothing and pocket money. Occupants wishing to work must find their own job. COA gives advice, but does not mediate. The occupants are involved in the day-to-day work at the asylum-seekers' centre and the grounds. They are paid a small amount for this. Occupants may also carry out voluntary work outside the asylum-seekers' centre.

The Immigration and Naturalization Services of the Netherlands set some other conditions for employment of asylum-seekers, as well. The conditions are that the asylum-seekers are not allowed to work during the first 6 months of reception and afterwards they must attain a work permit via the help of the future employer in order to be allowed to work (Immigration and Naturalization Services).

### *Conclusion*

The *Universal Declaration of Human Rights (1948)* states that everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.

The *Council directive 2003/9/EC* laying down minimum standards for the reception of asylum-seekers, gives the asylum-seekers the right to work but also gives the states the right to decide on the work conditions and the period length that the asylum-seekers are not allowed to work.

Article 31 of *EU Charter of Fundamental Rights (2009)* defines fair and just work conditions as conditions in which every worker has the right to working conditions which respect his or her health, safety and dignity and in which every worker has the right to limitation of maximum working hours, to daily and weekly rest periods and to an annual period of paid leave.

Based on the definition of fair and just working conditions by *EU Charter of Fundamental Rights*, neither Germany nor the Netherlands provide the asylum-seekers with fair conditions since they put limitations and interfere with the conditions of work, as shown in Figure 8.

|                             | The Right to Work | Fair and Just Working Conditions                            |
|-----------------------------|-------------------|---|
| <b>Minimum Standards</b>    | √                 | ×   |
| <b>Asylum Seekers in DE</b> | √ After 1 Year    | × e.g. 1.05 Euros per Hour, Pressure to Do the offered jobs |
| <b>Asylum Seekers in NL</b> | √ After 6 Months  | × e.g. Maximum 24 Weeks a Year, Need a Work Permit          |
| <b>National Citizens</b>    | √                 | √   |

**Figure 8 : The Right to Work and Access to Fair Working Conditions**

The *Council Directive 2003/9/EC* puts the Member States in charge of deciding over the conditions of work for asylum-seekers and that makes working conditions of the both countries unfair or unjust. The biggest difference is that in the Netherlands, the asylum-seekers are allowed to get a job after 6 months after they have applied for asylum and in Germany, after one year. In both cases, there are many obstacles for asylum-seekers to find suitable jobs and it is very hard to get in to jobs that match their qualifications.

### **4.3 Legal Instruments on Food and Water**

According to UN Office of High Commissioner for Human Rights (2014b), every person must have access to sufficient water. The access must also be continuous to meet the needs of drinking, food preparation, washing and hygiene. This water must be safe and free from elements that can threaten an individual's health. The color and smell of the water must be acceptable. Water and sanitation must be within safe reach of population and accessible for all, including children, people with disabilities and elderly. And lastly, water must be affordable for all. No one should be denied the access to safe water due to inability to pay for it.

The right to water is recognized in several international treaties and declarations. The 1979 *Convention on the Elimination of All Forms of Discrimination Against Women* and the 1989 *Convention on the Rights of the Child*, specifically recognize the right to water. The *United Nations Committee on Economic, Social and Cultural Rights* gives the clearest definition of the right to water by affirming that access to water is a condition for the enjoyment of the right to an adequate standard of living and to the right to the highest attainable standard of health.

The access to the water is not an issue for the reception of asylum-seekers since they are not denied with the access. However, food is a topic of discrimination in asylum. The focus of this part of the research will be on the access of asylum-seekers to food.

According to the UN *Special Rapporteur on the Right to Food* (2014a) "...the right to food is the right to have regular, permanent and unrestricted access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensure a physical and mental, individual and collective, fulfilling and dignified life free of fear".

This definition is compatible with the main elements of the right to food as defined by *General Comment No. 12 of the United Nations Committee on Economic, Social and Cultural Rights* (1999), which declares that "...the right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or means for its procurement. The right to adequate food shall

therefore not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins and other specific nutrients. The right to adequate food will have to be realized progressively. However, States have a core obligation to take the necessary action to mitigate and alleviate hunger even in times of natural or other disasters” (UN Office of High Commissioner for Human Rights 2014a).

#### 4.3.1 EU

In the *Council Directive 2003/9/EC*, "material reception conditions" means “the reception conditions that include housing, food and clothing, provided in kind, or as financial allowances or in vouchers, and a daily expenses allowance”. Thus, food is included in the parts that material reception conditions are mentioned, as shown in Figure 9. For complete text, see appendix.

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum Seekers  |
|-----------------------------|--|
| Chapter II                  | General Provisions and Reception Conditions  |
| Chapter II Article 13       | General Rules on Material Reception Conditions and Health Care   |
| Chapter II Article 13 §1    | Ensuring availability of material reception conditions to applicants   |
| Chapter II Article 13 §2    | Ensuring a standard of living adequate for the health of applicants  |
| Chapter II Article 13 §5    | Material reception conditions provided in kind, or in the form of financial allowances or vouchers or in a combination of these provisions |

**Figure 9 : Material Reception Conditions in Council Directive 2003/9/EC**

UNHCR shows concerns regarding the voucher system since prejudices and discrimination against asylum-seekers who are obliged to use vouchers for shopping have been observed (United Nations High Commissioner for Refugees 2003, p.12) and experience shows that the Member States have been retaining the power to introduce more favorable provisions (Cholewinski 2004, p.15).

The guidelines suffer from ambiguities. An ‘adequate standard of living’ in Article 13 §2, must be more accurately defined, otherwise Member States provide standards, which are too low for asylum-seekers. Also, the possibility of providing material reception provisions in vouchers from the Reception Directive must be removed, because “...they encourage stigmatisation and discriminatory behavior towards asylum-seekers (European Council on Refugees and Exiles 2005, p.21).

### 4.3.2 Germany

§ 3 of *AsylbLG* in Germany, with the title of “Basic Services” mentions the provision of food and states that the necessary demand for food, housing, heating, clothing, health and personal care and household goods are covered by contributions in kind. They can also be provided in the form of vouchers or other similar non-cash settlements.

The Federal Constitutional Court (Bundesverfassungsgericht – BVerfG) on 18 July 2012 decided that the cash benefits in accordance with the Asylum-Seekers Benefits Act (*Asylbewerberleistungsgesetz – AsylbLG*) are not adequate. After this decision, the following monthly cash benefits were determined for the asylum-seekers, shown in Figure 10, and compared with the benefits that the national citizens receive;

|                                      | Asylum-Seekers   | National Citizens             |
|--------------------------------------|--|-------------------------------|
| Single Persons or Adult Lone Parents | a. 217 € (physical existential minimum); b. 137 € (socio-cultural existential minimum) | 382 € (standard need group 1) |
| Spouse or Civil Partner              | a. 195 € (physical existential minimum); b. 123 € (socio-cultural existential minimum) | 345 € (standard need group 2) |
| Adult Members of the Household       | a. 173 € (physical existential minimum); b. 110 € (socio-cultural existential minimum) | 306 € (standard need group 3) |
| Children Aged from 14 to 18          | a. 193 € (physical existential minimum); b. 81 € (socio-cultural existential minimum)  | 289 € (standard need group 4) |
| Children Aged from 6 to 14           | a. 154 € (physical existential minimum); b. 88 € (socio-cultural existential minimum)  | 255 € (standard need group 5) |
| Children Aged up to 6                | 130 € (physical existential minimum); b. 80 € (socio-cultural existential minimum)     | 224 € (standard need group 6) |

**Figure 10 : Monthly Cash Benefits for Asylum-Seekers and National Citizens  
in Germany (EMN 2013)**

The amount of monthly allowance to be granted in each individual case depends on the further circumstances of the individual case. Cash benefits are only a part of the support that the asylum-seekers receive. Public authorities pay the costs of housing and heating. Food, clothes and health care are given to them in the shape of benefits in kind. Household durables are granted on a loan basis. Due to the benefits in kind, asylum-seekers get cash benefits only to cover their socio-cultural existential minimum (EMN 2013, pp.12–16).

The physical existential minimum which is mentioned at letter (a) in the table above is partly granted as a cash and partly as a benefit in kind; the procedure is not uniform and is implemented differently in each of the Federal Länder.

### **4.3.3 The Netherlands**

As mentioned before, the Centraal Orgaan opvang asielzoekers (The Central Agency for the Reception of Asylum-Seekers: COA) is responsible for the reception of asylum-seekers. The reception is provided in reception centers throughout the country, which are all run by COA. COA controls all the asylum procedures through *RVA* and *RVB*. Food is mentioned in Article 9, paragraph 1 of the *Rva (2005) (Regeling verstrekkingen asielzoekers, Regulation Provisions Asylum-Seekers)*. This article states that in all reception centers asylum-seekers receive:

- accommodation;
- a weekly financial allowance for food, clothing and other personal expenses;
- a non-recurrent clothing allowance;
- recreational and educational activities;
- coverage of medical supplies in accordance with an arrangement for medical expenses;
- liability insurance; and
- allowance for exceptional costs

The amount of the provisions that the asylum-seekers receive in the Netherlands is based on the minimum social benefits that nationals of the Netherlands receive. The rates of support provided to asylum-seekers is also linked to the standard rates for daily spending on food, which is set by the Netherlands National Institute for Family Finance Information. Thus, asylum-seekers enjoy benefits almost 100% like the support and benefits that are provided to nationals of the country. (EMN 2013, pp.24–25)

## *Conclusion*

Food and water have been recognized as human rights in several international agreements. The situation of asylum-seekers differs from the ones in poor countries. For those poor ones aid is needed to provide them with food and water. However, the asylum-seekers in Europe are already where there is abundant food and water and they need provisions to attain these rights.

*Council Directive 2003/9/EC* sets some rules for these provisions but they are ambiguous again and by giving the permission to the states to give the provisions as vouchers or goods, the asylum-seekers are discriminated.

As mentioned earlier, adequate food does not only mean enough calories or protein, but also access to appropriate material for individual's diet or culture. That is why, the provision of food in kind cannot be considered as adequate food. The asylum-seekers in Germany are provided with such kind of food provision while the ones in the Netherlands receive the provision in cash and can buy the food appropriate for them.

In case, the asylum-seekers do not want to eat the food that is provided in kind to them, they have to use their allowance to buy what is appropriate for them. Based on what was studied in the previous parts, the allowance that the asylum-seekers get in the Netherlands is as much as the national citizens but the allowance that the asylum-seekers in Germany receive is much less than national citizen. It means that if they use their allowance on the food and their other needs like social activities or clothes will not be satisfied.

Thus, if we consider access to adequate food as access to appropriate food for the culture and diets without the need to compromise the satisfaction of other needs, it can be concluded that compared to national citizen and asylum-seekers in the Netherlands, the asylum-seekers in the Germany do not have access to adequate food, as shown in Figure 11.

|                             | <b>Adequate Food</b> |
|-----------------------------|----------------------|
| <b>Asylum Seekers in DE</b> | ×                    |
| <b>Asylum Seekers in NL</b> | √                    |
| <b>National Citizens</b>    | √                    |

**Figure 11 : Access to Adequate Food**

#### **4.4 Legal Instruments on Health Care Access**

On the one hand, there are laws and guidelines, which give the impression that access to health care is everyone's right and no restrictions on that are allowed. For example, in Article 25 § 1 of *The Universal Declaration of Human Rights 1948*, it is stated that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...". Complying with that, Article 14 of *Resolution on Respect for Human Rights in the European Union in 1994*, represents a European Union system for the protection of human rights which affirms the right to the highest possible standards of health care which should be available according to the needs of a person.

But on the other hand, laws like Article 35 of *Charter of Fundamental Rights of the European Union 2007* state that "everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices". Such "conditioning" gives the states much power and possibility to shape the laws on right to health care access based on their own choice and interests. Accordingly, health policy on asylum-seekers can be very different among EU countries to the extent that these differences sometimes result in the fact that the asylum-seekers' health needs are not met adequately (Norredam et al. 2005, p.285).

Such controversy and the need for harmonization between the reality of national laws and the goals of European Union or human rights have led to the creation of several important directives on the situation of asylum-seekers in the EU, setting minimum standards for treating them. But whether these directives can do enough to fix such imbalances in the EU, is a matter to be discussed.

Before getting to the national laws of Germany and the Netherlands on health care access for asylum-seekers and comparing them, related parts of EU *Council Directive 2003/9/EC*, aiming at the rights of asylum-seekers for health care access, will be studied in order to find out how powerful these directives are in binding, to find any loopholes and to find the extent of leeway in them, resulting in the current national legislations on health care access for asylum-seekers in Germany and the Netherlands.

#### 4.4.1 EU

Health and access to health care is one of the topics which the *Council Directive 2003/9/EC* sets rules for through chapters II, III and IV in order to harmonize the conditions for the reception of asylum-seekers among the member states. In Figure 12, the articles and paragraphs mentioning health and health care access for asylum-seekers are presented. For complete text of laws, see appendix.

| Council Directive 2003/9/EC |  | Shall | May |
|-----------------------------|--|-------|-----|
| <b>Chapter II</b>           | <b>General Provisions and Reception Conditions</b>   |       |     |
| Chapter II Article 5 §1     | Informing the applicants about reception conditions, including health care, in 15 days   |       |     |
| Chapter II Article 9        | Medical screening of applicants on public health grounds   |       |     |
| Chapter II Article 13 §2    | Provisions by state on reception conditions to ensure standard of living adequate for applicants' health                                   |       |     |
| Chapter II Article 13 §3    | Provisions by state on reception conditions to ensure standard of living adequate for health of the ones that do not have sufficient means |       |     |
| Chapter II Article 13 §4    | Refund or contribution from the applicant for health care if they have sufficient resources  |       |     |
| Chapter II Article 15 §1    | Emergency care and essential treatment of illness  |       |     |
| Chapter II Article 15 §2    | Medical assistance for special needs   |       |     |
| <b>Chapter III</b>          | <b>Reduction or Withdrawal of Reception Conditions</b>   |       |     |
| Chapter III Article 16 §4   | Access to emergency health care even in withdrawal or refusal  |       |     |
| <b>Chapter IV</b>           | <b>Provisions for Persons with Special Needs</b>   |       |     |
| Chapter IV Article 17 § 1   | Health care for vulnerable   |       |     |
| Chapter IV Article 18 § 2   | Rehabilitation for minors  |       |     |

**Figure 12: Health Care Access for Asylum-Seekers in  
 Council Directive 2003/9/EC**

As observed in Figure 12, there are 10 paragraphs in this directive that mention health care for asylum-seekers during reception. 3 paragraphs among them are not mandatory. The term “may” is used in these paragraphs in order to give the states the power to choose whether they want to implement that guideline or not. Thus, based on Article 9, the states may do a medical screening on applicants for public health reasons. Based on Article 13 §3 and §4, the states may give more provisions to those in more need to ensure their well-being and health in reception and the states may ask the applicants for refund and contribution for the health care they have received.

The rest of the paragraphs contain the term “shall”, which makes them mandatory for the states to follow. Even though binding, some of these paragraphs lack adequate and explicit explanations. In Article 13 § 2, it is not clear what exactly is “adequate provisions” to ensure

a person's health. In Article 15 §1, the directive states that "member states shall ensure that applicants receive the necessary health care, which shall include at least emergency care and essential treatment of illness" but it is unclear what is meant by "essential treatment". This paragraph either serves as a tool to improve the standard of reception at some countries or allows some countries to lower their provisions of health care to just emergency care (Norredam et al. 2005, p.289). Paragraph 2 of the same article states that "member states shall provide necessary medical or other assistance to applicants who have special needs". It will surely require some countries to enhance their level of health service provision for asylum-seekers. However, the paragraph could be more explicit in its requirements of what constitutes "necessary medical or other assistance" (Norredam et al. 2005, p.289).

Thus, based on these paragraphs of the directive, special medical and psychological care must be given to pregnant women, elderly, minors, the mentally ill, the disabled and victims of rape and other forms of violence. However, in 2004, asylum-seekers in 10 of 25 EU states were provided with just emergency care (Norredam et al. 2005, p.288). This situation indicates that even though the directive attempts to create a common system and set minimum standards for asylum-seekers, it suffers from some ambiguity, which allows creation of widely differing national laws

Certainly, the directive has been contributing to some extent to the development of a common European asylum system. According to Norredam et al. (2005), the directive does provide asylum-seekers with certain minimum reception standards regarding access to health care, which the member states are obliged to fulfill. But "the flexible and general character of the articles allow member states to maintain very different national policies that in some cases may fall short of an adequate standard of health care".

As a result, health care provisions for asylum-seekers are still so different among EU member states and some countries limit the rights to only the minimum standards. The terms that are used in the directive, as mentioned before, are broad and not explicit, thus, it is up to the states to decide on how much medical rights and care they give to their asylum-seekers as long as they provide them with at least the minimum.

#### **4.4.2 Germany**

Only in Germany, the legal access to health care for asylum-seekers changes over the time (Norredam et al. 2005, p.288). After 48 months of their arrival, asylum-seekers get full access

to care like the German citizens. But during the first 48 months, they have very limited access to health care and this period is the focus of this research.

The paragraphs and subparagraphs in *AsylbLG* which mention health care access for asylum-seekers are presented in Figure 13. For complete text of laws, see appendix.

| <b>Asylum-seekers Benefit Act (AsylbLG) 1993</b> |   |
|--|---|
| <b>§3</b>  | <b>Basic Services</b>   |
| AsylbLG § 3 Subpara. 1                           | In-kind provision of food, housing, heating, clothing, health care and household goods by the state plus an allowance |
| <b>§4</b>  | <b>Sickness, Pregnancy and Birth</b>  |
| AsylbLG § 4 Subpara. 1                           | Treatment of acute diseases and pain  |
| AsylbLG § 4 Subpara. 2                           | Care for pregnant women and new mothers   |
| AsylbLG § 4 Subpara. 3                           | Medical/dental care, vaccinations and checkups  |
| <b>§6</b>  | <b>Other Services</b>   |
| AsylbLG § 6 Subpara. 1                           | Benefits for children with special needs to secure their health (can be in cash)                                      |
| AsylbLG § 6 Subpara. 2                           | Care and assistance for vulnerable persons or persons with special needs  |

**Figure 13: Health Care Access for Asylum-Seekers in AsylbLG 1993**

Based on § 4 *AsylbLG*, free of charge treatment is given to asylum-seekers just in case of pain, acute diseases, to the pregnant women and new mothers. If asylum-seekers have chronic illnesses or disabilities, they will be treated only in case of acute pain. Also a lot of limitation is put on dentures (Groß 2005, p.7).

In §6 Subparagraph 1, it is stated that “Other benefits may be granted in particular, if they are necessary in individual cases indispensable for securing the livelihood and health...”. In practice, granting these rights come to many limitations. For outpatient care, a Krankenschein (health insurance certificate) from social welfare office must be attained. In this situation, there is leeway for arbitrariness and harassment (Groß 2005, p.8). Firstly, if a patient has pain, s/he cannot go to doctor directly and instead should wait first for an appointment with social welfare office (Classen 2009, p.8). At the appointment, the officer at the social welfare office might not believe in the asylum-seekers pain (Groß 2005, p.8). If the pain and problem is accepted by the officer, the whole procedure can take up to weeks or months till the asylum-seeker can visit the doctor that the office has chosen for him/her (Classen 2009, p.8). If they try to visit a doctor without a Krankenschein, either they are rejected or they have to pay for the care (Proasyl). Sometimes the care given in the hospitals is unlawfully limited to only life-threatening or unpostponable cases (Groß 2005, p.8).

Apart from these paragraphs in *AsylbLG*, asylum-seekers are mentioned in the *Book of Social Code V (Sozialgesetzbuch V)* and the *Book of Social Code XII (Sozialgesetzbuch XII)*, which apply to them after 48 months. In *SGB V §264 Subparagraph 2*, it is stated that asylum-seekers can enjoy Statutory Health Insurance like German nationals and *SGB XII* is about the social helps that they can get. The focus of this research will be on the first 48 months, in the course of the application of the laws by *AsylbLG*. See Figure 14

| Access to Health Care |  |   |   |   |                       |  |
|-----------------------|--|---|---|---|-----------------------|--|
|                       |  | Primary   | Secondary (Outpatient)  | Hospitalization (Inpatient)   | Emergency             | Ante-postnatal                                     |
| Germany               |  | Access free of charge if residence above 48 months                                | Access free of charge if residence above 48 months                                | Access free of charge if residence above 48 months                                | Access free of charge | Access free of charge if residence above 48 months |
|                       |  | otherwise only if "illness or acute pain" and if get in advance the Krankenschein | otherwise only if "illness or acute pain" and if get in advance the Krankenschein | otherwise only if "illness or acute pain" and if get in advance the Krankenschein |                       | otherwise if get in advance the Krankenschein      |

**Figure 14: Access to Health Care and Treatment for Adult Asylum-Seekers According to Applicable National Legislation (Collantes 2009)**

Putting the *Council Directive 2003/9/EC* and the *AsylbLG* together, it becomes apparent that *AsylbLG* fulfills the demands of the directive on the health care access for asylum-seekers but keeping it at absolute minimum services possible. This situation differs greatly with the health care access at the reception for asylum-seekers in the Netherlands, being discussed in the following part.

#### 4.4.3 The Netherlands

The Netherlands, among the other EU countries, stands out for its systematic attention to the health of migrants (Rechel et al. 2011, p.196). It was the only country, which with the cooperation of WHO supported the first ever conference on migrant health, in 1983 (Colledge et al. 1986). In this country, from the beginning of reception, the asylum-seekers have access to health care almost like the Dutch citizens. Health and long-term care are free, with coverage which is similar to standard benefit packages. However, asylum-seekers do not have

free choice of physicians and dental care for adults is restricted to acute treatment or pain relief (Rechel et al. 2011, p.190).

RVA mentions access to health care for asylum-seekers directly and gives them the right to have an insurance that covers the costs for them (Verdonk 2005).

The RVA and RVB laws, affecting the health care access for asylum-seekers in the Netherlands, are seen in Figure 15 and Figure 16. For the complete text of the laws, refer to appendix.

| <b>Regulation on Provisions to Asylum Seekers / Regeling Verstrekkingen Asielzoekers en Andere Categorieën Vreemdelingen (RVA) 2005</b> |   |
|---|---|
| <b>Chapter IV</b>   | <b>The Benefits During the Reception</b>                                  |
| RVA Chapter IV Article 9 § 1  | Coverage of the costs of medical benefits under a health insurance scheme |
| RVA Chapter IV Article 9 § 2  | Health study of the asylum-seeker at reception                            |
| RVA Chapter IV Article 16 § 1   | Health insurance contract   |

**Figure 15: Health Care Access for Asylum-Seekers in RVA**

| <b>Scheme Benefits in Certain Categories of Aliens/ Regeling Verstrekkingen Bepaalde Categorieën Vreemdelingen (RVB)</b> |   |
|--|---|
| RVB Article 3 §1 Subpara. B  | Coverage of the costs of medical benefits under a health insurance system |
| RVB Article 7 §1   | Health insurance contract for asylum-seekers                              |

**Figure 16: Health Care Access for Asylum-Seekers in RVB**

Putting all these pieces of rights and entitlements together, it is concluded that the medical care granted to asylum-seekers in the Netherlands is as similar as possible to the health care that a regular Dutch receives. Asylum-seekers can visit hospitals, general practitioners and midwives, just like Dutch residents (COA 2014), however they do not have free choice of practitioner. But this difference does not have a major impact on the services received (Collantes 2009, p.15).

Furthermore, asylum-seekers in the Netherlands cannot get the regular health insurance but instead they benefit from the *Regulation on Provisions to Asylum-Seekers (RVA)*. Based on that, their health care expenses are covered by COA through the insurer Menzis, a non-profit insurance company (Collantes 2009, p.108).

In this system, asylum-seekers are entitled to free of charge access to all types of health care, except in gender reassignment surgery, vitro fertilization and some types of aesthetic surgery (Collantes 2009, p.108).

Regarding the *Council Directive 2003/9/EC*, the Dutch laws not only follow all the rules set by the directive, but they also do not limit the given care just to the most minimum. They provide the asylum-seekers with benefits like the Dutch residents from the beginning of the reception. See Figure 17.

| Netherlands | Access to Health Care |                        |                             |                       |                       |
|-------------|-----------------------|------------------------|-----------------------------|-----------------------|-----------------------|
|             | Primary               | Secondary (Outpatient) | Hospitalization (Inpatient) | Emergency             | Ante-postnatal        |
|             | Access free of charge | Access free of charge  | Access free of charge       | Access free of charge | Access free of charge |

**Figure 17: Access to Health Care and Treatment for Adult Asylum-Seekers According to Applicable National Legislation** (Collantes 2009)

### Conclusion

The related parts of national laws of Germany and the Netherlands, international legal instruments and EU *Council Directive 2003/9/EC* , which affect asylum-seekers' access to health care services were studied, in this part. Figure 18 shows a summary of what was discussed.

|                          | Access to Health Care   |   |   |   |   |
|--------------------------|---|---|---|---|---|
|                          | Primary   | Secondary   | Hospitalization   | Emergency   | Ante-postnatal  |
| <b>Minimum Standards</b> |   |   |   |    |   |
| <b>Asylum Seekers</b>    |    |    |    |   |    |
| <b>National Citizens</b> |   |   |   |   |   |

**Figure 18: Access with No Restrictions<sup>1</sup>**

In Figure 18, access to health care means access with no restrictions. It means that no Krankenschein, no payment or anything of such kind that hinders the access, is required. The

---

<sup>1</sup> Own Illustration

German laws provide the asylum-seekers with such access, in emergency cases, as ordered by the *EU Council Directive* and not much more. For access to other types of services, they have to overcome several administrative difficulties and obtain *Krankenschein* or persuade that they have acute pain or illness.

However, the Dutch laws provide the asylum-seekers with much more rights of access to health care than the minimum standards, suggested by the directive. The asylum-seekers just need to have an insurance, like a national Dutch, and they will have access to various services.

In conclusion, it is clear that the national laws in these two countries differ significantly, when it comes to the health care access for asylum-seekers and the ones in the Netherlands definitely enjoy more entitlements and have better conditions in this case.

## 4.5 Legal Instruments on Housing

As mentioned in the previous part, *The Universal Declaration of Human Rights* (1948) states that everyone has the right to a standard of living which is adequate for his/her well-being and that includes factors such as housing. Housing rights are considered as an integral part of economic, social, and cultural rights within the international human rights instruments.

For instance, according to the Article 5 of *International Convention on the Elimination of All Forms of Racial Discrimination* (1965), the states are obliged “to prohibit and eliminate racial discrimination in all of its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of ... (e) (iii) the right to housing”. In the *UN Convention on the Elimination of All Forms of Discrimination Against Women* (1979), women’s rights to enjoy adequate living conditions, such as housing, sanitation, electricity and communications are promoted, as well.

Some other relevant UN instruments mentioning housing rights include the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, *Convention on the Rights of the Child*, the *UN Global Strategy for Shelter to the Year 2000* and the *UN Convention Relating to the Status of Refugees 1951*. Several other international instruments on the rights to housing have been ratified by the states around the world (Commissioner for Human Rights 2008).

The United Nations Fact Sheet on the right to adequate housing explains the right to adequate housing and introduces the key aspects of the right. According to that, the right to adequate housing contains freedoms including protection against forced evictions and the arbitrary destruction of one’s home, the right to be free from arbitrary interference with one’s home, privacy and family, and the right to choose one’s residence, to decide where to live and to freedom of movement. The right to adequate housing also includes entitlements to security of tenure, participation in housing-related decision-making, housing and property restitution and equal and non-discriminatory access to adequate housing (United Nations 2009, p.3).

The fundamental elements of adequate housing, according to the United Nations Right to Adequate Housing, are:

- Security of tenure: if the occupants do not have a degree of tenure security, guaranteeing legal protection against forced evictions, threat or harassment, housing is not adequate.
- Affordability: if the cost compromises the occupants' enjoyment of other human rights, housing is not adequate.
- Availability of services, materials, facilities and infrastructure: if occupants do not have safe drinking water, adequate sanitation, lighting, energy for cooking, heating, food storage and refuse disposal, housing is not adequate.
- Habitability: if the housing does not guarantee physical safety or if it does not provide adequate space, protection against the cold, damp, rain, wind, heat and other threats to health, it is not adequate.
- Location: if the housing is located in polluted or dangerous areas or if it is cut off from health-care services, schools, employment opportunities, childcare centers and other social facilities, then, it is not adequate.
- Cultural adequacy: if the housing does not take into account the expression of cultural identity, it is not adequate
- Accessibility: housing is not adequate if the specific needs of disadvantaged and groups are not considered.

Access to adequate housing can affect enjoyment of several other human rights, such the rights health, social security, privacy or education (United Nations 2009, p.9). Thus, in this part, in order to compare the laws on housing for asylum-seekers in the two countries and EU, the categories of adequate housing will be used.

#### **4.5.1 EU**

*Council Directive 2003/9/EC* , laying down minimum standards for the reception of asylum-seekers ensures that the asylum-seekers have a comparable dignified standard of living in all the EU member states (Official Website of European Union). As stated earlier, according to this directive, based on the nature of minimum standards, states have the power to introduce or maintain more favorable provisions. The directive applies to all nationals of third countries and stateless persons who ask for asylum at the territory or border of the member states.

Article 14 of this directive is concerned with Modalities for Material Reception Conditions, describing the minimum standards for housing conditions for asylum-seekers, as seen in Figure 19. For the complete text of the laws, see appendix.

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum-Seekers  | Shall | May |
|-----------------------------|--|-------|-----|
| Chapter II                  | General Provisions and Reception Conditions  |       |     |
| Chapter II Article 14       | Modalities for Material Reception Conditions   |       |     |
| Chapter II Article 14 § 1   | Housing forms such as accommodation centers or private houses  |       |     |
| Chapter II Article 14 § 2   | Assuring protection, communication opportunities, prevention of assault  |       |     |
| Chapter II Article 14 § 3   | Lodging children with their guardians  |       |     |
| Chapter II Article 14 § 4   | Ensuring minimum transfer  |       |     |
| Chapter II Article 14 § 5   | Use of adequately trained personnel in the centers   |       |     |
| Chapter II Article 14 § 6   | Involving applicants in managing the resources and non-material aspects of life in the centre  |       |     |
| Chapter II Article 14 § 7   | Access to accommodation  |       |     |
| Chapter II Article 14 § 8   | Setting different conditions for material reception if an assessment is needed, if capacities are exhausted or not available, if the asylum-seeker is in detention.<br>The different conditions shall cover in any case basic needs. |       |     |

**Figure 19: Housing for Asylum- Seekers in  
 Council Directive 2003/9/EC**

UNHCR generally welcomes this provision. However, they have several suggestions to make the conditions of housing for asylum-seekers more adequate. In the annotated comments on the directive, UNHCR suggests that

- accommodation in collective centers should be for the shortest possible duration.
- accommodation in centers should respect privacy and provide for the basic necessities of life, including sanitary and health facilities.
- to respect cultural and religious customs, asylum-seekers must be provided with the necessary means to prepare their own food.
- language training, orientation and cultural awareness programs, social and legal counseling should be offered by community services.
- there must be access to independent arbitrator for resolving complaints.
- residents should be allowed to participate in the management of material resources and aspects of life in the centre.

(United Nations High Commissioner for Refugees 2003)

§8 of this article, however, gives the countries a lot of freedom to have very differing conditions. In the following parts, the laws on housing for asylum-seekers in the Netherlands and Germany will be reviewed and the extent to which the asylum-seekers are provided with adequate housing will be compared.

#### **4.5.2 Germany**

Chapter III of *Asylum Procedure Act/AsylVfG* (1993) mentions accommodation of asylum-seekers and puts the Länder in charge of taking care of that. According to the laws in this chapter, asylum-seekers shall live in reception centers less than three months and after that they will be sent to a collective accommodation in the responsible Land. For complete text, see appendix.

Under § 3 of *AsylbLG*, housing is also mentioned. According to that law, the accommodation need will be covered through provision in kind. Thus, due to the “in kind provision”, it will be decided for the asylum-seekers where and in what kind of accommodation to live, what to wear or even what to eat. The social consequences of this exclusion policies are disastrous, as the refugees due to the violations of their privacy rights and human dignity are often permanently physically and mentally ill (Flüchtlingsrat Berlin e.V. 2014, p.6).

*AsylVfG* and *AsylbLG* set some rules for the accommodation of asylum-seekers but there are no specific laws on provision of adequate housing for asylum-seekers and the situation differs from Land to Land.

#### **4.5.3 The Netherlands**

*The act of 19 May 1994 laying down rules for the establishment of an independent administrative body in charge of the material and immaterial reception of asylum-seekers* makes COA responsible for taking care of asylum-seekers in the Netherlands.

COA keeps asylum-seekers at an asylum-seekers’ centre until the Immigration and Naturalization Service or the court reach a decision on their request for asylum. In principle, asylum-seekers stay at a reception centre for a maximum of one year.

The occupants usually live in housing units in groups of between five and eight persons. Each housing unit has a number of bedrooms and a shared living room, kitchen and sanitary facilities. The occupants are responsible for keeping their housing tidy.

Refugees are accommodated in houses provided by local authorities. There are no legal restrictions on freedom of movement within the country but the choice for domicile is not up to the asylum-seeker: social housing will only be offered in one municipality. (Government of the Netherlands 2014, p.8)

Until refugees find employment, they are entitled to social security allowance. Just like Dutch nationals, refugees have to use this monthly allowance to pay for the rent of the house, medical care, third party insurance, clothing, food, gas, electricity, water, etc.

## *Conclusion*

Adequate Housing components are security of tenure, affordability, availability of material/services/facilities, habitability, location, accessibility and cultural adequacy. While national citizens have the entitlement to all these rights, for asylum-seekers the only right recognized in the *2003/9/EC Directive* is the right to protection and security. Thus, the directive is not enough to provide asylum-seekers across Europe with adequate housing.

The housing conditions for asylum-seekers in Germany and the Netherlands were explained, in this part. The conditions might slightly be better in the Netherlands since there is room for some cultural adequacy in the accommodations. For example, in the Netherlands, the asylum-seekers get the money to buy food and cook what they want on their own but in Germany the provisions are given in kind and they cannot cook what they like.

What was learnt through this part of the paper on the housing of asylum-seekers can be summarized as in Figure 20.

|                          | <b>Right to Adequate Housing</b> |
|--------------------------|----------------------------------|
| <b>Minimum Standards</b> | ×                                |
| <b>Asylum Seekers</b>    | ×                                |
| <b>National Citizens</b> | √                                |

**Figure 20 : The Right to Adequate Housing**

Asylum-seekers in Germany and the Netherlands do not have access to adequate housing and we should remember that adequate housing is one of the effective social determinants of health status. The *2003/9/EC directive* does not set enough rules to assure access to adequate housing for asylum-seekers in all the destination countries.

## **4.6 Actual Implementation of the Laws**

In each section of this chapter, legal international/ European/ national instruments on different aspects of working and living conditions for asylum seekers were introduced. The existence of these legal instruments, however, does not guarantee complete implementation and obedience to them.

The international legal instruments can sometimes be too general, the European instruments (such as Directive 2003/9/EC) might suffer from too many ambiguities and the national laws, even mostly strict and binding, do not guarantee obedience by all.

There are several examples in the histories of the host countries pointing at the disobedience to asylum laws. Such disobedience can go to both directions: giving the asylum-seekers services that they are not legally entitled to or hindering their access to what they actually are entitled to. For example in February 2014, Ahmed J. died with lung disease in Plauen, Germany and in April 2014, a four-week old baby died in Hannover, both within hours after being rejected to receive emergency care (Flüchtlingsrat Berlin e.V. 2014, p.36), though they were entitled to that. But on the other hand, I, the author of this paper, have met asylum-seekers who could study, work, live in a preferred place and receive health care services for affordable prices, because the other party wanted to help them or benefit from this agreement.

The actual implementation of asylum laws and obedience to them are, of course, important and interesting topics for research and discussion. However, the focus of his research remains on just the legal instruments, assuming that most (if not all) of the authorities and people in charge follow the legal instructions laid down by the laws.

## **4.7 Conclusion of the Chapter**

In this chapter the entitlements to living and working, based on the legal instruments, were reviewed and interpreted. At the international level, there are several instruments like *The Universal Declaration of Human Rights* (1948), *International Convention on the Elimination of All Forms of Racial Discrimination* (1965) or *United Nations Committee on Economic, Social and Cultural Rights* that work on ensuring the access of everyone around the world to their rights.

For the case of asylum-seekers in Europe, the most important legal instrument, having influenced the rights of asylum-seekers in the last years more than any other EU instruments,

is the *Council Directive 2003/9/EC*, which has the purpose of harmonizing fair and just treatment of asylum-seekers in all the European countries. It has made many changes across the Europe, however, due to the existing ambiguities in the directive, countries have been able to find loopholes and offer differing entitlements to asylum-seekers based on their national laws.

In Germany, the main national legal instruments in handling asylum-seekers are *AsylbLG*, *AsylVfG* and *SGB* and in the Netherlands, *Aliens Act 2000*, *RVA* and *RVB* which are implemented through *COA*.

Based on the mentioned legal instruments at international level, EU level and national level, giving entitlements to the asylum-seekers, the following conclusions in the case of Germany and the Netherlands could be made. The asylum-seekers in both countries have no fair or adequate access to employment opportunities and housing. The asylum-seekers in the Netherlands have more access to education, adequate food and health care services than the asylum-seekers in Germany, as shown in Figure 21.

| Healthy Living and Working Conditions | DE | NL          |
|---------------------------------------|----|-------------|
| Mainstream Education                  | x  | only minors |
| Fair and Just Working Conditions      | x  | x           |
| Adequate Food                         | x  | √           |
| Free Access to Health Care            | x  | √           |
| Adequate Housing                      | x  | x           |

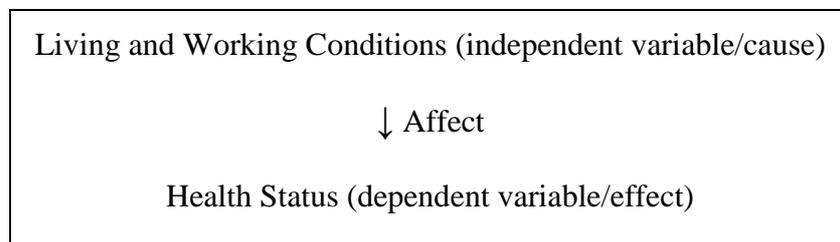
**Figure 21: Conditions for Asylum-Seekers in DE and NL**

Thus, all put together, the asylum-seekers in the Netherlands enjoy better living conditions. Following Dahlgren and Whitehead’s model of determinants of health, this independent variable (living conditions) is supposed to affect the dependent variable (health status). In the following chapter, the health status of asylum-seekers, affected by the living and working conditions, will be discussed.

## 5 Health Status of Asylum-Seekers: The Dependent Variable

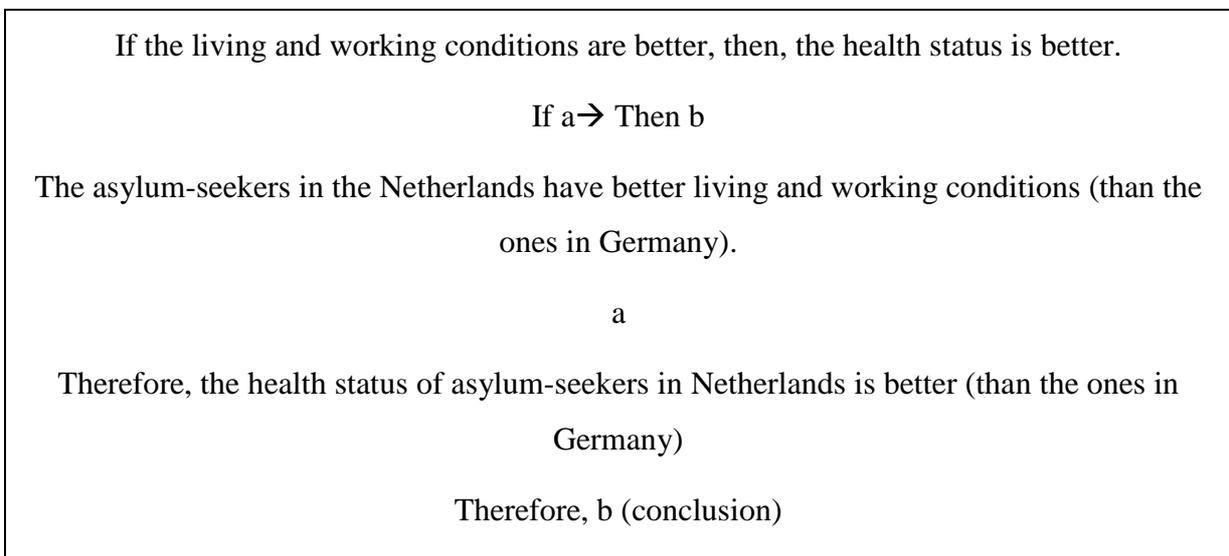
The hypothesis leading this study is that the asylum-seekers in Netherlands, with access to better living and working entitlements, have better health status than the ones in Germany with limited access. The objective of this chapter is to perform a hypothesis-testing focused-structured comparison and confirm (or not) the initial hypothesis.

In chapter 4 (Review of the Legal Instruments), also known as Analysis A, different types of entitlements to living and working conditions were clarified and these differing types serve as the independent variables for this section of the research, also known as Analysis B. Thus;



(Dahlgren & Whitehead 1991)

Deductive reasoning is used to shape the research and reach conclusions, as shown below:



This kind of deduction is called law of detachment and is the most common rule used in deductive arguments. The conclusion is deduced from the combination of conditional “ $a \rightarrow b$ ” and the “a” statement (Chang 2014, p.30).

Based on this deductive reasoning, the intention is to conclude that the health status of asylum-seekers in the Netherlands is better than the ones in Germany due to better living

conditions. To confirm this conclusion, information must be gathered and data analyzed, which is the goal of this chapter.

## **5.1 Availability of Data**

The phenomenon of “healthy migrant effect” suggests that the migrants are often comparatively healthy. However, they are vulnerable to threats to their mental and physical health. It happens frequently that the communication between the migrants and the health care providers are poor, the health needs of migrants are poorly understood and the health care systems cannot respond to their needs adequately. Migrants face problems even in getting their human rights such as access to adequate housing or proper and well paid jobs. These problems are still bigger when it comes to migrants such as asylum-seekers and undocumented migrants (Rechel et al. 2011, p.4).

In addition to the mentioned problems, there is a lack of clear data on immigrants and their health status. For instance, it is not clear how many asylum-seekers are in any given country or there is no high quality data on health status, health determinants or health utilization for migrants in most of EU countries (Rafnsson & Bhopal 2008).

According to Kraler & Reichel (2010), this lack of data not only limits the possibility of provision of appropriate services to the migrants, including the most vulnerable groups like asylum-seekers, but also limits the possibility of conducting comparative research on inequalities in access to health care and health status.

Two major reasons for the lack of data, suggested by Rechel et al. (2011), are;

- There is a lack of any system for collection of data on the health of migrants. Unlike Canada, Australia, USA and New Zealand, most of the European countries do not collect data on migrants' health. The Netherlands and Belgium have great experience in collecting such data through surveys. However, many EU countries do not collect data on migrants and countries like Germany and Belgium have only recently begun to carry out such surveys. It is important to mention that, even if data on health of migrants is collected, information on the most fragile groups such as asylum-seekers is lacking.

- There are methodological and conceptual problems in collecting data on migrants' health since factors such as number of immigrants or who constitutes to specific kind of migrants are undetermined.

## *Germany*

Health information systems in the majority of European countries do not identify people by their migration status (Juhasz et al. 2010) but the death registries in many countries include migration or ethnicity indicators (Rechel et al. 2011, p.87). The initial plan for this paper was to gather data on disease specific mortality rate, as the health status indicator, among asylum-seekers in the Netherlands and Germany and compare them. However, access to such data in the case of Germany was not possible.

Several authorities that could be responsible for gathering such data including World Health Organization (WHO), International Organization for Migration (IOM) in Germany, Federal Office for Migration and Refugees (BAMF) in Germany, Amnesty International Germany and several public health departments of Bundesländer were contacted. No reply was received from the Bundesländer and all the other authorities had no access to such data.

ProAsyl was also among the authorities that were contacted. The National Working Group ProAsyl was formed in 1986 in order to protect asylum-seekers from the significant restrictions that appeared in German asylum law in the 1980's. The group comprises churches, unions, refugee councils and welfare and human rights organizations. The group's aim is to protect rights of refugees and give voice to their concerns (Pro Asyl 2015). The Deputy General Manager of Pro Asyl, Mr Bernd Mesovic, in his response to the request for data on the health status of asylum-seekers, on 6/10/2014, wrote:

“I am afraid that no such data that you are looking for have ever been collected and evaluated in Germany. I have never seen any statistics concerning mortality figures among asylum-seekers or diseases in connection with countries of origin. I am almost sure, that BAMF, being the relevant authority for the status determination procedure, would not be able to help you either.

BAMF has nothing to do with issues of social assistance and benefits, accommodation and health care which is within the responsibility of the Länder (16). Medical data is difficult to obtain due to data protection in this field.

Medical care is limited by the Asylbewerberleistungsgesetz (Law on Benefits for Asylum-Seekers). This creates discrimination and certain risks for the health situation of asylum-seekers. I will send you a link covering the main problems”.

In further contacts, Mr Mesovic introduced the Bremer Model, which in his words is probably the only available study on the asylum-seekers that includes disease diagnosis in Germany. The Bremer Health Program, called Das Bremer Modell, began in 1993 and since then it has followed the aim to promote access to comprehensive health care for asylum-seekers (Jung 2011). Through contacts with Health Department of Bremen and Ms Jung, the responsible person for the Bremer Health Program, it became clear that no one out of the health department can have access to detailed data and the only available data on the health of asylum-seekers is published in Das Bremer Modell Gesundheitsversorgung Asylsuchender Jung (2011). Therefore, this publication will serve as the main resource about the health status of asylum-seekers in Germany for this research

### *The Netherlands*

In the case of the Netherlands, there is not only a great extent of literature on the health of asylum-seekers, but there is also a national system that collects such data.

In the Netherlands, the Central Agency for the Reception of Asylum-Seekers has put the Community Health Services (CHS) in charge of providing preventative health services to asylum-seekers in asylum centers. CHS provides services such as child healthcare, hygiene inspections, health education and referral of asylum-seekers to health care professionals. The CHS have also developed a system since 2002, which gathers data on mortality of asylum-seekers. When an asylum-seeker dies in an asylum center, the medical staff report it to the regional office. Then, a doctor verifies and sends the data as anonymous to the central office of CHS (Goosen 2014, p.32). However, the public access to the data is limited.

There is a great amount of data on the health of asylum-seekers in the Netherlands, however, the data from Germany is limited. Therefore, only the data from the Netherlands that matches the only existing data from Germany (Bremer Model) is used and discussed in this research.

## *PubMed*

PubMed is the search engine that is used to find the related literature on the health of asylum-seekers in the Netherlands. PubMed is a free resource, developed and maintained by the National Center for Biotechnology Information (NCBI), at the U.S. National Library of Medicine (NLM) (PubMed 2014).

This search engine has access to database of references and abstracts on biomedical topics, health, behavioral, life and chemical sciences. The primary resource of the search engine is MEDLINE database and further more access to PubMed Center (PMC) citations, older references from print version, a collection of books in full text and very recent entries to records for an article before it is indexed is provided. PubMed comprises of 24 million citations for biomedical literature (PubMed 2015). Many of the records in PubMed are linked to full text articles, some of which are free to use (Roberts 2001).

The information in MEDLINE, the basic resource of PubMed, is leased to a number of private vendors such as EBSCO, Dialog and Ovid, as well (US National Library of Medicine 2014). Thus, for this research, PubMed is used as the strongest search engine in medical literature, containing most of the available literature.

## *Aggregated Data*

Almost all the available data from the Bremer Model and also from the literature in PubMed are aggregated and raw data is rarely available. On the one hand, such data is easy and fast to read and understand. But on the other hand, collection of aggregated data for a meta-analysis can be problematic due to effect of missing data at the micro level and lack of information on correlation coefficients (Jones et al. 2009, p.16). These issues will be discussed in detail, in the discussion part, after the collection of the available data.

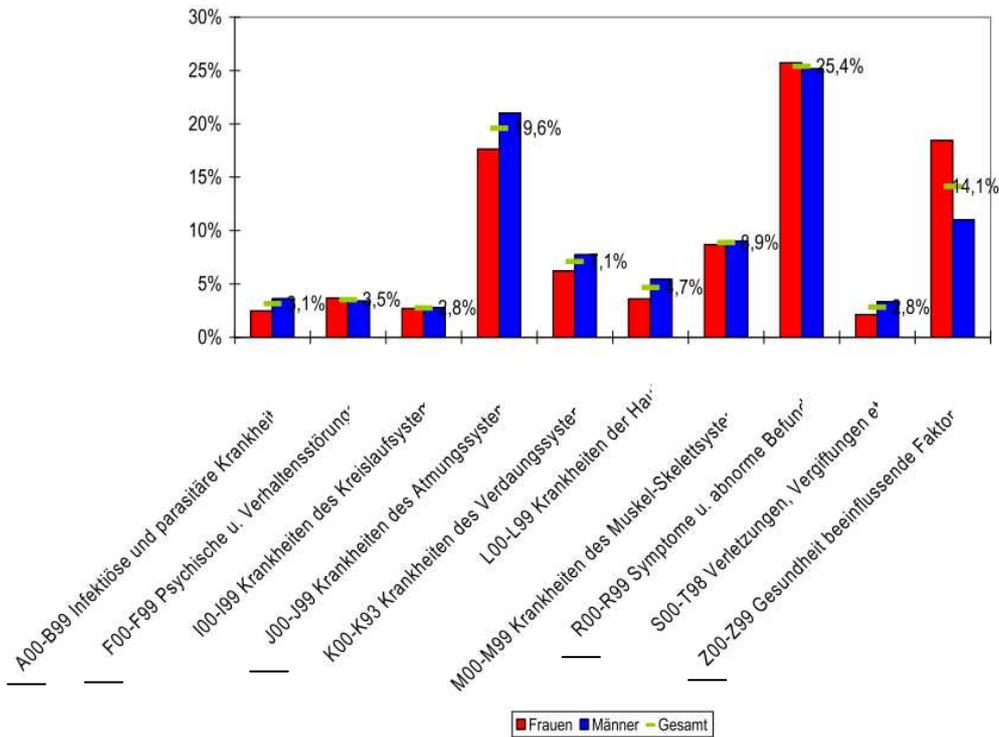
## **5.2 Study of the Literature**

The Bremer Model provides very general data on a couple of diseases and some more extended data on the following illnesses, which are categorized with the codes of International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010;

- Certain Infectious and Parasitic Diseases (A00-B99)

- Mental and Behavioral Disorders (F00-F99)
- Diseases of Respiratory System (J00-J99)
- Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)
- Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Bremer Model has gathered data from the year 2001 to the year 2008. In this time period, the doctors who cooperated with the Bremer Program treated 2.341 refugees and asylum-seekers, 744 of which were women and 1.597 men. The doctors carried out 18.198 treatments and made 20.752 diagnoses (Jung 2011, p.7). The most common results are shown in Figure 22. Unfortunately, access to complete and raw data collected by Bremer Program is not possible.



**Figure 22: Diagnoses Based on Gender, ICD 10, Most Frequent Diseases, Years 2001-2008, (All Diagnoses N=20.752, Women n=8.763 Men n=11.989)**  
 (Jung 2011, p.49)

Based on the available data in the publication of the Bremer Model, comparable data from the literature on asylum-seekers in the Netherlands is gathered. The collection of literature about the Netherlands is based on results found by the PubMed search engine.

### **5.2.1 Certain Infectious and Parasitic Diseases (A00-B99)**

Poor hygiene, weak general conditions, stress, hard living conditions and factors as such make asylum-seekers vulnerable to infectious and parasitic diseases.

#### *Bremer Program (Germany)*

Infectious and parasitic diseases are a small part of the diagnoses done in the Bremer Model, with a share of 3.1%. These diseases affected 15% of the men and 11.8% of women. The largest number of diagnosis was the skin fungal infection, called Dermatophytosis, with 1.7% of all findings. Lice and crab louse parasitic diseases were the second most common diagnoses with 0.4% all findings. Such diseases are transferred because of inadequate hygiene and poor general conditions.

Only 19 diagnoses found serious infectious diseases like Hepatitis, Tuberculosis and HIV in the Bremer program. 14 people in the program were diagnosed with these diseases (8 men and 6 women), which means 0.8% of women and 0.5% of men in the program from 2001 to 2008. In other words, out of 1,000 asylum-seekers, 6 people were diagnosed with serious infectious diseases. The ones in the program who were diagnosed with HIV infection were from Africa. Most of the asylum-seekers diagnosed with Tuberculosis and Hepatitis were from Soviet Union and Yugoslavia.

The prevalence of tuberculosis in the program was 2.65 per 1,000 or 265 per 100,000. In 2007, worldwide the tuberculosis prevalence was 206 per 100,000 people. The prevalence among asylum-seekers in the Bremer program is a small number, however, larger than the prevalence worldwide. HIV prevalence in the program was 88 per 100,000, higher than Germany with 77 per 100,000 but well below the prevalence in the world. The prevalence of Hepatitis A, B and C with 0.27% was below the prevalence in Germany with 0.4-0.8% and the world's 5-6%.

Thus, in the Bremer program, only a small number of asylum-seekers were infected with serious infectious diseases among which tuberculosis was the most common. The largest disease was skin diseases, affecting men to a greater extent. Gender specific factors were observed. Men suffered more from Dermatophytosis, showing possible inadequate hygienic methods. Women suffered more frequently from lice, possibly because of their close contact with their children who carried lice from kindergartens or schools (Jung 2011, pp.53–54).

### *Literature on PubMed (The Netherlands)*

The key words used to search PubMed for the related literature on the health of asylum-seekers in the Netherlands comprised: asylum-seekers, the Netherlands, A00-B99, infectious diseases, parasitic diseases and disease specific words as HIV, Hepatitis, Tuberculosis and Dermatophytosis. Three results were found containing information on asylum-seekers in the Netherlands and Tuberculosis, HIV and infectious diseases.

A study done by Koppenaal et al. (2003), describes the causes of death among asylum-seekers in the Netherlands based on the information derived from COA, the reception center for asylum-seekers. The studies by Goosen (2014) and van Oostrum et al. (2011) contain the extensive similar information but cannot be used for this paper since the only available information in Germany is not concerned with the mortality rate and causes of death among asylum-seekers.

van Burg et al.(2003) study medical records of 46.424 asylum-seekers in the Netherlands between January 1994 and March 1997. They found out that in their sample group, prevalence of Tuberculosis among asylum-seekers when entering the country was 222 per 100.000, with the least prevalence among the asylum-seekers coming from Iran, Iraq, Afghanistan and Bosnia. After primary therapy and follow up phases this prevalence was 173 per 100.000 (van Burg et al. 2003, p.142).

The last study that was found on PubMed relating to the asylum-seeker' infectious diseases in the Netherlands is a study on treatment of Tuberculosis and drug resistance done by Kuyvenhoven et al. (1997). There is no data in this study that can be used to compare with the data from Bremer Program.

### **5.2.2 Mental and Behavioral Disorders (F00-F99)**

Asylum-seekers suffer from serious psychiatric and trauma-related problems. The key themes in their cases are grief and loneliness. Furthermore, they face practical problems which affect their life quality (Strijk et al. 2011).

### *Bremer Program (Germany)*

In the Bremer Program only 3.5% of diagnoses were mental disorders (F00-F99). It included 16.9% of people in the program. Non-organic sleep disorders, with 1.6% of all findings and Somatoform, mental disorder characterized by physical illness, with 1.4% of all diagnoses

were among the most common mental problems in Bremer Program. Post traumatic stress disorder was found only in 0.2% of all diagnoses (1.1% of all the patients). Problems like headaches, back pains and menstrual pains, R00-R99 of ICD-10, can also be connected to mental disorders. They made 22.8% of all findings in the Bremer Program and will be discussed in the following parts. According to Jung (2011,p.52), diagnosis of such diseases is not always completely and properly done and even though the Bremer program diagnosed 16.9% of the asylum-seekers with mental disorders, there are other statistics that consider this percentage up to 80%.

In the Bremer Program 17 people were diagnosed with post traumatic stress disorder, 30 people with Somatoform disorders, 13 people with insomnia, seven people with drug and alcohol dependence, five people with depressive episodes and four people with anxiety disorders (Jung 2011, pp.62–65).

### *Literature on PubMed (The Netherlands)*

The key words used to search for the related literature on PubMed were asylum-seekers, the Netherlands, F00-F99, mental disorders, behavioral disorders, disease specific word as Depression, Anxiety, Post Trauma Stress Disorder, Insomnia, Somatoform, alcohol and drug dependence. Four major related results were given.

Laban et al. (2007) study two randomly selected groups of asylum-seekers, one group being in the Netherlands for six months and one group for more than two years. They interviewed these asylum-seekers with structured and culturally validated questionnaires, which contained instruments to measure life quality, psychiatric disorders, physical health and post-migration living problems. Among the 294 asylum-seekers that they focused on, they found out that the asylum-seekers who have been in the Netherlands for more than two years, suffer from higher prevalence rates of psychiatric disorders (66.2%) than the ones who have been there for six months (42%). They also found drug consumption in 45.7% of the group with longer stay and 32.2% in the group with the shorter length of stay.

Gerritsen et al. (2006) found even a greater number in the drug consumption among asylum-seekers. Among the 230 asylum-seekers in their studies, 57.8% made use of medication and 15.4 people use mental health services.

Through a cross-sectional study, Gerritsen et al. (2006) estimated the prevalence of mental and health problems among asylum-seekers. In their study, out of 232 asylum-seekers, 89%

answered. 68% of the asylum-seekers who answered had symptoms of anxiety/depression and 28% PTSD.

In another article Gerritsen and Van der Ploeg mention that 43.4% of Iranian asylum-seekers in their studies showed symptoms of PTSD (Gerritsen & Van der Ploeg 2006, p.5). Calculating the given data in the Bremer program, almost 33% of Iranian asylum-seekers in Germany suffer from sleep disorders and Somatoform.

### **5.2.3 Diseases of Respiratory System (J00-J99)**

Respiratory systems diseases exist among asylum-seekers since they come from poor countries where such diseases prevail. Furthermore, these types of migrants are more vulnerable and at a higher risk to get these disease due to their suppressed immune system because of mal-nutrition (Van den Brande et al. 1997, p.613) , stress and bad living and working conditions.

#### *Bremer Program (Germany)*

Diseases and infections of respiratory system are the second most common diagnoses in the Bremer Program. They cover 19.6% of all findings.

#### *Literature on PubMed (The Netherlands)*

Key words used to search for related articles on PubMed were asylum-seekers, the Netherlands, J00-J99, respiratory system diseases and disease specific words as Influenza, Pneumonia and Lung disease. No articles comparable with the data from Bremer Program were found.

### **5.2.4 Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)**

#### *Bremer Program (Germany)*

This category has the largest proportion in the Bremer Program. 25.4% of all diagnoses are related to R00-R99 among the asylum-seekers in the program (52.5% of all the patients). 17.2% of the diagnoses were headache (40.5% of the people in the program), 2.2% abdominal pain, 1.2% cervical pain plus back pain, neck pain or heart complaints (Jung 2011, p.56).

### *Literature on PubMed (The Netherlands)*

Key words used to search PubMed for finding the relevant literature were asylum-seekers, the Netherlands, R00-R99, headache, cervical, abdominal and heart pain. One relevant literature was found.

Gerritsen & Van der Ploeg (2006) found in their study that the most frequently reported chronic conditions were severe neck/shoulder problems (33.4%), severe/ chronic back complaints (32.7%) and migraine/severe headaches (32.6%).

### **5.2.5 Factors Influencing Health Status and Contact with Health Services (Z00-Z99)**

#### *Bremer Program (Germany)*

In the Bremer Program, 14.1% of all findings were in this category, which includes gene treatments, consultations on issues of reproduction, various types of preventive consultations, investigations and infection prevention. Numbers in all the categories, as well as this one can show the overall health status of the asylum-seekers.

The most common reason to contact health services in the health program was identification of pregnancies (2.5% of findings in women). African women used this service more than other nationalities and the reason might be that African women apply for asylum after getting pregnant (Jung 2011, p.59).

### *Literature on PubMed (The Netherlands)*

Key words used to search PubMed for relevant literature were asylum-seekers, the Netherlands, Z00-Z99, reproduction, consultation and pregnancy. No relevant match could be found.

## **5.3 Results**

Only in the categories of A00-B99, F00-F99 and R00-R99, similar data from PubMed literature and Bremer program could be found. Based on the available material and data that we just mentioned, the following results could be drawn.

Among the Infectious and Parasitic Diseases A00-B99, tuberculosis was the only disease about which some data on asylum-seekers in both countries were available, as shown in Figure 23.

| Disease:           | Tuberculosis   |   |
|--------------------|--|---|
| Asylum Seekers in: | DE   | NL  |
| Resource:          | Bremer Program   | Van Burg et al. (2003)  |
| Data               | 0.265% of asylum seekers in the program were diagnosed | 0.173-0.222% of asylum seekers in the study were diagnosed (The numbers differed depending on the length of stay) |

**Figure 23: Data on Tuberculosis among Asylum-Seekers in DE and NL**

Apparently, the number of Tuberculosis diagnoses among asylum-seekers in the Bremer Program of Germany is higher than the number of diagnoses in the study by Van Burg et al. of the Netherlands (2003) and this fact might suggest that in the category of A00-B99 diseases, the asylum-seekers in the Netherlands have a better health status. However, no certain conclusion can be made due to limited data and the intervening factors that will be discussed in the discussion part, in the following section.

Among the Mental and Behavioral Disorders F00-F99, there were some limited data on mental disorders in general and PTSD in both countries, shown in Figure 24 and Figure 25.

| Disease:           | Mental Disorders  |   |
|--------------------|---|---|
| Asylum Seekers in: | DE  | NL  |
| Resource:          | Bremer Program  | Laban et al. (2007)   |
| Data               | 16.9% of asylum seekers in the program were diagnosed (some statistics are up to 80%) | 42-66.2% of asylum seekers in the study were diagnosed (The numbers differed depending on the length of stay) |

**Figure 24: Data on Mental Disorders among Asylum-Seekers in DE and NL**

| Disease:           | Post Traumatic Stress Disorder                       |   |
|--------------------|--|---|
| Asylum Seekers in: | DE   | NL  |
| Resource:          | Bremer Program                                       | Gerritsen et al. (2006)                                 |
| Data               | 1.1% of asylum seekers in the program were diagnosed | 28% of asylum seekers in the study showed signs of PTSD |

**Figure 25: Data on PTSD among Asylum-Seekers in DE and NL**

The data differ greatly and it is possible that the studies have been measuring different factors. Therefore, no conclusions can be drawn from comparing the data from these existing literatures.

Among the Symptoms, Signs and Abnormal Clinical and Laboratory Findings R00-R99, there was some comparable data available on the diagnosis of headaches among asylum-seekers in the two countries, shown in Figure 26.

| Disease:           | Headaches   |   |
|--------------------|---|---|
| Asylum Seekers in: | DE  | NL  |
| Resource:          | Bremer Program  | Gerritsen & van der Ploeg (2006)                    |
| Data               | 40.5% of asylum seekers in the program were diagnosed | 32.6% of asylum seekers in the study were diagnosed |

**Figure 26: Data on Headaches among Asylum-Seekers in DE and NL**

According to these numbers, a higher percentage of asylum-seekers in Germany have been diagnosed with headaches than the ones in the Netherlands.

Headaches are not only related to physical health but also mental health. Breslau & Davis (1993) found associations between migraine or chronic headaches and increased rates of anxiety disorders, major depression, drug use disorders and suicide attempts. Also, people with headaches compared to the ones with no history of chronic headaches had more physical symptoms, described their general health as poor or fair, were more regularly absent from work and used mental health services more.

Thus, only looking at these numbers, we can say that the asylum-seekers in the Netherlands enjoy a better status than the ones in Germany. However, the settings of each group are so different and many intervening factors are involved that no definite conclusions can be made. More detailed discussions follow.

## 5.4 Discussions

Here, three topics of intervening factor, research designs and the budget, which are responsible for the attained results, are discussed.

### *Intervening Factors*

Even though there are some data available on the health status of asylum-seekers in both countries, no conclusions can be drawn because there are several intervening factors involved, which cannot be isolated due to lack of micro or raw data. These intervening factors are included in the other layers of determinants of health suggested by Dahlgren and Whitehead (1991). In order to make sure that our conclusions are absolutely based on the living and

working conditions, the intervening factors must be isolated, which is not possible due to lack of data. The intervening factors include factors of age, gender, origins, personal habits, lifestyle, and social and community networks;

- In most of the reviewed studies, the *age* of the sample groups is not mentioned. The age of the people being studied matters. Studies show that physical and emotional health and energy level vary among different age groups. For instance, Eugene et al. (1989) found that with an increase in age, there is decrease in energy level and physical well being and in contrast increase in mental health. Thus, in order for the comparison between asylum-seekers in two countries to be exact and accurate, the age of the sample groups must be comparable.
- *Gender* of each person in the sample groups must be considered, as well since it can have profound effects on health and wellbeing. Men take part in more risky acts such as drinking and smoking while women give care to others which results in problems such as stress and physical injuries (SGBA 2015).
- Asylum-seekers, coming from different countries, are from different races and socioeconomic backgrounds. In order for the comparisons to be accurate, the data about the *ethnicity* of the asylum-seekers are needed. There is some of such data in the Bremer Model publication but the literature on the Netherlands did not provide such data publicly.
- None of the reviewed studies show the *marital status*. Marital Status affects health status, as well. Schoenborn (2004) found in her study that regardless of age, sex, race, education, income, or nativity, married adults are generally found to be healthier than adults in other marital status categories. In the available data for this thesis, marital status of the asylum-seekers could not be considered, making the results of comparisons less accurate, since we cannot conclude that the health status difference is absolutely due to differing living and working entitlements.
- Several other factors such as the *level of education* of individuals, *eating habits*, *amount of daily activities*, *history of diseases in the family* and the *social engagements* are among the determinants of health that must be considered and isolated if the effects of other layers of determinants are meant to be compared and studied.

## *Differences in Research Designs*

In addition to the intervening factors which could not be isolated and made the comparison of our cases impossible, there are other obstacles posed by the specific characteristics of each research.

- Asylum-seekers are people who claim they are refugees but their claims have not yet been evaluated. National authorities decide whether the person needs international protection or not. If the judges decide that there is no need for protection, that asylum-seeker can be sent back home. If the judges decide that the protection is needed, then the asylum-seekers get refugee status and benefit the host country (UNHCR 2015). Different studies include different sample groups. Some studies study asylum-seekers and refugees together. Some studies study the asylum-seekers who have just arrived and some studies study asylum-seekers who have been waiting for their refugee status for several years and some include the rejected asylum-seekers, as well. As long as the sample groups differ like that and the duration of their stay and their exact status are not the same, no comparisons can be done. Because for instance, the ones who have just arrived might carry diseases like Tuberculosis from their countries of origin and their sicknesses cannot count as the consequences of entitlements in the host countries for this research. Or the longer the wait for the refugee status, the higher the stress and the depression gets. Thus, if a comparison is to take place, the sample groups must be in the same status, with the same duration of stay.
- The sample group size matters. The larger the sample groups are, the more precise estimates of the parameter under study can be done (Bakken & Bond 2013). In Bremer Program, 2.341 asylum-seekers and refugees were included in the study while in the other available literature, the numbers were much smaller.
- It is also important to have data from similar years. Every now and then, new laws are developed by the EU and used by the member states. In a research like this thesis that cross-national comparisons are supposed to be done, if the study subjects are affected by the new laws, the comparison cannot be done in one country after the new laws have come into force and in one country before the new laws had come into force.
- It is necessary to specify the disease that the people are diagnosed with, in detail. The stage of the disease must be considered, as well. For instance, mental disorders can be

diagnosed and interpreted differently and that is why no conclusion from the data available for this study could be drawn. Mental disorders were referring to different diseases and different stages of diseases in each literature.

In the available literature on the health status of asylum-seekers in Germany (Bremer Model) and the Netherlands, no comparable data, having all the above mentioned information and criteria, could be collected. The Bremer Model studies asylum-seekers and refugees together while the other literature did not include refugees. In none of the studies the duration of stay was considered. Age and gender were considered in the studies but more raw data on that is needed. Marital status was not considered in any of the studies. Countries of origin were recognized in Bremer Model but not in the other literature. The sample group sizes were different in each study. The studies were done on asylum-seekers in different years and finally the exact stages of the diseases were not mentioned with focus.

Great attention must be paid to the mental health of asylum-seekers, as well as their physical health. There are several studies done in the Netherlands on the mental health of asylum-seekers such as suicide rates in the study by Goosen (2014) or psychiatric disorders among specific asylum-seekers in the studies by Laban et al.(2004) and Gerritsen et al. (2006). Yet, there are very limited studies on this topic done on the asylum-seekers in other countries. The number of studies on refugees' mental health is higher than the number of studies on asylum-seekers. Asylum-seekers are one of the most powerless and marginalized groups in the society in constant fear of deportation. They have little access to private accommodation, work, education and social welfare benefits and the hard living conditions put them at risk of mental disorders. In the study by Ryan et al. (2009), high prevalence rates of mental disorders and psychological distress levels among asylum-seekers were discovered. More data on the health of asylum-seekers must be collected to force appropriate changes to the social policies and asylum procedures.

### *Budget*

It is a possibility that specifying no budget to this research has affected the results. Though several articles on the PubMed were free for public use, some of the literature were available only as abstracts and payments had to be made for access to the full texts. If this research had been provided with some budget for purchasing the literature, there could be a chance of finding more data related to our comparisons.

## **6 Summary, Conclusions and Recommendations**

This research started with discussing asylum as one of the human rights and mentioning that many asylum-seekers go to Europe every year to ask for refugee status. The asylum-seekers influence the host countries in various ways and one of the most important factors that affects the performance of asylum-seekers in the host countries is their health status.

While the asylum-seekers wait for the assessment of their cases by the host governments, the asylum laws of the host countries apply to them, giving them entitlements to different aspects of life and working. These entitlements (entitlements to education, employment, food, health care access and housing) affect the health status of individuals. The associations between living/working conditions and health were discussed in chapter 3.

Two countries of Germany and the Netherlands were chosen to be studied. They were chosen since they treat asylum-seekers in very different ways. Germany is a country with the reputation of extreme discrimination against asylum-seekers while the Netherlands gives extensive life and working entitlement to its asylum-seekers.

Based on the Social Model of Health (Dahlgren & Whitehead 1991), the theory which claims that living and working conditions affect health status, the hypothesis for this research was made. The hypothesis was that the better the living and working conditions, the better the health status; thus, the asylum-seekers in the Netherlands with better living and working conditions enjoy better health status than the ones in Germany. The research was based on a positivist approach, finding linkages between causes (independent variables: living and working conditions) and effects (dependent variables: health status).

The research included two sets of analyses, Analysis A and Analysis B. The objective of Analysis A was to carry out an idiographic case study through which the legislations on education, employment, food, health care access and housing for asylum-seekers in the Netherlands and Germany are reviewed and compared. The objective of Analysis B was to find the impacts of different types of living and working conditions (discussed in Analysis A) on the health status of asylum-seekers.

The *Council Directive 2003/9/EC*, which came into force in order to harmonize and improve the way countries treat their asylum-seekers, was the main EU legal instrument that was discussed. Based on Analysis A, studying the national asylum laws of the two countries, it was concluded that asylum-seekers in both countries have no fair or adequate entitlements to

housing and employment but the access to education, health care services and adequate food for asylum-seekers in the Netherlands is more than the access for the asylum-seekers in Germany. Thus, the health status (dependent variable) of asylum-seekers in the Netherlands must be better than the ones in Germany.

To assess and compare the health status of asylum-seekers in Germany and the Netherlands, a meta-study of existing literature to collect data was needed. There is some literature about the asylum-seekers' health in the Netherlands, but there was a lack of data in Germany. Several authorities such as IOM, WHO, Amnesty International, the ministries, Pro Asyl and Office for Migration and Refugees (BAMF) in Germany were contacted. The result was that the only public data about the asylum-seekers in Germany that could be used for this research was provided by Bremer Program, a program which focuses on improving health of asylum-seekers. Thus, meta-study of the existing literature on the health of asylum-seekers in the Netherlands was based on the available data from Bremer Program of Germany and done through PubMed search engine, containing a great percentage of medical research.

Some data could be found which matched with the data from Bremer Program, however due to existence of several intervening factors which were mentioned in part 5.4 (Discussions), no conclusions from the comparison of existing data could be drawn and the hypothesis could neither confirmed nor negated.

Most EU countries do not collect data on health status and morbidity of asylum-seekers or in general migrants. When sometimes in some countries data is collected, it is mostly based on disease monitoring and other factors such as age, gender, personal behaviors, migration status and entitlements are neglected (WHO Regional Office for Europe 2010).

In order to make comparative research between countries possible, data on morbidity and health status of asylum-seekers must be collected in a synchronized manner and harmonized systems. As Bischoff & Wanner (2004) mention, there is a great need for standardized definitions and inclusion of relevant questions on migration and health in data collection activities like health surveys and national statistics. Meanwhile, respect for confidentiality must be ensured and people must be able to take part voluntarily and with informed consent.

In future researches, during collection of data, not only diseases must be monitored but also the topics, which we discussed in the discussion part, must be involved;

- The exact residence status must be clarified.

- Information on duration of stay in the host country must be obtained.
- Data on age, gender and marital status must be gathered.
- Information on the origins of the migrants/asylum-seekers must be obtained. In this case, the data is needed not only for knowing the genetics and biological characteristics but also for recognizing different cultures and how they perceive health and diseases.
- Sample groups sizes must be as large as possible to reduce errors.
- The studies must be done at the same time, when EU laws are the same in every country.
- When gathering data on diseases, the exact stage of disease must be diagnosed.
- And any other intervening factor must be considered in order to make the comparisons more accurate: for instance, level of education.

Promoting a cooperation among countries and carrying out such research will not be an easy task. EU has funded many projects on data collection on health of migrants, however, there is an obvious need for further research, which can happen through more collaboration at European level. For such collaboration to happen, EU guidance or legislations for development and implementation of data collection on the health of migrants are needed. If European countries agree to collect data on the health of migrants and if major stakeholders, like WHO and IOM, cooperate in the process, collection of coherent and comparable data can be ensured (Rechel et al. 2011, p.95).

According to Rechel et al. (2011), the right wing backlash against immigration, politically charged nature of immigration and practical resource constraints in collecting data are the obstacles to improving migrant health in Europe. Even though, there have been several attempts to put migrant health on the top of European agenda, most of these attempts were not followed by changes in national regulations and policies. In order to advance migrant health in Europe, EU needs to gather the necessary political engagements and commitments.

Based on findings of this research and what the results pointed out, lack of research and data on the health of asylum-seekers, the following recommendations are made.

### *Recommendations for Further Research*

As long as there is no sufficient and coherent data on asylum-seekers and their health status, a comparison of their conditions among different countries can be hardly achieved. The hypothesis of this research could not be confirmed due to this lack of data and in case further research in this area is to be carried out, some adjustments based on the availability of data must be done. For instance, status of the asylum-seekers with the same origins on a specific disease in different host countries can be compared and if there are any significant differences in the status, the reasons for that can be found. However, since the health depends on many factors, great amount of exact data for accurate conclusions are needed and that cannot be done without the cooperation of EU bodies and the governments.

As mentioned earlier, the budget might play a role, as well. The more the budget for such research is, the more the access to the available literature can be. Through a sufficient access to all the available literature, more data might be gathered and the possibility of making an exact comparison can increase.

Attraction of Germany for asylum-seekers might be an interesting topic for further research. As discussed in this research, Germany is one of the countries with the most difficult conditions for asylum-seekers and yet, the greatest numbers of asylum-seekers enter this country. In 2014, the highest number of asylum seekers from outside of the EU-28 has been reported by Germany, 203 thousand (EC & Eurostat 2015b). What makes all these asylum-seekers enter this country despite the hard asylum conditions?

### *Further Recommendations*

If EU bodies get involved and aim at improving health of asylum-seekers, the following points must be considered in the measures they take;

- Improvement of health of immigrants, especially the most vulnerable ones like asylum-seekers, should be given priority in the policy agenda.
- Policies with the goal of reducing health inequities, especially in women and children, should be promoted.
- The ambiguities in the directives with the aim of creating a common asylum system must be amended.

- EU bodies should come up with more recommendations and guidelines for the states for improvement of health of asylum-seekers.
- EU bodies should promote adoption of EU legally binding norms that provide non-discriminatory access to health care (Collantes 2009, p.182) for all immigrants, including asylum-seekers.
- An agreement among governments for synchronized, coherent and extended research on the health of asylum-seekers must be promoted.
- EU bodies must watch over and hold the governments responsible for the effects of their policies on the health of immigrants.

And if the states have the aim of improving health status of asylum-seekers, the following points could be considered;

- The states should reduce discriminatory treatment of asylum-seekers such as giving provisions in vouchers or limiting their access to factors that affect health status.
- States should take part in a cooperative cross-national collection of data on the health of asylum-seekers, in order to make comparisons among countries possible. The results of such comparisons have a great potential to inform future policy and decision makings of countries regarding asylum.
- More transparency is needed. Even though, data on the health of asylum-seekers in some countries are available, they cannot be used and seen by the public.
- States must not have the freedom and possibility to put asylum-seekers in conditions in which their human rights can be violated.

### *Policy Recommendations by WHO*

WHO Regional Office for Europe makes recommendations for policy makings concerning determinants of health (Dahlgren & Whitehead 1991) for migrants, which are worth being mentioned here. At the general, socioeconomic and cultural level of determinants they suggest that measures must be taken to

- improve rights of non-citizens, combat exclusion and improve policies on individual and institutional discrimination.

They suggest that at the living and working level of determinants of health, measures must be taken to

- promote inclusive educational policies with attention to linguistic and cultural barriers,
- reduce barriers to labor market and reduce occupational health hazards,
- increase availability of healthy food and water,
- provide better housing with reduced hazards and good transportation,
- and make appropriate health services accessible, improve monitoring of health status and do more and better research.

At the social and community network level of determinants of health, measures must be taken to

- combat isolation, vulnerability and loneliness,
- empower migrant communities,
- and strengthen migrants' social networks.

And at the individual life style level of determinants of health, measures must be taken to

- encourage avoidance of unhealthy life style,
- improve knowledge of health,
- question unhealthy ones
- and strengthen healthy cultural traditions (Rechel et al. 2011, p.8).

Migration is not a risk on its own; however, conditions surrounding the migration process can affect the health of individuals. This statement is especially true for the people who migrate involuntarily, like asylum-seekers, fleeing from disasters or human rights violations (Davis et al. 2006, p.7). The irregular migrants usually find themselves in exploitative situations, get involved in dangerous or degrading jobs and face discrimination in many aspects of life. According to Clapham & Robinson (2009), the fact that these migrants are at high risk of discrimination and abuse and have the least access to health, is contrary to notions of social justice.

If a just European community, free of discrimination and violation of human rights is to happen, changes such as the ones mentioned in the recommendations must be made. Comment No.14 of the Committee on Economic, Social and Cultural Rights mentions that discrimination regarding access to health care or other determinants of health based on "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal

enjoyment or exercise of the right to health” is forbidden. According to Fitzpatrick & Brotman (2002), the prohibition of discrimination based on “other status” in comment No.14 makes it possible to interpret that status of migrants are included, as well. Also, according to the Committee on the Elimination of Racial Discrimination, measures must be taken by the state to “respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services”.

Even though the hypothesis of this research, due to lack of data, could not be confirmed, we should not forget that asylum-seekers, like anyone else, have a right to “the highest attainable standards of physical and mental health”. Thus, in case factors such as socioeconomic status or residence status affect the attainment of the highest standards of health, their human rights are being violated and measures must be taken to prevent any further treatment of human beings in that way.

Just recently, due to the huge number of asylum-seekers arriving to Germany, the German Minister for Home Affairs, Thomas de Maiziere, has recommended changing the provisions for asylum-seekers to even more unattractive ones (Spiegel Online 2015). Finding the balance between granting the asylum-seekers their human rights and dignity and protecting a host country’s economy and society, will not be easy to achieve.

Word Count: 23 385

## 7 References

- Altgeld, T., 2004. Gesundheitsfördernde Settingansätze in benachteiligten städtischen Quartieren. *Expertise E&C: Entwicklung und Chancen Junger Menschen in sozialen Brennpunkten*.
- Anckar, C., 2008. On the Applicability of the Most Similar Systems Design and the Most Different Systems Design in Comparative Research. *International Journal of Social Research Methodology*, 11(5), pp.389–401.
- Bakken, D. & Bond, M., 2013. *Does Sample Size Still Matter?*, KJT Group.
- Benach, J., Muntaner, C. & Santana, V., 2007. *Employment Conditions and Health Inequalities*, World Health Organization.
- Benedict, R. et al., 2010. Migration and Health in the European Union. *Tropical Medicine & International Health : TM & IH*, 16(1), pp.936–44. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17625645>.
- Bischoff, A. & Wanner, P., 2004. Ein Gesundheitsmonitoring von MigrantInnen: Sinnvoll? Machbar? Realistisch? *Neuchâtel: Swiss Forum for Migration and Population Studies*.
- Bonnefoy, X., 2007. Inadequate Housing and Health: An Overview. *International Journal of Environment and Pollution*, 30(3/4), pp.411–429.
- Van den Brande, P., Uydebrouck, M., Vermeire, P. & Demedts, M., 1997. Tuberculosis in asylum seekers in Belgium. VRGT (Flemish Lung and Tuberculosis Association). *ERI*, 10(3).
- Breslau, N. & Davis, G.C., 1993. Migraine, Physical Health and Psychiatric Disorder: A Prospective Epidemiologic Study in Young Adults. *Journal of Psychiatric Research*, 27(2).
- Bundesamt für Migration und Flüchtlinge, 2011. Asylkompromiss garantiert Schutz für politisch Verfolgte. Grundgesetzänderung soll Missbrauch des Asylrechts verhindern. Available at: <http://www.bamf.de/DE/Migration/AsylFluechtlinge/Asylverfahren/EntwicklungAsylrecht/Asylkompromiss/asylkompromiss.html> [Accessed March 25, 2014].
- Bundesverfassungsgericht, 2012. BVerfG ( Federal Constitutional Court), 1 BvL 10/10. Available at: [http://www.bundesverfassungsgericht.de/entscheidungen/ls20120718\\_1bv1001010.html](http://www.bundesverfassungsgericht.de/entscheidungen/ls20120718_1bv1001010.html).
- Van Burg, J., Verver, S. & Borgdorff, M., 2003. The Epidemiology of Tuberculosis among Asylum Seekers in The Netherlands: Implications for Screening. *The International Journal of Tuberculosis and Lung Disease*.
- Chang, M., 2014. *Principles of Scientific Methods*, CRC Press.

- Cholewinski, R., 2004. ECRE Conference on Social and Economic Rights of Refugees and Asylum Seekers - Education and Employment Overview of Social and Economic Rights of Refugees and Asylum Seekers in Europe : International Obligations – Education and Employment 2 . Economic and. , (November), pp.1–24.
- Clapham, A. & Robinson, M., 2009. *Realizing the Right to Health*, Zürich: rüffer & rub.
- Classen, G., 1999. *Menschenwürde mit Rabatt: Leitfaden und Dokumentation zum Asylbewerberleistungsgesetz*, ProAsyl.
- Classen, G., 2009. Wertgutscheine und Krankenscheine nach dem Asylbewerberleistungsgesetz. In *Flüchtlingsrat Berlin e.V.* Berlin.
- COA, 2014. Centraal Orgaan Opvang Asielzoekers: Healthcare. Available at: <http://www.coa.nl/en/asylum-seekers/living-at-a-reception-centre/medical-care> [Accessed March 23, 2014].
- Cohen, D. & Crabtree, B., 2006. *Qualitative Research Guidelines Project*, RWJF.
- Cohen, D.A., Mason, K., Bedimo, A., Scribner, R., Basolo, V. & Farley, T.A., 2003. Neighborhood Physical Conditions and Health. *American Journal of Public Health*, 93(3).
- Collantes, S., 2009. *Access to the Health Care for Undocumented Migrants and Asylum Seekers in 10 EU Countries; Law and practice*, HUMA Network.
- Colledge, M., Van Geuns, H.A. & Svensson, P.G., 1986. *Migration and Health: Towards an Understanding of the Health Care Needs of Ethnic Minorities. Proceedings of a Consultative Group on Ethnic Minorities (The Hague, Netherlands, 28–30 November 1983)*, Copenhagen: WHO Regional Office for Europe.
- Commissioner for Human Rights, 2008. *Housing Rights: The Duty to Ensure Housing for All*, Strasbourg: Council of Europe.
- Committee on Economic Social and Cultural Rights, 1999. *General Comment 12, Right to adequate food*, New York.
- Council of European Union, 2003. *Council Directive 2003/9/EC : Laying Down Minimum Standards for the Reception of Asylum Seekers*, Brussels.
- D’Ancona, H., 1994. *COA: Wet Centraal Orgaan Opvang Asielzoekers*, The Hague.
- Dahlgren, G. & Whitehead, M., 1991. *Policies and Strategies to Promote Social Equity in Health*, Stockholm: Institute for Future Studies.
- Davis, A.A., Basten, A. & Frattini, C., 2006. *Migration: A Social Determinant of the Health of Migrants*, Geneva: International Organization for Migration (IOM).
- EC, 2013a. Beyond GDP: Measuring Progress, True Wealth and the well-being of Nations: Gross Domestic Product. *European Commission*. Available at:

- [http://ec.europa.eu/environment/beyond\\_gdp/indicators\\_gdp\\_en.html](http://ec.europa.eu/environment/beyond_gdp/indicators_gdp_en.html) [Accessed November 9, 2013].
- EC, 2013b. Common European Asylum System. *European Commission*. Available at: [http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/index\\_en.htm](http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/index_en.htm) [Accessed February 3, 2014].
- EC & Eurostat, 2015a. Asylum Statistics. *European Commission and Eurostat*. Available at: [http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum\\_statistics#Asylum\\_applicants](http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics#Asylum_applicants) [Accessed April 19, 2015].
- EC & Eurostat, 2015b. Eurostats ; Statistics Explained; Asylum Statistics. Available at: [http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum\\_statistics#Main\\_statistical\\_findings](http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics#Main_statistical_findings) [Accessed July 21, 2015].
- EC & Eurostat, 2013. Asylum Statistics. *European Commission and Eurostat*. Available at: [http://epp.eurostat.ec.europa.eu/statistics\\_explained/index.php/Asylum\\_statistics](http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Asylum_statistics) [Accessed February 3, 2014].
- ECRE, 2009. Comments from the European Council on the European Commission Proposal to Recast the Reception Conditions Directive.
- Elovainio, M., Leino-Arjas, P., Vahtera, J. & Kivimaki, M., 2006. Justice at Work and Cardiovascular Mortality: a Prospective Cohort Study. *Journal of Psychosomatic Research*, (61).
- EMN, 2013. *Ad-Hoc Query on Asylum Support Rates*, European Commission.
- Eugene, N., Hays, R.D., Arnold, S., Kwoh, K. & Sherbourne, C., 1989. *Age and Functional Health Status*, DTIC.
- European Commission, 2009. *EU Charter of Fundamental Rights*,
- European Commission, 2015. Migration and Home Affairs: Common European Asylum System. Available at: [http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/index\\_en.htm](http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/asylum/index_en.htm) [Accessed March 4, 2015].
- European Council on Refugees and Exiles, 2005. *The EC Directive on the Reception of Asylum Seekers: Are Asylum Seekers in Europe Receiving Material Support and Access to Employment in Accordance with European Legislation?*, ECRE.
- European Migration Network, 2006. *Impact of Immigration on Europe ' s Societies: An Introduction to the EMN Pilot Research Study*, Luxembourg: Office for Official Publications of the European Communities.
- European Parliament, 1994. *Resolution on Respect for Human Rights in the European Union*,
- European Parliament/Commission/Council, 2007. *Charter of Fundamental Rights of the European Union*,

- Evans, G.W., 2003. The Built Environment and Mental Health. *Journal of Urban Health*, 80(4).
- Fagan, A., 2005. Theodor Adorno 1903-1969. Available at: <http://www.iep.utm.edu/adorno/> [Accessed February 1, 2015].
- Federal Republic of Germany, 1993. *Asylbewerberleistungsgesetz*, Germany.
- Federal Republic of Germany, *Book of Social Code V (Sozialgesetzbuch V) : Gesetzliche Krankenversicherung*, Germany.
- Federal Republic of Germany, *Book of Social Code XII (Sozialgesetzbuch XII): Sozialhilfe*, Germany.
- Fitzpatrick, J. & Brotman, S., 2002. *The Human Rights of Migrants*, Geneva.
- Flüchtlingsrat Berlin e.V., 2014. Stellungnahme zum Referentenentwurf des BMAS für ein verfassungskonformes Asylbewerberleistungsgesetz. , pp.1–58.
- Van Gelder, A.-L., 2003. *Overview of The Netherlands' Asylum System*, Uniya Jesuit Social Justice Centre.
- George, A.L. & Bennett, A., 2005. *Case Studies and Theory Development in the Social Sciences*, Belfer Center Studies in International Security.
- Gerritsen, A.A.M., Bramsen, I., Devillé, W., van Willigen, L.H.M., Hovens, J.E. & van der Ploeg, H.M., 2006. Use of Health Care Services by Afghan, Iranian, and Somali Refugees and Asylum Seekers Living in The Netherlands. *European Public Health Association*, 16(4). Available at: <http://eurpub.oxfordjournals.org/content/16/4/394>.
- Gerritsen, A.A.M., Bramsen, I., Devillé, W., van Willigen, L.H.M., Hovens, J.E., van der Ploeg, H.M. & van der Linden, F., 2006. Mental and Physical Health Problems of, and the Use of Healthcare by, Afghan, Iranian and Somali Asylum Seekers and Refugees. *Ned Tijdschr Geneesk*, 150(36).
- Gerritsen, A.A.M. & Van der Ploeg, M., 2006. Physical and Mental Health of Afghan , Iranian and Somali Asylum Aekers and Refugees Living in the Netherlands.
- Goosen, S., 2014. *A Safe and Healthy Future ?*, Utrecht.
- Government of Germany, 1993. *Asylum Procedure Act (AsylVfG)*.
- Government of the Netherlands, 1969. *Compulsory Education Act*,
- Government of the Netherlands, 2014. *UNHCR Resettlement Handbook: Netherlands*, UNHCR.
- Groß, J., 2005. Möglichkeiten und Grenzen der medizinischen Versorgung von Patienten und Patientinnen ohne legalen Aufenthaltsstatus.

- Héritier, A., 2008. Causal Explanation. In *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective*. Cambridge University.
- Hernandez, L.M. & Blazer, D.G., 2006. *Genes, Behavior, and the Social Environment: Moving Beyond the Nature/Nurture Debate*, National Academy of Sciences.
- Immigration and Naturalization Services, Asylum. *Dutch Ministry of Security and Justice*. Available at: <https://ind.nl/EN/individuals/residence-wizard/asylum> [Accessed November 17, 2014].
- International Labor Organization (ILO), 1964. *Employment Policy Convention*, Geneva.
- IOM, 2013. Migration Health. *International Organization for Migration*. Available at: <http://www.iom.int/cms/migration-health> [Accessed November 5, 2013].
- Italian Government, 1998. *Unified Text of Provisions on Immigration and the Status of Foreign Citizens*, Italy.
- Jones, A., Riley, R., Williamson, P. & Whitehead, A., 2009. Meta-Analysis of Individual Patient Data versus Aggregate Data from Longitudinal Clinical Trials. *Society for Clinical Trials*, (6), pp.16–27.
- Juhasz, J., Makara, P. & Taller, A., 2010. *Possibilities and limitations of comparative research on international migration and health. Promoting Comparative Quantitative Research in the Field of Migration and Integration in Europe (PROMINSTAT)*, Brussels.
- Jung, F., 2011. Das Bremer Modell Gesundheitsversorgung Asylsuchender.
- Koppenaar, H., Bos, C. & Broer, J., 2003. High Mortality Due to Infectious Diseases and Unnatural Causes of Death among Asylum Seekers in the Netherlands, 1998-1999. *Nederlands Tijdschrift Voor Geneeskunde*.
- Kraler, A. & Reichel, D., 2010. *Statistics on Migration, Integration and Discrimination in Europe: PROMINSTAT Final Report*, Brussels.
- Kuyvenhoven, J.V., Lambregts-van Weezenbeek, C. & Année-van Bavel, J., 1997. Tuberculosis in Asylum Seekers in The Netherlands. *Ned Tijdschr Geneeskde*, 141(12).
- Laban, C., Gernaat, H., Komproe, I., Schreuders, B. & De Jong, J., 2004. Impact of a Long Asylum Procedure on the Prevalence of Psychiatric Disorders in Iraqi Asylum Seekers in The Netherlands. *J Nerv Ment Dis*, 192(12).
- Laban, C.J., Gernaat, H.B.P.E., Komproe, I.H. & De Jong, J.T.V.M., 2007. Prevalence and Predictors of Health Service Use among Iraqi Asylum Seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 42(10).
- Lagro-Janssen, T., Lo Fo Wong, S. & van den muijsenbergh, M., 2008. The Importance of Gender in Health Problems. *PubMed*, pp.33–37.
- Levy, J., 2008. Case Studies: Types, Designs, and Logics of Inference. *Conflict Management and Peace Science*, 25(1), pp.1–18. Available at:

- <http://www.informaworld.com/openurl?genre=article&doi=10.1080/07388940701860318&magic=crossref||D404A21C5BB053405B1A640AFFD44AE3> [Accessed June 2, 2014].
- Da Lomba, S., 2004. *The Right to Seek Refugee Status in the European Union*,
- Maxwell, J.A. & Mittapalli, K., 2008. Explanatory Research. In *The SAGE Encyclopedia of Qualitative Research Methods*. SAGE Publications.
- Mladovski, P., 2007. Migrant Health in the EU. *Eurohealth*, 13(1).
- Norredam, M., Mygind, A. & Krasnik, A., 2005. Access to Health Care for Asylum Seekers in the European Union--a Comparative Study of Country Policies. *European Journal of Public Health*, 16(3), pp.285–90. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16230318> [Accessed January 16, 2014].
- OECD Health Division, 2013. OECD Health Data 2013 - Frequently Requested Data. Available at: <http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm> [Accessed April 24, 2014].
- Official Website of European Union, Minimum Standards on the Reception of Applicants for Asylum in Member States. Available at: [http://europa.eu/legislation\\_summaries/justice\\_freedom\\_security/free\\_movement\\_of\\_persons\\_asylum\\_immigration/133150\\_en.htm](http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons_asylum_immigration/133150_en.htm) [Accessed March 13, 2014].
- Van Oostrum, I.E. a, Goosen, S., Uitenbroek, D.G., Koppenaar, H. & Stronks, K., 2011. Mortality and causes of death among asylum seekers in the Netherlands, 2002-2005. *Journal of epidemiology and community health*, 65(4), pp.376–83. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20515894>.
- Pelzer, A., Tietje, I. & Piatkowski, R., 2003. Und wo bleiben wir? Die Schul- und Ausbildungssituation minderjähriger Flüchtlinge in Deutschland. *Nah und Fern*, 29(17).
- Pharr, J.R., Moonie, S. & Bungum, T.J., 2012. The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors. *International Scholarly Research Notices Public Health*.
- Della Porta, D. & Keating, M., 2008. *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective*, Cambridge University.
- Pro Asyl, 2015. Pro Asyl: About Us. Available at: <http://www.proasyl.de/en/about-us/>.
- Proasyl, Gefesselte Medizin: Aerztliches Handeln und Aufenthaltsrecht. Available at: <http://www.proasyl.de/lit/medizin/fessel2.htm> [Accessed February 19, 2014].
- PubMed, 2014. PubMed Help. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK3827/#pubmedhelp.FAQs> [Accessed January 21, 2015].
- PubMed, 2015. PubMed Home. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/> [Accessed January 21, 2015].

- Rafnsson, S.B. & Bhopal, R.S., 2008. Migrant and Ethnic Health Research: Report on European Public Health Association Conference 2007. *European Journal of Public Health*.
- Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R. & McKee, M., 2011. *Migration and Health in the European Union*, World Health Organization.
- Relph, E., 1976. *Place and Placelessness*, London: Pion.
- Roberts, R., 2001. PubMed Central: The GenBank of the published literature. *Proceedings of the National Academy of Sciences*, 98(2).
- Robson, C., 2002. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* 2nd ed., Malden: Blackwell.
- Ryan, D.A., Kelly, F.E. & Kelly, B.D., 2009. Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries. *International Journal of Mental Health*, 38(3).
- Schoenborn, C.A., 2004. No Marital Status and Health: United States, 1999–2002. *Advanced Data from Vital and Health Statistics*.
- Scmitz, E., 2007. *RVB: Regeling Verstrekkingen Bepaalde Categorieën Vreemdelingen*, The Netherlands.
- SGBA, 2015. Gender Matters in Health. Available at: <http://sgba-resource.ca/en/concepts/module-2-gender/objective-describe-gender-and-health-connection/> [Accessed January 29, 2015].
- Spanish Government, 1986. *General Health Law (Ley 14/1986 General de Sanidad)*, Spain.
- Spiegel Online, 2015. Zurück zu Sachleistungen: De Maizière fordert unattraktivere Leistungen für Asylbewerber. Available at: <http://www.spiegel.de/politik/deutschland/asylbewerber-thomas-de-maiziere-will-zurueck-zu-sachleistungen-a-1048105.html> [Accessed August 20, 2015].
- Stansfeld, S. & Candy, B., 2006. Psychosocial Work Environment and Mental Health - A Metaanalytic Review. *Scand J Work Environ Health*, (32).
- Strijk, P., van Meijel, B. & Gamel, C., 2011. Health and Social Needs of Traumatized Refugees and Asylum Seekers: An Exploratory Study. *Perspectives in Psychiatric Care*, 47(1).
- The Ministry of Justice, 2004. *The Aliens Act 2000: Aliens in the Netherlands: Admission and Reception*, The Netherlands.
- The Netherlands, 1999. *Aliens Act 2000*, The Hague.
- The World Bank, 2014. Health Expenditure per Capita (Current US\$). Available at: <http://data.worldbank.org/indicator/SH.XPD.PCAP/countries/1W-NL-DE?display=graph> [Accessed April 24, 2014].

- Trochim, W.M.K. & Donnelly, J.P., 2008. *Research Methods Knowledge Base*, Cengage.
- UAF, 2014. Study and Work Support for Highly Educated Refugees. Available at: <http://www.uaf.nl/home/english> [Accessed November 20, 2014].
- UN, 1979. *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*,
- UN, 1966. *International Covenant on Economic, Social and Cultural Rights*, United Nations.
- UN, 1951. *United Nations Convention on the Status of Refugees*, United Nations.
- UN General Assembly, 1979. *Convention on the Elimination of All Forms of Discrimination Against Women*, New York.
- UN General Assembly, 1948. *Universal Declaration of Human Rights*, United Nations.
- UN Office of High Commissioner for Human Rights, 1990. *Convention on the Rights of the Child (CRC)*, New York.
- UN Office of High Commissioner for Human Rights, 2014a. Special Rapporteur on the Right to Food. Available at: <http://www.ohchr.org/EN/Issues/Food/Pages/FoodIndex.aspx> [Accessed November 20, 2014].
- UN Office of High Commissioner for Human Rights, 2014b. The Right to Water and Sanitation Toolkit. Available at: <http://www.ohchr.org/EN/Issues/ESCR/Pages/Water.aspx> [Accessed November 20, 2014].
- UN/DESA, 2013. Total International Migrant Stock. *United Nations Department of Economic and Social Affairs*. Available at: <http://esa.un.org/unmigration/migrantstocks2013.htm?mtotals> [Accessed November 4, 2013].
- UNESCO, 2014. The Right to Education. Available at: <http://www.unesco.org/new/en/education/themes/leading-the-international-agenda/right-to-education/> [Accessed November 18, 2014].
- UNHCR, 2015. Asylum Seekers. Available at: <http://www.unhcr.org/pages/49c3646c137.html> [Accessed January 28, 2015].
- UNHCR, 1951. *Geneva Convention on the Protection of Refugees*, Available at: <http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf>.
- United Nations, 1989. *Convention on the Rights of the Child*, New York.
- United Nations, 1965. *International Convention on the Elimination of All Forms of Racial Discrimination*,
- United Nations, 2009. *The Right to Adequate Housing*, Geneva.

- United Nations High Commissioner for Refugees, 2010. *The Right to Adequate Food*, Geneva: United Nations.
- United Nations High Commissioner for Refugees, 2003. *UNHCR Annotated Comments on COUNCIL DIRECTIVE 2003 / 9 / EC*,
- US National Library of Medicine, 2014. Leasing Journal Citations. Available at: <http://www.nlm.nih.gov/databases/journal.html> [Accessed January 21, 2015].
- De Vaus, D., 2001. *Research Design in Social Research*, University of Queensland: SAGE Publications.
- Verdonk, M., 2005. *RVA: Regeling Verstrekkingen Asielzoekers en Andere Categorieën Vreemdelingen*, The Netherlands.
- Voigt, C. & Hügel, V.M., 2011. *Das „Bildungspaket“ - die neuen Leistungen für Bildung und Teilhabe*, Münster.
- Whitehead, M. & Dahlgren, G., 1992. *Policies and Strategies to Promote Equity in Health*, Copenhagen: World Health Organization.
- WHO, 1946. *Constitution of the World Health Organization*, World Health Organization.
- WHO, 2014. Employment Conditions. Available at: [http://www.who.int/social\\_determinants/themes/employmentconditions/en/](http://www.who.int/social_determinants/themes/employmentconditions/en/) [Accessed November 24, 2014].
- WHO Department of Health Statistics and Informatics, 2013. World Health Statistics 2013. Available at: [http://www.who.int/gho/publications/world\\_health\\_statistics/2013/en/](http://www.who.int/gho/publications/world_health_statistics/2013/en/) [Accessed April 24, 2014].
- WHO Regional Office for Europe, 2010. *How Health Systems can Address Health Inequities Linked to Migration and Ethnicity*, Copenhagen: WHO.
- World Health Organization, 1948. *Constitution*,
- World Health Organization, 2010. International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Available at: <http://apps.who.int/classifications/icd10/browse/2010/en#/I>.

## 8 Appendix

*Council Directive 2003/9/EC*

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum Seekers   | Shall | May |
|-----------------------------|---|-------|-----|
| <b>Chapter II</b>           | <b>General Provisions and Reception Conditions</b>  |       |     |
| Chapter II Article 5 §1     | Member States shall inform asylum seekers, within a reasonable time not exceeding fifteen days after they have lodged their application for asylum with the competent authority, of at least any established benefits and of the obligations with which they must comply relating to reception conditions.<br>Member States shall ensure that applicants are provided with information on organisations or groups of persons that provide specific legal assistance and organisations that might be able to help or inform them concerning the available reception conditions, including health care. |       |     |
| Chapter II Article 9        | Member States may require medical screening for applicants on public health grounds.  |       |     |
| Chapter II Article 13 §2    | Member States shall make provisions on material reception conditions to ensure a standard of living adequate for the health of applicants and capable of ensuring their subsistence.  |       |     |
| Chapter II Article 13 §3    | Member States may make the provision of all or some of the material reception conditions and health care subject to the condition that applicants do not have sufficient means to have a standard of living adequate for their health and to enable their subsistence.  |       |     |
| Chapter II Article 13 §4    | Member States may require applicants to cover or contribute to the cost of the material reception conditions and of the health care provided for in this Directive, pursuant to the provision of paragraph 3, if the applicants have sufficient resources, for example if they have been working for a reasonable period of time.<br>If it transpires that an applicant had sufficient means to cover material reception conditions and health care at the time when these basic needs were being covered, Member States may ask the asylum seeker for a refund.                                      |       |     |
| Chapter II Article 15 §1    | Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illness.  |       |     |
| Chapter II Article 15 §2    | Member States shall provide necessary medical or other assistance to applicants who have special needs.   |       |     |
| <b>Chapter III</b>          | <b>Reduction or Withdrawal of Reception Conditions</b>  |       |     |
| Chapter III Article 16 §4   | Decisions for reduction, withdrawal or refusal of reception conditions or sanctions referred to in paragraphs 1, 2 and 3 shall be taken individually, objectively and impartially and reasons shall be given. Decisions shall be based on the particular situation of the person concerned, especially with regard to persons covered by Article 17, taking into account the principle of proportionality. Member States shall under all circumstances ensure access to emergency health care.  |       |     |
| <b>Chapter IV</b>           | <b>Provisions for Persons with Special Needs</b>  |       |     |
| Chapter IV Article 17 §1    | Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, in the national legislation implementing the provisions of Chapter II relating to material reception conditions and health care.  |       |     |
| Chapter IV Article 18 §2    | Member States shall ensure access to rehabilitation services for minors who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts, and ensure that appropriate mental health care is developed and qualified counseling is provided when needed.  |       |     |

## References

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum Seekers  |
|-----------------------------|--|
| Chapter II                  | General Provisions and Reception Conditions  |
| Chapter II Article 10       | Schooling and Education of Minors  |
| Chapter II Article 10 § 1   | Member States shall grant to minor children of asylum seekers and to asylum seekers who are minors access to the education system under similar conditions as nationals of the host Member State for so long as an expulsion measure against them or their parents is not actually enforced. Such education may be provided in accommodation centres.<br>The Member State concerned may stipulate that such access must be confined to the State education system.<br>Minors shall be younger than the age of legal majority in the Member State in which the application for asylum was lodged or is being examined. Member States shall not withdraw secondary education for the sole reason that the minor has reached the age of majority. |
| Chapter II Article 10 § 2   | Access to the education system shall not be postponed for more than three months from the date the application for asylum was lodged by the minor or the minor's parents. This period may be extended to one year where specific education is provided in order to facilitate access to the education system.  |
| Chapter II Article 10 § 3   | Where access to the education system as set out in paragraph 1 is not possible due to the specific situation of the minor, the Member State may offer other education arrangements.  |
| Chapter II Article 12       | Vocational Training  |
|                             | Member States may allow asylum seekers access to vocational training irrespective of whether they have access to the labour market. Access to vocational training relating to an employment contract shall depend on the extent to which the applicant has access to the labour market in accordance with Article 11.  |

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum-Seekers   |
|-----------------------------|---|
| Chapter II                  | General Provisions and Reception Conditions   |
| Chapter II Article 11       | Employment  |
| Chapter II Article 11 §1    | Member States shall determine a period of time, starting from the date on which an application for asylum was lodged, during which an applicant shall not have access to the labour market.   |
| Chapter II Article 11 §2    | If a decision at first instance has not been taken within one year of the presentation of an application for asylum and this delay cannot be attributed to the applicant, Member States shall decide the conditions for granting access to the labour market for the applicant. |
| Chapter II Article 11 §3    | Access to the labour market shall not be withdrawn during appeals procedures, where an appeal against a negative decision in a regular procedure has suspensive effect, until such time as a negative decision on the appeal is notified.                                       |
| Chapter II Article 11 §4    | For reasons of labour market policies, Member States may give priority to EU citizens and nationals of States parties to the Agreement on the European Economic Area and also to legally resident third-country nationals.  |

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum Seekers   |
|-----------------------------|---|
| Chapter II                  | General Provisions and Reception Conditions   |
| Chapter II Article 13       | General Rules on Material Reception Conditions and Health Care  |
| Chapter II Article 13 §1    | Member States shall ensure that material reception conditions are available to applicants when they make their application for asylum.  |
| Chapter II Article 13 §2    | Member States shall make provisions on material reception conditions to ensure a standard of living adequate for the health of applicants and capable of ensuring their subsistence.<br>Member States shall ensure that that standard of living is met in the specific situation of persons who have special needs, in accordance with Article 17, as well as in relation to the situation of persons who are in detention.   |
| Chapter II Article 13 §3    | Member States may make the provision of all or some of the material reception conditions and health care subject to the condition that applicants do not have sufficient means to have a standard of living adequate for their health and to enable their subsistence.  |
| Chapter II Article 13 §4    | Member States may require applicants to cover or contribute to the cost of the material reception conditions and of the health care provided for in this Directive, pursuant to the provision of paragraph 3, if the applicants have sufficient resources, for example if they have been working for a reasonable period of time. If it transpires that an applicant had sufficient means to cover material reception conditions and health care at the time when these basic needs were being covered, Member States may ask the asylum seeker for a refund. |
| Chapter II Article 13 §5    | Material reception conditions may be provided in kind, or in the form of financial allowances or vouchers or in a combination of these provisions.<br>Where Member States provide material reception conditions in the form of financial allowances or vouchers, the amount thereof shall be determined in accordance with the principles set out in this Article.  |

## References

| Council Directive 2003/9/EC | Laying Down Minimum Standards for the Reception of Asylum-Seekers  |
|-----------------------------|--|
| Chapter II                  | General Provisions and Reception Conditions  |
| Chapter II Article 14       | Modalities for Material Reception Conditions   |
| Chapter II Article 14 § 1   | Where housing is provided in kind, it should take one or a combination of the following forms:<br>(a) premises used for the purpose of housing applicants during the examination of an application for asylum lodged at the border;<br>(b) accommodation centres which guarantee an adequate standard of living;<br>(c) private houses, flats, hotels or other premises adapted for housing applicants.  |
| Chapter II Article 14 § 2   | Member States shall ensure that applicants provided with the housing referred to in paragraph 1(a), (b) and (c) are assured:<br>(a) protection of their family life;<br>(b) the possibility of communicating with relatives, legal advisers and representatives of the United Nations High Commissioner for Refugees (UNHCR) and non-governmental organisations (NGOs) recognised by Member States. Member States shall pay particular attention to the prevention of assault within the premises and accommodation centres referred to in paragraph 1(a) and (b).   |
| Chapter II Article 14 § 3   | Member States shall ensure, if appropriate, that minor children of applicants or applicants who are minors are lodged with their parents or with the adult family member responsible for them whether by law or by custom.   |
| Chapter II Article 14 § 4   | Member States shall ensure that transfers of applicants from one housing facility to another take place only when necessary. Member States shall provide for the possibility for applicants to inform their legal advisers of the transfer and of their new address.   |
| Chapter II Article 14 § 5   | Persons working in accommodation centres shall be adequately trained and shall be bound by the confidentiality principle as defined in the national law in relation to any information they obtain in the course of their work.  |
| Chapter II Article 14 § 6   | Member States may involve applicants in managing the material resources and non-material aspects of life in the centre through an advisory board or council representing residents.  |
| Chapter II Article 14 § 7   | Legal advisors or counsellors of asylumseekers and representatives of the United Nations High Commissioner for Refugees or non-governmental organisations designated by the latter and recognised by the Member State concerned shall be granted access to accommodation centres and other housing facilities in order to assist the said asylumseekers. Limits on such access may be imposed only on grounds relating to the security of the centres and facilities and of the asylumseekers.   |
| Chapter II Article 14 § 8   | Member States may exceptionally set modalities for material reception conditions different from those provided for in this Article, for a reasonable period which shall be as short as possible, when:<br>— an initial assessment of the specific needs of the applicant is required,<br>— material reception conditions, as provided for in this Article, are not available in a certain geographical area,<br>— housing capacities normally available are temporarily exhausted,<br>— the asylumseeker is in detention or confined to border posts.<br>These different conditions shall cover in any case basic needs. |

AsylbLG

| Asylum-seekers Benefit Act (AsylbLG) 1993 |   |
|---|---|
| <b>§3</b>                                 | <b>Basic Services</b>   |
| AsylbLG § 3 Subpara. 1                    | The necessary requirements for food, housing, heating, clothing, health and personal care and household goods shall be covered by contributions in kind. They can also be awarded in the form of vouchers or other similar non-cash settlements. In addition, beneficiaries receive monthly<br>1 until the age of 14, 40 German Marks,<br>2 from the beginning of the 15th Year, 80 German Marks.   |
| <b>§4</b>                                 | <b>Sickness, Pregnancy and Birth</b>  |
| AsylbLG § 4 Subpara. 1                    | For the treatment of acute diseases and pain states the required medical and dental treatment, including the provision of medication and dressings as well as other services necessary to provide for recovery, improvement or for alleviation of disease or illness consequences shall be granted. A supply of dentures occurs only when it cannot be postponed for medical reasons in individual cases.   |
| AsylbLG § 4 Subpara. 2                    | Pregnant women and new mothers are granted with medical and nursing assistance and care, midwives' help, medication, dressings and therapy.   |
| AsylbLG § 4 Subpara. 3                    | The competent authority shall ensure the medical and dental care, including the officially recommended vaccinations and medical checkups offered. As far as the services are performed by resident physicians or dentists, compensation is governed by the force at the place of establishment of the physician or dentist contracts according to § 72 paragraph 2 of the Fifth Book of the Social Code. The competent authority shall determine which party shall apply. |
| <b>§6</b>                                 | <b>Other Services</b>   |
| AsylbLG § 6 Subpara. 1                    | Other benefits may be granted in particular, if they are necessary in individual cases indispensable for securing the livelihood and health, offered to meet special needs of children, or to provide an administrative duty to cooperate. The benefits are to be in kind, in special circumstances in cash.  |
| AsylbLG § 6 Subpara. 2                    | persons who have a residence permit in accordance with § 24 Section 1 of the Residence Act and have special needs, such as unaccompanied minors or persons who have undergone torture, rape or have suffered other serious forms of psychological, physical or sexual violence, are granted with medical or other assistance.   |

| Asylum-Seekers Benefit Act (AsylbLG) 1993 |  |
|---|--|
| <b>§ 5</b>                                | <b>Job Opportunities</b>   |
| AsylbLG § 5 Subpara. 1                    | In reception facilities, according to § 44 of the Asylum Procedure Act and similar institutions, work opportunities are to be provided in particular for the maintenance and operation of facility; the provision of work opportunities should not stop the beneficiary to perform activities of self-sufficiency. Moreover, job opportunities are made available at government, at the municipal and non-profit institutions, provided that the work to be performed would be otherwise, not done to this extent or not at this time. |
| AsylbLG § 5 Subpara. 2                    | The work to be performed pursuant to paragraph 1 shall be paid an allowance of 1.05 euros per hour.  |
| AsylbLG § 5 Subpara. 3                    | The work opportunity should be temporally and spatially in such a way that it can be exercised hourly on reasonable manner.  |
| AsylbLG § 5 Subpara. 4                    | capable of working, non-working beneficiaries who are no longer of compulsory school age are required to carry out a shared work opportunity. In rejection of such an activity, the beneficiary is not entitled to benefits under this Act. The beneficiaries shall be informed in advance.  |
| AsylbLG § 5 Subpara. 5                    | In an employment relationship, for the purposes of labor law and employment, the statutory health and pension insurance are not covered. § 61 para. 1 of the Asylum Procedure Act and asylum and migration law regulations concerning the prohibition and limitation of employment are not against paragraphs 1 to 4. The legislation on worker protection and the principles of reducing employees' liability shall apply mutatis mutandis.   |

## AsylVfG

| Asylum Procedure Act (Asylverfahrensgesetz, AsylVfG) |  |
|--|--|
| Chapter III  | Accommodation and Distribution   |
| Chapter III Article 44                               | Setting up and Maintaining Reception Centres   |
| Chapter III Article 44 §1                            | The Länder shall be required to set up and maintain reception centres necessary to accommodate asylum applicants and to provide the necessary number of places in the reception centres for newly arrived asylum applicants allocated to them on the basis of their respective admission quotas. |
| Chapter III Article 44 §2                            | The Federal Ministry of the Interior or the authority designated by it shall inform the <i>Länder</i> each month of the number of new asylum applicants, the prospective trend and the prospective need for accommodation.   |

| Asylum Procedure Act (Asylverfahrensgesetz, AsylVfG) |  |
|--|--|
| Chapter IV   | Right of Residence During the Asylum Procedure   |
| Chapter IV Article 61                                | Employment   |
| Chapter IV Article 61 §1                             | Foreigners shall not be allowed to take up paid employment as long as they are required to reside in a reception centre.   |
| Chapter IV Article 61 §2                             | An asylum applicant who has lawfully resided in the Federal territory for a year may, in derogation from Section 4 (3) of the Residence Act, be permitted to take up employment if the Federal Employment Agency has granted its approval or a statutory instrument stipulates that taking up such employment is permissible without the approval of the Federal Employment Agency. Previous periods of tolerated or lawful residence shall be counted as part of the waiting period under sentence 1. Sections 39 through 42 of the Residence Act shall apply mutatis mutandis. |

## RVA

| Asylum Procedure Act (Asylverfahrensgesetz, AsylVfG) |  |
|--|--|
| Chapter IV   | Right of Residence During the Asylum Procedure   |
| Chapter IV Article 61                                | Employment   |
| Chapter IV Article 61 §1                             | Foreigners shall not be allowed to take up paid employment as long as they are required to reside in a reception centre.   |
| Chapter IV Article 61 §2                             | An asylum applicant who has lawfully resided in the Federal territory for a year may, in derogation from Section 4 (3) of the Residence Act, be permitted to take up employment if the Federal Employment Agency has granted its approval or a statutory instrument stipulates that taking up such employment is permissible without the approval of the Federal Employment Agency. Previous periods of tolerated or lawful residence shall be counted as part of the waiting period under sentence 1. Sections 39 through 42 of the Residence Act shall apply mutatis mutandis. |

| Regulation on Provisions to Asylum Seekers / Regeling Verstrekkingen Asielzoekers en Andere Categorieën Vreemdelingen (RVA) 2005 |   |
|--|---|
| Chapter IV   | The Benefits During Reception   |
| RVA Chapter IV Article 9 § 1 Subpara. E  | The care in a shelter provides at least the following benefits:<br>a. shelter;<br>b. a weekly financial allowance for food, clothing and other personal expenses;<br>c. public transport tickets for travel to and from the legal aid provider in relation to the asylum procedure, apart from the days that are available for the examination of the asylum application during the general asylum procedure;<br>d. recreational and educational activities;<br>e. cover the cost of medical benefits under a health insurance scheme;<br>f. insurance against the financial consequences of civil liability;<br>g. extraordinary expenses. |
| RVA Chapter IV Article 9 § 2   | As soon as possible after an asylum seeker is in a shelter, a first study of his/her health resort must be done.  |
| RVA Chapter IV Article 16 § 1  | The adoption of a sickness insurance scheme provided in Article 9 first paragraph, section E involves the completion of a health insurance contract to cover the cost of the package specified by the medical benefits.   |

*RVB*

| <b>Scheme Benefits in Certain Categories of Aliens/ Regeling Verstrekkingen Bepaalde Categorieën Vreemdelingen (RVB)</b> |  |
|--|--|
| RVB Article 3 §1 Subpara. B  | The provision of the necessary conditions of existence for aliens referred to in Article 2, first paragraph, subparagraphs a to d and f to g, involves providing the following benefits:<br>a. financial allowance;<br>b. cover the cost of medical benefits under a health insurance system adopted by COA. |
| RVB Article 7 §1   | The adoption of a sickness insurance scheme provided in Article 3, paragraph b, involves completion of a health insurance contract to cover the cost of the package approved by the medical benefits.  |

*Act of 19 May 1994*

| <b>ACT of 19 May 1994<br/>Laying Down Rules for the Establishment of an Independent Administrative Body, Responsible for the Material and Immaterial Reception of Asylum-Seekers</b> |   |
|--|---|
| Article 3 § 1  | The COA is responsible for:<br>a. the material and immaterial reception of asylum seekers;<br>b. placing asylum seekers in a care facility;<br>c. placing asylum seekers in municipal shelters, and the payment of contributions to the relevant municipality for the cost of this care;<br>...e. carrying out other tasks associated with the reception of asylum seekers. |