Public Health Ethics, Asylum & Protection

Summary Report
28 July 2011- 8 October 2014
Final Version 16.10.2014

Follow-Up of the Research Outlined in the Project Plan
‘Part 1 ‘Acute Humanitarian Need’ from July 2011

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The work in this report has been conducted in collaboration with Etikkommissionen i Sverige (The Ethics Commission Sweden). I would like to dedicate a heartfelt thank you to everyone who has had an input in and/or commented on the research undertaken in this report since July 2011, including Etikkommissionen i Sverige and the Human Rights group at Mèdecins du Monde/Doctors of the World Sweden. With special thanks to Professor Angus Dawson, Ms Anita D’Orazio, Associate Professor Hans-Peter Søndergaard, Professor Emerita Elisabeth Hultcrantz, and Dr Göran Bodegård for invaluable expert comments and wisdom. Thank you also to Mr Ed Paulette and Mr Andrew Blight for volunteer proof-reading of peer-reviewed articles and chapters.
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SUMMARY OF RESEARCH
JULY 2011- SEPT 2014

Aim (revised: see Appendix 1 for the original version and Appendix 2 for background):

1) To critically explore the health, social and legal realities of treatment and outcomes for children and their families in Sweden who have been rejected asylum and protection. In particular for children who have developed Pervasive Arousal Withdrawal Syndrome¹ (PAWS), (other terms used are ‘depressive devitalisation’, ‘apathy’, or ‘dissociative stupor’).

2) To use the information in aim 1) to apply ethical and philosophical reflection to understand processes of emotional minimisation and dehumanisation. Assumptions the present system poses risks of a) emotional minimisation, b) processes of dehumanisation which, contribute to: i) poor public mental health and ii) compromise ethics (e.g. moral disengagement²) and human rights. Main Research Questions: 1) how can the asylum process/migration management/ immigration control processes be described and understood using a public health ethics approach? 2) In what ways can the system be said to contribute to emotional minimisation and dehumanisation? 3) [Outside of public health ethics] are there principles/rules that can be applied to enhance understanding and better promote public health? 4) What are the ‘must haves’ (or ‘pre-requisites’) for a humane process? For overarching responses to research question 1-3 see Appendix 3 (page 21-24) and for research question 4, see page 7. Theoretical frameworks draw from public health (including violence prevention) and public health ethics, bio- and medical ethics, law, economy and human rights. Qualitative methods and analyses³: the processes have been studied using qualitative methods. The analysis has been carried out using a variety of qualitative methods influenced by medicine and the humanities: these draw from discourse-, case study-, personal narrative-, interpretive- and testimony approaches (Buchanan, 2000, Denzin, 2001, Denzin and Lincoln, 2003a, Woods, 2013).

¹ This is a stress-induced and severely disabling condition involving extensive, or complete, loss of bodily function resulting from exceptional or high levels of cumulative stress (Bodegård, 2005, 2013, Søndergaard et al. 2012). Cumulative stressors that forced migrants may be exposed to include traumatising life events and fear of return due to an arbitrary asylum process (Johansson Blight et al. 2014). Regarding underlying theories of PAWS, this has been succinctly described by Søndergaard et al. 2012 and was included in the presentation Johansson Blight and Søndergaard (2013). Updated information about PAWS amongst forced migrants is also available in Swedish in Envall (2013) and Ascher and Hjern (2013) and in English in Bodegård (2013) and Ascher and Hjern (2014).

² ‘Moral disengagement’ is explored through ‘emotional minimisation’, which refers to actions that diminish victims’ psychological realities of pain and ‘dehumanisation’, which refers to actions that treat victims as less than human (Leidner et al. 2010, Johansson Blight, 2014a).

³ Being qualitative studies, common limitations apply (Denzin and Lincoln, 2003a): for example, in terms of generalizability this is approached as a reflective rather than a statistical matter, and validity and representativeness, for example of rejected asylum seekers’ experiences are limited for example due to that 1) the empirical data draws from secondary sources of data, 2) not all case files contain all documents used in the processing of the case, and 3) law is a context and time bound practice.
**Empirical data** I have analysed, snowball sampled, existing case file evidence i.e. asylum decisions and medical certificates. I have also reviewed medical scientific articles, ethics references, migration policy reports, legal and human rights frameworks, as well as news reports. I have aimed for information distribution through a range of publishers and various fora. **Academic outputs** cover *four process themes*: Asylum Assessment; Commissioned Medical Doctors & Medical Terminology; New Public Management & Economic Reasoning, and Values & Ideologies. The themes have been summarised from the research presented in articles, book chapters and reports, which so far includes six research articles and book chapters subject to (or due) peer/editorial review (for details see Appendix 4):

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Attention has been paid towards the migration authorities’ argument as to why children with PAWS (and children and adults with other symptoms of severe distress/poor mental health) should not be granted residency and Sweden’s obligation towards rejected asylum seekers and vulnerable persons. I have also reflected on common denominators amongst persons rejected in the documents reviewed (for further information see page 6-7). An extensive literature review has been undertaken with specific focus on literature in public health ethics, bioethics (primarily in Sweden), psychiatry and national and international law and Human Rights Conventions. The literature reviews have mainly focused on published academic work searched for using Pubmed, Google, Amazon, and at the British Library. Specific attention has been paid to identifying and discussing empirical data (asylum decisions and medical certificates) in relation to normative frameworks agreed at national and international level, specifically in relation to children and adults who have been rejected asylum and protection and who can be considered vulnerable. In eight of the article, book chapters and reports (in the table above) case studies of children and adults with PAWS or other symptoms of severe distress are referred to. Finally, for a full list of documents available, see Appendix 5.
GENERATED KNOWLEDGE
SYSTEM, PROCESS & HEALTH OUTCOMES

System and process

- The research in this report focuses on ethical issues in practice, which relates to and/or impacts on public health, social justice and medicine (Dawson, 2009, 2011).

- For many forced migrants in Sweden and elsewhere, the asylum process can be a process of social exclusion (Grewcock, 2009).

- It is theoretically and practically useful to research the asylum system, including its legal framework, policy and case work to understand how this system works. This can be done as the asylum system is a social, structural, determinant of health (Kickbusch and Buse, 2001, Herrman et al. 2010, McDavid Harrison and Dean, 2011).


- As in medicine/public health in general, qualitative and quantitative research methods can be applied to existing data (asylum decisions, medical certificates, etc.) that is collected directly by state authorities or through state commissioning to private sector services. Purpose-made studies (through interviews, observations, surveys, etc.), including larger studies are possible (such as quantitative health outcome studies), by using available, existing data, or purpose-made longitudinal or cross-sectional studies.

- As this research since July 2011 has shown, health has been politicised in migration policy and case law in Sweden. Awareness must thus be made about potential obstacles. This includes for example inconsistencies in frequency reporting and/or dissonance as to what is agreed in society in general, in the interpretation of health and mental health in migration policy and by the migration authorities.

- What the research reported here has shown is that new or different meanings have been applied to medical constructs from those agreed in mainstream society. For this reason I suggest that the health care sector (including public health) should increase its efforts to abide by bioethics, public health ethics and human rights and apply person-centred care in dialogue with patients, a non-discriminatory approach and insist on this primary expertise in relation to migration authorities and society generally.
• It appears that in the process of assessing asylum and protection a focus is often placed on the form of evidence and not primarily its content. Quantitative, continuous, measures are given greater weight than that of narratives of persecution and humanitarian need, seemingly to facilitate rejections. I suggest that this can pose specific risks to social justice and equity in health for all. This has a specific impact on social exclusion: a reductionist interpretation of the process, health and illness, influences what counts as evidence and devalues narratives, which is at the core of the asylum process. The data I have reviewed suggests the existence of discrimination in a way that is contrary to human rights conventions, international law and to medicine and public health, medical-, bio- and public health ethics. This contributes to the exclusion of vulnerable persons from protection, many of ethnic minority belonging.

**Health outcomes**

• Since July 2011, scientific (medical) advances, grounded in extensive bioethical debate, have been made in terms of PAWS. This has helped to *denounce* politically driven myths that some children, due to their cultural heritage, would simulate or malinger severe distress, or be poisoned by their parents, to secure residency (Kihlbom, 2007). This work has improved Swedish public health through a deeper understanding of exceptional levels of stress on the health of forced migrant children, adults and families and the role migration policy and the asylum system as social determinants has in this (Sondergaard et al. 2012, Bodegård, 2013, Ascher and Hjern, 2014). Prior to this the unequal distribution of health risks to persons seeking or rejected asylum compared to residents, was not really recognised. Deriving from this work is also a medical diagnosis, based on patient narratives, that now is available to better identify children (and adults) who have symptoms of PAWS, to facilitate access to competent and appropriate treatment and improve communication (Envall, 2013, Hultcrantz and von Knorring, 2012, Johansson Blight et al. 2014).

• Evidence suggests that public health issues such as alleged violence exposure and violent persecution including undisclosed and disclosed rape, as well as rape as a form of torture, has been missed in migration authorities’ case law (Butchart et al. 2004, Karin Johansson Blight, 2014b, 2014e). This demands the health field’s attention.

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4 ‘These are the ICD diagnoses F32.3A, a sub-group of the ICD F32.3 that includes ‘Severe psychomotor retardation or a state of stupor of a severe grade’; and Z65.8A, ‘Problems in connection with refugees and those seeking asylum’. The latter is a subgroup of Z65.8W, ‘Other specific problems connected to psychosocial condition’ (Johansson Blight et al. 2014: 309).
This study provides evidence that there are vast, what is called *inequalities and inequities in health* (Wilson, 2011), in Sweden, which raises concerns about state obligations towards rejected asylum seekers and vulnerable persons. This research also suggests that there is a conflict in values between legitimate interests in harm prevention and in immigration control. There appears to be a decline in human rights values and disengagement in the asylum system. The research presented here indicates the presence of nationalistic, institutionalised prejudice and racism that seems to be encouraged by far right driven ideologies, and which is likely to impact on matters of cost and, probably, control and the use of technology. This supports Cohen’s (2006) notion that immigration controls are inherently harmful and unfair.

**Pre-requisites for a humane process (response to research question 4):** There are limits to the scope of what can be seen as acceptable national sovereignty (Johri et al. 2012). In today’s globalised world, nations need to facilitate protection for people in need without discrimination or selection depending of the receiving Nation State’s perceived needs or ambitions (economic, cultural, etc.). In order to protect vulnerable people this means that practice needs to abide by the social contracts agreed through national and international law, public health, bioethics and human rights. On the basis of the research presented in this report, I suggest that Sweden should a) review its adherence to principles of ethics (public health-, medical- and bioethics), human rights and social justice in migration b) review its work on health inequalities and equities, and on social justice to include forced migrant populations (including rejected asylum seekers and undocumented migrants), c) review the granting of protection for political reasons, d) recognise that rape is also a form of torture, e) consider general grounds for residency for asylum seekers from countries where many civilians are persecuted, such as Eritrea, Armenia and Kazakhstan, and finally, f) recognise that asylum seekers, refugees, and other forced migrants can also be victims of trafficking and rejected vulnerable persons are at a greater risk of becoming victims of trafficking.

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5 ‘Vulnerable persons’: includes ‘unaccompanied minors, disabled people, single parents with minor children and ‘persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence’ (Council Directive, 2003: 1).
6 Since May 2013 forced returns to Eritrea from Sweden have been temporarily stopped and in September 2014 the First Secretary of the Eritrean embassy was asked to leave Sweden within 48 hours and is believed to be involved in refugee espionage in Nordic countries (Makar, 2013, TT et al. 2014).
8 ‘Trafficking’ refers to a relationship that involves forms of power abuse for the purpose of exploitation (see Hathaway, 2005:404). Sweden ratified the Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and
**System and process:** Describe, explore, analyse, explain and/or evaluate...

- … protection for vulnerable migrants. This can be done by focusing on social protection, transparency, accountability, non-discrimination\(^9\) in the migration system and asylum process including the legal system and case law.

- … the discourse on ‘threats’ in migration policy and in case law. This can be done using public health ethics and violence prevention frameworks (Martin, 2009).

- … immigration control measures such as speedy decisions, detention and deportation,

- … the commonly applied cost perspective in migration policy in Sweden and internationally (Fekete, 2001). Johansson Blight and Johanson (2014) explore migration management in relation to ‘New Public Management’ (NPM) as this appear applicable to the system description. NPM in this setting should be further researched.

- … how well-founded fear is assessed as well as the use of safe countries (as a ‘nudge’) and its impact on decisions on asylum, protection and health.

- … the IT and digitalisation of migration and the use of biometrics.

- … and assess the moral value of present migration policy and practice and its compatibility with existing social contracts in health and public health practice, bioethics, public health ethics, medical ethics.

- … institutional prejudice and racism, and the extent of prejudice and racial bias directed against individuals or groups in decision making. This needs to be explored and practice aligned with national and international law.

- … adherence to basic principles of bioethics. This includes for example non-maleficence, which also needs to be ensured amongst migration authorities’ commissioned medical doctors. Guidance and certificates for medical certification in the asylum process ought to be placed under the health authority rather than other authorities such as the migration authority, as presently in Sweden.

- … the discourse in migration policy and case law that seems to suggest that some asylum seekers are applying for asylum and protection out of a ‘desire’ to reside in the country rather than a ‘need’ for protection. This should be further researched.

- Work also needs to be done to improve institutions’ trust towards the forced migrants they are paid to case work.

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\(^9\) In terms of ethnicity, gender, nationality, and other statues.
Health outcomes: Describe, explore, analyse, explain and/or evaluate:

- … the relationship between traumatising life events, cumulative stressors, serious distress and fear in rejected asylum seeking populations (by gender, age, and co-morbidity).

- … the relationship between suicide and PAWS.

- … migration management, immigration control, the asylum system and process (including the legal system) and the impact on the health (morbidity, disability, mortality), humanity and human dignity of forced migrants. Public health and health professionals ought to critically appraise and systematically research the health impact of this system and its control mechanism on asylum seeking and other forced migrant populations for example by applying Human Rights Impact Assessments (Mann et al. 1999, Gruskin et al. 1999, Hunt, 2006, Marmot, 2013, Johansson Blight et al. 2014). Public health/medical research (academic/scientific) funding ought to be made available for this purpose (in Sweden and elsewhere).

- … health exposures in migrant populations systematically (this includes pre-, during-, and post migration experiences of rape and violence, torture and other forms of human rights abuse) and compare this with how well migration authorities and other societal actors are meeting rights and expressed and unexpressed health needs. Public health, health and medical professionals can approach this from a range of public health ethics perspectives (Dawson and Verweij, 2009, Goldberg, 2009).

- … the public health burden of immigration control (specifically amongst persons rejected asylum and protection and vulnerable groups), using group level health outcomes including on suicide, PAWS, and cost measures such as DALYS or EQ-5D, or other evaluation measures (Anand et al. 2006).

- … health outcomes in various sub-groups including vulnerable persons (for example exploring the presence of PAWS amongst unaccompanied minors and/or family separation and severe distress in the asylum process) and across the migration process journey (BenEzer, 2006).

- … migrant health outcomes ought to be included in the general population health accounts (including mortality, morbidity, impairment and disability) to enable monitoring and ensure that migrants are treated with dignity, humanity and respect by state authorities or commissioned private sector actors.
REFERENCE LIST


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10 This list includes references mentioned on page 3-9 and in Appendices 1-5.


Appendix 1
Project Plan (Part 1) 28 July 2011: THREE WORDS- Acute Humanitarian Need

Research Proposal- Summary (English)¹¹

“The present project is set within the fields of public health ethics and migration. There is an international interest to evolve the knowledge base in particular in relation to forced migration, as knowledge often becomes fragmented or lost in the process of acceptance or rejection. Research evidence in transcultural/cultural psychiatry and psychology indicates that health and mental health is dependent on e.g. cumulative experiences from before migration to after resettlement. The present system poses particular challenges to forced migrants, in part linked to the administrative categorisations of status linked to the right to stay. The focus is on public mental health and structural impacts on this: 1) to improve mental/health for children and adults who are ill, 2) to understand processes such as how the reception system can allow for a treatment of people (children and adults), which is very different from how citizens, are treated, despite signs of poor health and expressed needs of protection. The hypotheses [assumptions]: The present system poses risks of a) emotional minimisation, b) processes of dehumanisation, which contributes to i) poor public mental health and ii) compromises ethics (e.g. moral disengagement) and human rights. Overarching aims Project Part 1: 1) To critically explore the health, social and legal reality of treatment and outcomes for children and their families in Sweden; a) specifically, identify what is needed in practice for residency to be granted on the basis of ‘acute humanitarian need’ and, b) in particular for children with symptoms / diagnoses of pervasive refusal syndrome [the revised term used is: Pervasive Arousal Withdrawal Syndrome, ‘PAWS’, or ‘apathy’]. 2) To use the information in aim 1) to apply ethical and philosophical reflection to understand processes of emotional minimisation and dehumanisation. Research questions: How can the migration management processes be described and understood using a public health ethics approach; a) what are the must haves for a humane reception, b) in what ways can the system be said to contribute to emotional minimisation and dehumanisation, c) [Outside of public health ethics] are there principles/rules that can be applied to enhance understanding and better promote public health? Methods: To explore narrative information gathered over a six months period. The information will be presented as cases and analysed through focus group interviews with experts in the field. The narrative information will be collected through a voluntary organisation working with human rights and health in relation to forced migration. The information will be supplemented by legal and expert statements as well as information produced by the Swedish Migration Board.” (2)

Larger revisions made to the original study plan above¹²: Overarching project aims:
Whilst the study has critically explored the health, social and legal reality of treatment and outcomes primarily for children who have developed PAWS and their families in Sweden, the aim to “a) identify what is needed in practice for residency to be granted on the basis of ‘acute humanitarian need’” has not specifically been approached in the way it was put in the original project plan. Methods: Narrative information has been gathered on an on-going basis throughout these years (since July 2011). Cases has been selected in dialogue with human rights advocates and medical experts in the field using snowball sampling as well as an action research approach (Greenwood and Levin, 2003). The information has been presented through case summaries, case studies and group level frequencies.

¹¹ Some minor proof-reading changes have been made to this text.
¹² This study, since July 2011, has not included a retrospective follow-up of children with PAWS. Moreover, whilst I have reflected on the construct of dehumanisation and the process of such, I have not explored the construct of ‘humanity’. This study has not used focus groups as originally outlined, instead to enhance quality, expert opinions have been sought in relation to all articles/chapters prior to submission for peer or editorial review.
Appendix 2 Background- From Project Plan (Part 1) 28 July 2011

Appendix 2 contains some up-dates/revisions from the original in July 2011.

Introduction

Part 1 of the proposed research aims to contribute with understandings that can be used to prevent suffering and strengthen public mental health in the population of forced migrants in Sweden. It is a collaborative project between legal advice and healthcare service for rejected asylum seekers and other migrants. The pilot project specifically concern children who are categorised as having Pervasive Arousal Withdrawal Syndrome (PAWS) (Bodegård, 2013) or symptoms and/or signs thereof. It is important to acknowledge that the situation for children within the Swedish asylum seeking and refugee reception system is highly political. In the Swedish debate forced migrant children have, arguably, been used in political discourse, and in action to promote more restrictive and controlled migration. The reality is that children who are clearly displaying symptoms of severe distress are being deported or are under consideration for deportation back to places the children themselves or their families have alleged to have been forced to leave. It is clear that there are children and families in the Swedish system of migration management who are suffering hugely. There are children living with symptoms of poor mental/health, which if encountered in the general population would likely be treated as alarming, needing medical attention and care.

With this socio-political reality in mind, scientific medical research provides a forum for critical scrutiny and reflection to prevent illness and promote mental/health. To explore this, relevant research questions include for example: what is the reasoning behind decisions to reject permission to stay? How can this reasoning be understood; are there trends around decisions that can be noted? There should be a possibility to grant permission to stay on the basis of ‘acute humanitarian need’; what are the arguments for this not applying to children with pervasive refusal syndrome or symptoms of pervasive refusal syndrome? What is seen as relevant to the safeguarding of children’s mental/health? Moreover, in line with the aim in the proposed main study, which is to apply ethical and philosophical reflection to understand processes of emotional minimisation and dehumanisation, a) how can the migration management processes be described and understood using a public health ethics approach; b) are these processes abiding by specific ethical principles/rules? C) [Outside of public health ethics] are there principles/rules that can be applied to enhance understanding and better promote public health?

The project is carried out step-wise, and whilst resting on a predominantly qualitative paradigm there is an awareness that quantitative approaches that abide to principles of public health ethics and bioethics, would also be scientifically possible: a mixed methods approach would be good. Nevertheless, a scientific requirement linked to qualitative methods is that pre-notions need to be made explicit. One important pre-notion in this study is that no child deserves the suffering many forced migrant children in Sweden are presently enduring.
Migration: Forced Migration

There are different types of migration. Internal migration commonly refers to migration within a country’s border and concerns for example the urbanisation of the world’s population. International migration on the other hand refers to migration across international borders, and this is what the present project plan concerns. An international migrant has been defined by the United Nations (UN) Recommendations on Statistics of International Migration as ‘… any person who changes his or her country of usual residence’ (UN, 2009:1).

International migration can be either voluntary or forced. Whilst acknowledging overlaps, voluntary migration can be said to refer to labour market migration and family reunion. Forced migrants, who the present project plan concern, have commonly been affected by, what Forced Migration Online (FMO) describes as armed conflict including civil war, generalized violence, or persecution on the grounds of nationality, race, religion, political opinion or social group and have for these reasons been forced to leave their homes. In addition to this, state authorities are unwilling or unable to protect them and thus, asylum and protection are sought in other countries. According to the United Nations High Commissioner for Refugees (UNHCR), refugee status is a common form of protection in for example Germany and France, and in these countries subsidiary protection status is a complement to refugee status. However, the opposite applies for example in Sweden (UNHCR, 2007); where humanitarian reasons are more common than (non-Quota refugee) protection status (European Council on Refugees and Exiles, 2004). This means that a first time asylum applicant would potentially be granted refugee status in one EU country but not another, purely on the basis that the level of acceptance rates in relation to different categories available for forced migrants differ between countries. Moreover, a large proportion of people who have migrated due to conflicts, violence and/or persecution, will include asylum seekers under international law. People who are displaced from their country of living due to conflicts, violence and/or persecution may however also become anonymous migrants for fear of being rejected asylum and protection, and of return (FMO, 2011). In some cases, people in this situation may also for this or other reasons, including other involuntary reasons turn to smuggling and trafficking operations to be able to avoid immigration controls (ibid.).

The current state of managed migration: context description

This section intends to briefly describe the context forced migrants within the EU and on entrance to EU face. The Swedish reception system is part of the overall European Strategy to manage migration, an organised effort which has grown in force since the 1990s. The emphasis is on border control and security, and presently there is substantial amount of money and efforts put into managing migration, primarily at the borders. The gradual increase in border control and security in migration management has in part been motivated by economic arguments such as: ‘[c]loser cooperation and integrated policies can help countries to protect their borders without obstructing the economic development and international trade that can enable the effective management of international migration’ (Martin and Widgren, 2002: 36). A driving organisation for migration management within the EU is the intelligence-driven, autonomous, agency called ‘Frontex’.
That is, the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (European Commission, 2004). Frontex was established on 26 October 2004, has its own financial regulation and works closely with the International Organisation for Migration (IOM), the UNHCR and the International Centre for Migration Policy Development (ICMPD), Europol, Interpol and United Nations Office on Drugs and Crime (UNODC) (European Commission, 2006, Frontex, 2010, Frontex 2014a). Frontex’s management board consists of representatives of the heads of the EU member states’ border agencies that are signatories to the Schengen agreement as well as Iceland, Norway and Switzerland (Frontex, 2010). Frontex promotes, coordinates and develops European border management to enhance external border security and to coordinate operational cooperation (Frontex, 2010, 2014b). The core activity is operational to “…reinforce and streamline cooperation between Europe’s border-control players”, promoting a “pan-European model of Integrated Border Management” (Frontex, 2014c). A main task is to assist in the co-ordination of return flights in cases of forced return, and to coordinate operational cooperation between Member States at the EU external land, sea and air level (Frontex, 2010). Frontex staff are employed on temporary contracts as “Temporary and Contract Agents”, and “Seconded National Experts” the latter refers to ‘national or international civil servants or persons employed in the private sector…” (Frontex, 2014d: 1). Frontex also manage a pooled resource consisting of between 600 officers ‘Rapid Border Intervention Teams’ (‘RABIT’) from various member states, undertaking, for example, surveillance and interviewing undocumented persons. The officers are technologically equipped, and have access to aircrafts, boats, heartbeat detectors, and dogs (Jones, 2014). RABIT team members are also entitled to carry weapons and ammunition, across borders, that are permitted for use in self-defence or to defend another person (European Commission, 2007).

Further developments within the managed migration framework, now include deportation of unaccompanied minors to government funded ‘reception houses’ in countries at war (Ecpat, 2010, Hammarberg, 2010). On the 22 April 2010 a position paper was published by the Defence for Children-ECPAT the Netherlands and UNICEF-the Netherlands. The documents refer to the fact that since 2005 the Dutch government finances reception houses, also often named ‘orphanages’, in Angola and Congo for the return of separated children to their country of origin. Another reception house was started in Sierra Leone in 2009, and as further stated in the report; Norway, Denmark, the UK and Sweden fund houses in countries of origin or are planning to. As highlighted in the position paper requests for asylum are being refused (Ecpat, 2010), on the grounds that there is a safe and adequate place for return in their countries of origin. Nevertheless, this is not without problems and questions interpretations of safety and protection, as pointed out in the report:

‘[t]here are certainly cases where it would be best for the child to go back to the home environment, especially if there exists a caring family context. However, we should be aware that minors who have migrated in many cases have done this with the support of their families, who wanted them to escape from hardship and severe risks’ (Hammarberg, 2010:1).
Migration management and mental health

If interested in the health of vulnerable people and populations, the processes of migration management raise several concerns. For example, it seems that there has been a gradual introduction of mechanisms that make claiming asylum difficult and puts migrants, particularly those judged to be ‘… undeserving of the protection and welfare provision of EU states’ (Watters, 2007: 397) at high risk of social exclusion and many of the deterrence policies pose a risk to mental health (Silove et al. 2000, Kinzie, 2006, Johansson Blight 2009). It is arguably the case that much of the migration management system has been designed to keep unwanted migrants out of western countries, and what this contribute to (and constitute) are conditions that, as they would in general populations, pose threats to mental health (social determinants such as discrimination and racism, housing problems, unemployment, and limited health care access) (Johansson Blight, 2009).

As highlighted in Johansson Blight (2009) a particular concern is the practice of ‘speedily denying refugee status’, which within the EU has been argued to be the rule rather than the exception (Oakley, 2007). The concerns are that this practice compromise fairness in the asylum procedure due to difficulties in assembling supporting documentations to asylum applications, and this may have particularly negative effects on vulnerable people including torture victims and persons with mental disorder (ibid.), other persons with mental health problems, and children. Moreover, as has been shown in reviewed health research, there are additional mental health threats relating to detention, temporary visa protection, and also long asylum periods, etc. (see for example Johansson Blight, 2009, Dudley et al. 2012).

It is important to acknowledge that it is under these restricted conditions that people have to cope and live, with the concurrent effects of war experiences, forced migration, a life in uncertainty, family separation, concern for the family in the home country, fear of deportation, etc. Mental disorder development in forced migrant populations can be explained as relating to a) individual factors (such as age at the time of stress exposure) as well as b) the type of event (for example a particularly strong association has been found between torture and post-traumatic stress, and high levels of pre-migration trauma have been found to increase the risk of long-term chronic psychiatric disability) and c) the social environment—i.e. the exposure to stressors in the pre-migration-, migration- and, importantly, also the post-migration environment (the country in which the person settles) (Johansson Blight, 2009, Harvey, 1996). Theoretically the development of poor mental health can be derived by cumulating stress exposures across the migration phases (i.e. pre-, during, and post-migration). In other words, the post-migration environment can pose threats to mental health, and can also add to previous traumatic experience. The social conditions are hence important to mental/health for all people residing within the nation borders. However, while it is not possible to change the past, what can be done is to understand how the social environment can minimise risks of increased stress on already pressured individuals and instead provide opportunities for improving public mental health and prevent disorder development. To do so, stressful socio-environmental exposures firstly need to be known and to some extent understood, and the relationship and impact on mental health outcomes need to be acknowledged.
Appendix 3 Summary of Answers to Research Questions 1-3

1) How can the asylum process, migration management and immigration control be described and understood using a public health ethics approach? Some suggestions:

- **Justice, health and human rights (in Johansson Blight, 2014a)**
  I have used a framework that allows for a flexible account of justice (Wilson, 2009). Including Mann’s (1997) paradigm, which proposes that the practice of medicine and public health, bioethics and human rights ought to work together for health.

  Bioethics is of upmost importance in the asylum process (Søndergaard, 2005, Bodegård, 2013, see also Ashcroft, 2005). How institutions are supported and work is important to public health (Peter, 2004, Wilson 2009). I have focused on structural determinants (legal and policy factors) (McDavid Harrison and Dean, 2011).


  Research theory and methods to do with public health ethics, mental health and social exclusion have highlighted a need to focus on relationships (Bhui, 2002, Pogge, 2004, Dawson, 2009, 2010, 2011, Herlihy and Turner 2009, Bhugra et al. 2010). In this research, the focus is on relationships between different groups, categorisations and group divisions (Bhugra and Bhui, 2002, Dawson, 2009).

  I have used intersectional analysis that includes ethnicity, race and gender. In line with social epidemiology, I have approached the asylum process as a process of exclusion, and the legal system as a social determinant of health that matters to social justice (Shaw et al, 1999, Krieger, 2000, Oakes and Kaufman, 2006, Kamali, 2009, Grewcock, 2009, Bhui, 2009, Venkatapuram and Marmot, 2009).
• Economic reasoning (in Johansson Blight and Johanson, 2014)
Economic reasoning in migration policy and case law has been explored to better understand the mechanisms behind how persons may be excluded throughout the process, to inform the assessment of justice in the asylum process and in its institutions (Sen, 2004, Peter, 2004, Marmot et al. 2012). For this purpose we referred to Fuchs (1998) who argues that economic analysis can provide some information about the consequences of distributions but cannot on its own determine how basic values are formed or inform choices for people.

• System and process values (in Johansson Blight, 2014a, 2014b, 2014c, 2014d)
In terms of understanding system and process values I have for example referred to Buchanan (2000). I have also used value theory (Schroeder, 2012) to explore ‘subject matters in migration policy and case law. Further, to gain an insight into systematic discriminatory action and abuse (Krieger, 2000, Kamali, 2001), institutional prejudice and racism are considered ideological problems (Bhui, 2002, McKenzie, 2002). Rather than a dichotomous positioning of ‘social conditions that cause disease and targeted interventions’ (Goldberg 2009:76) to improve public health, the research undertaken here has been conducted with a notion that the values driving systems and processes will impact on what is considered a ‘threat’ to public health and decisions on who, how and why individuals and/or groups are targeted.

2) In what ways can the system [asylum process/migration management/immigration control] be said to contribute to emotional minimisation and dehumanisation? Some findings:

• The research findings also indicate that there is a conflict in values between migration authorities practice and health care outside this system. Where, migrants are treated in a way that in the general population would be considered risky or harmful to health.

• I have found indications of serious flaws in the assessments of asylum and protection that conflicts with principles agreed through international law, human rights conventions, justice and social justice (Johansson Blight, 2014b, 2014e). Findings suggest that in the assessment of asylum applications, political persecution, rape as torture, well-founded fear and severe and cumulative stress have been left largely unexplored. This seems to have contributed to rejections of protection.
I have found that interpretations of health in migration policy, the expectations of Commissioned Medical Doctors, and the focus on “objective” measures that are not always readily applicable to the illness state, and where requests are made for quantitative evidence (weights, dates, etc.), as this is viewed as enhancing credibility, seem to contribute to discrimination, disengagement and dehumanisation (Johansson Blight, 2014a, 2014d). However, in the legal process it is the content of information that should have priority, and not the form (Johansson Blight, 2014b).

Further, if such vital information is missed in the application of case law this may be described as epistemic kinds of injustices (Carel and Györffy, 2014). Two forms of which are testimonial injustice that is, when ‘prejudice causes a hearer to unfairly assign a lower level of credibility to a speaker’s testimony or report. This can be done by doubting, ignoring, or failing to take someone’s testimony seriously until it is corroborated by another’ (Carel and Györffy 2014: 1256). Or hermeneutical injustice, ‘which occurs when a gap in collective interpretative resources puts a speaker at a disadvantage. This injustice occurs when society as a whole lacks an interpretative framework to understand particular experiences’ (ibid.). This can also contribute to secondary traumatisation, create an unjust process, and introduce wider social injustice (Johansson Blight, 2014b, 2014d).

What counts as credible evidence of health and persecution in the process is likely to influence budgeting through the decision makers’ decisions. Caution needs to be applied to the potential presence of institutionalised perceptions of economic reasons. Further, a substantial proportion of the aid budget is spent on the administration of migration management within Sweden (Johansson Blight and Johanson, 2014); part of which seems to be to budget for technology for immigration control, speedy decisions and deportations. However, to cost deportations through the aid budget is a paradox as the latter is there to improve the conditions for poor people.

The findings in this research (Johansson Blight, 2014a, 2014d, Johansson Blight and Johanson, 2014) raise the concern that the original harm prevention perspective becomes secondary to the control of immigration. The present research also finds supports to Cohen’s (2006) notion of the existence of a racism of controls. A key concern is whether immigration control per se is inherently harmful and/or intrinsically unfair, thus discrediting the very idea of immigration control as a legitimate state interest. These concerns need further research and discussion.
3) [Outside of public health ethics] are there principles/rules that can be applied to enhance understanding and better promote public health? Some suggestions:


- **Human Rights Conventions**: United Nation conventions that I have referred to, or that are applicable to, this research includes for example (for signatures and ratifications see United Nations (UN) Treaty Collection, available at: https://treaties.un.org): UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984). This Convention is useful to refer to when exploring aspects of rape and in families who have sought asylum and protection and who have children with symptoms of PAWS. This includes Article 1 and 14 (the right to rehabilitation as part of redress) (Sveaass, 2013); UN Convention relating to the Status of Refugees (1951) and related protocols and conventions concerning Refugees and Stateless Persons (UN, 2006); UN Convention on the Rights of the Child (1989); UN Convention on the Rights of Persons with Disabilities (2006); UN Universal Declaration of Human Rights (1948); UN International Covenant on Civil and Political Rights (1966); UN International Convention on the Elimination of All Forms of Racial Discrimination (1966), and Human Security such as the UN Convention against Transnational Organized Crime (2000) (UN, 2006).

- **Bioethics**: There are many bioethical principles that are useful when researching the health and public health implications of the asylum system and process. These include the Hippocratic Oath (Miles, 2004). As well as, for example, WMA International Code of Medical Ethics, WMA Declaration of Lisbon on the Rights of the Patient and the WMA Declaration of Geneva Right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Right to Health) (available at: http://www.wma.net/). As well as guidance promoted at national level (for Sweden see for example Engström, 2010).
Appendix 4 Research Articles and Book Chapters Subject to Peer/Editorial Review

<table>
<thead>
<tr>
<th>Author/s</th>
<th>Title</th>
<th>Methods/Empirical Info.</th>
<th>Content</th>
<th>Publication info.</th>
</tr>
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<tbody>
<tr>
<td>3. Johansson Blight, K.</td>
<td>‘Questioning Fairness in Swedish Asylum Decisions’</td>
<td>Article</td>
<td>The article focuses on the way the asylum process is administered through case law and in relation to migration policy. It includes an outline of the impact of asylum assessments on mental health and social exclusion.</td>
<td>State Crime, Pluto journals. Accepted for publication 25 February 2014. Anticipated publication spring 2015, and online in 2014.</td>
</tr>
<tr>
<td>5. Johansson Blight, K., Johanson, U.</td>
<td>‘The Use of Economic Arguments in the Asylum Process’</td>
<td>Article</td>
<td>This article gives some insight into how economy may influence decision making with regards to asylum and protection for vulnerable persons. As well as the amalgamation of Swedish foreign aid with Swedish domestic expenditure relating to the asylum process and migration management.</td>
<td>Public Health Ethics Submitted 13/07/2014. Under review.</td>
</tr>
<tr>
<td>6. Johansson Blight, K.</td>
<td>‘Prevalent values and ideologies in contemporary Swedish migration policy- the impact on and recognition of vulnerable groups’</td>
<td>Article</td>
<td>This article discusses values and ideologies in migration by exploring and discussing the implementation of the system and process and its legitimacy. Value theory is used to analyse subject matter used in migration policy and case law, which appears to polarise.</td>
<td>Public Health Ethics Submitted 26/09/2014. Under review.</td>
</tr>
<tr>
<td>7. Johansson Blight, K.</td>
<td>‘Rejected Asylum Seeker But in Need of Protection’</td>
<td>Article</td>
<td>In this article rape as torture and well-founded fear is specifically discussed. The legal documents refer to a woman from Eritrea. Reference is made to a violence prevention perspective.</td>
<td>Due submission for peer-review.</td>
</tr>
</tbody>
</table>
Appendix 5 List of Published & Unpublished Work since the Project Plan in July 2011

### Peer reviewed articles Published


### Under Review/Due submission


### Book Chapters Published


### Accepted

Newspaper articles Published


Reports Published


Unpublished


13 Unpublished documents are available on: http://independent.academia.edu/KarinJohanssonBlight or by contacting me directly via email: acblight@hotmail.com.


**Presentations**


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14 In addition to this, I have also been part contributing, with expert advice towards University students’ essays: 1 BSc in Social work and 1 MA in law as well as to lawyers and journalists.
The title of this report: The title is ‘Public Health Ethics, Asylum and Protection’ and the report is a study summary of the Project Plan ‘Part 1 ‘Acute Humanitarian Need’.

Report author: This report is written by Dr Karin Johansson Blight. Dr Johansson Blight is a Registered General Nurse (RGN) in Sweden and the United Kingdom (UK). She has a BSc in Nursing (from the Red Cross University College, Sweden, 1997), an MSc Public Health (from London School of Hygiene and Tropical Medicine, UK, 1999), and a PhD in Psychiatry (from Karolinska Institutet, Sweden, 2009).

Researcher: The report author, Karin Johansson Blight, PhD, has also carried out the research in this report. Dr Johansson Blight is an Independent Researcher who lives in the United Kingdom. The research undertaken by Dr Johansson Blight has been undertaken in collaboration with Etikkommissionen i Sverige (the Ethics Commission Sweden) and other experts in this field. Funding and finance of this research: The research in this report has been undertaken unfunded. This means that the report author (and researcher) has worked in an unpaid, voluntary, uncompensated, capacity when conducting this research.