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Exploring the links between social connections, care and integration

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Exploring the links between social connections, care and integration

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Table of contents

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Editorial: Exploring the links between social connections, care and integration

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Editorial on the Research Topic
Exploring the links between social connections, care and integration

It was around the time when late professor Castles (2003) published a seminal article reflecting on the past and future of a sociology of forced migration that Ager and Strang (2004) authored the first paper of what would eventually form the core of integration policy in the UK and beyond (Ager and Strang, 2008; Strang and Ager, 2010), the Indicators of Integration framework (Ndofor-Tah et al., 2019). Already a notion defined in myriad ways, yet still suffering from an utter lack of consensus around what it actually means, is and does, integration was thrust into European public and policy discussions after the "death" of European multiculturalism—a problematic narrative that has endured despite Schinkel's (2013, 2017, 2018, 2019) admirable correctives. If Ager and Strang's (2008; see also Strang and Ager, 2010) conceptual approach to understanding integration through social connections lent itself favorably to integration research and policy, the complexity of forced migration continues to furnish lively debate around how we can fully appreciate the politics of acculturation (see, for instance, Spencer and Charsley, 2021).

There is indeed a wide spectrum from which academics and policymakers employ (or attempt to contest) the concept. On one side, scholars take integration as a normative given, or approach integration for what "ought" to be occurring, rather viewing integration as an empirical "is" (Spencer and Charsley, 2021). There are others "writing against integration" (Rytter, 2019) who attempt to end the neocolonial othering of people on the move (Schinkel, 2018). The authors and editors of this Research Topic do not collectively come down on the side of dismissive critique or of uncritical acceptance of the term. As a collective, we instead dialectically straddle a normative vision for what could be possible for integration both in the Global North and Global South and take a step back to empirically observe what integration and *dis*integration is producing in these localities.

The issue we are grappling with in this Research Topic is the processes by which human beings "do belonging:" accessing health services, finding suitable education for their children and suitable employment for them, finding spaces and activities for release, connecting with people, institutions and organizations, negotiating ways of living normal lives, and more. All in an increasingly polarized world of othering and alterity where events such as the global COVID-19 pandemic in 2020, acutely accelerated changes in sociability and social life. It is a complex issue to behold and access. But it is one that necessarily depends on the fragilizing relationships of giving and receiving care, which Caduff (2019) so eloquently attunes us toward. In this context, our unique contribution draws out the links between social connections, care and integration, which are often implicitly assumed to be closely intertwined, but in this Research Topic we explicitly bring to the fore across diverse contexts.

It was findings emerging from two large-scale research projects, one on protracted displacement in Somalia, the Democratic Republic of Congo (DRC), Kenya, and South Africa and one on refugees' pathways toward integration in the UK with a focus on Scotland, that provided the empirical bases from which to explore the relationship between care, connection and integration (see for instance Käkelä et al., 2023; Vera Espinoza et al., 2023). Together with contributions from Sweden, Jordan and Chile, these confront us with the interconnections and ambivalences between alterity and intimacy (Caduff, 2019) in what is commonly referred to as integration but often substantively points toward *dis*integration (Hinger and Schweitzer, 2020).

By putting care at the center of debates on integration and social connections, the papers of this Research Topic contribute to enhancing our understanding of these contested, daily, multi-dimensional and non-linear processes in several ways. First, the papers invite us to unsettle the geographical narrowness of debates around integration, by creating a cross-regional dialogue around integration and *dis*integration experiences across settings.

Second, all the papers in the Research Topic shift the focus from the refugee/migrant as the main "subject" of integration, by raising questions around who other pivotal actors/agents are and where these processes and experiences are taking place.

By putting an emphasis on other actors, dynamics and spaces where care as part of integration happens, the papers focus both on those who receive care and those who provide it, as well as in the ambivalences of this exchange and the shifting roles of carer/caree. In other words, acts of integration and care are simultaneously done by and to migrants and refugees. For instance, Baillot calls for integration to be understood in relation to family and their exchanges of care within the settlement country. Focusing on data collected in Glasgow and Birmingham, Baillot argues that a focus on familial relationships of care re-positions refugees as active subjects who also offer care to others. Jordan adds to this reconceptualization of refugees as both providers and recipients of care, by focusing on refugee-refugee hosting dynamics, drawing on qualitative research conducted with Sudanese refugee men in Jordan. Strange and Askanius, on the other hand, explore relations of care both within the public healthcare system and the media in Sweden to understand the disproportionately exclusion affecting migrants in the country, which the authors attribute to a wider disintegration of Swedish society.

The contributions by Kerlaff and Bile et al. shift the focus to the "local" as the spaces where integration is negotiated daily. Kerlaff sheds light on the links between local and individual context in facilitating or hindering processes of integration for reunited refugee families settling in unchosen areas in the UK. Bile et al. draw on research with IPDs and refugee returnees to Somalia, to advocate for the inclusion of "local integration" as a conceptual lens that allows better grasping of the nuances of social connections and integration domains within spaces in the Global South.

Another set of papers emphasizes the experiences of refugees and migrants integration into health systems or the extent to which a "lack of care" in this sector can contribute to wider experiences of exclusion and assimilation. Here, healthcare workers emerge as key actors and health services as relevant spaces where to explore processes by which people negotiate belonging. For instance, Reyes Muñoz and Reyes Muñoz analyse migrant women's experiences as part of the "National Child Health Programme" in Chile. While most women appreciated the support their children received as part of the programme, they also felt constantly judged by nursing professionals who transmitted specific and racialized "values and expectations" about migrant mothers' care practices. Boeyink et al. find similar processes of (dis)integration and (mis)integration drawing on interviews with healthcare professionals and Congolese and Somali refugees in Kenya. While both groups have similar understandings on the barriers to healthcare, healthcare professionals focus on the changes of behavior that refugees should have instead of looking at structural inequalities. McAteer et al. also identify challenges in displaced population access to health in Kenya, particularly in relation to documentation, information and language barriers. By exploring these barriers within health pathways, the authors reflect on the potential pitfalls of integrated health care systems for urban refugees.

The outcomes of processes of (dis)integration and otherization lead in many cases to impact on mobile peoples' mental health and wellbeing, as demonstrated by the research paper by Walker et al., which explores mental health issues faced by Congolese and Somali asylum seekers and refugees in South Africa. Through the findings, the authors suggest understanding "alienation" as a conceptual tool that provides accounts of both acts of alienation and feelings of alienation.

This Research Topic also brings to light the contested notions of integrating plural forms of healthcare for IDPs in DRC. The policy brief of Mutombo et al. highlights the disconnect between policy and practice of implementing mental health interventions for IDPs across the country. A lack of human and financial resources does not match the progressive policies and conventions that the government has signed on to. This national policy analysis is contrasted by Kazamwali et al. who zoom in to the local dynamics of accessing Traditional, complementary and alternative medicine (TCAM) in IDP areas in South Kivu province of Eastern DRC. Despite IDPs and non-IDPs accessing TCAM at high rates, IDPs are more reliant than non-IDPs. This study demonstrates that these actors and services are not monolithic and offer a typology of care and services from TCAM providers that are trusted to widely varying degrees by their interlocutors.

Offering a broad range of case studies across world regions, the papers in the Research Topic not only emphasize a spectrum of integration and *dis*integration experiences, they also shed light on different understandings of care that underpin social relations within these experiences of (dis)integration. Care can be then understood as a value and a practice (Raghuram, 2016), as well as a range of tasks, activities and practices aimed at promoting "the personal health and welfare of people" (Yeates, 2004, p. 371). But also, care emerges as an expression of "intimate connection" (Caduff, 2019, p. 788) core to our social relations, that can be felt and perceived differently by those who give it and those who receive it.

This exchange of care is central to exploring "lives that seek to live through something that's without resolution" (Caduff, 2019, p. 802), reminding us of the emotional and structural ambivalences inherent in the contested processes of "integration." Collectively, the papers in this Research Topic offer three broad reflections: (i) much of the world's hierarchies are negotiated within the everyday tension between care and service provision; (ii) the contingencies surrounding how individuals, families, and communities position themselves and each other within specific places remain under-explored; and (iii) the "messiness" between policy commitments and their practical implementations remains insufficiently addressed.

Author contributions

MVE: Writing – original draft, Writing – review & editing, Conceptualization. AD: Writing – original draft, Writing – review & editing, Conceptualization. CB: Writing – review & editing, Conceptualization.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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"I just try my best to make them happy": the role of intra-familial relationships of care in the integration of reunited refugee families

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Migration through managed routes such as spousal and work visas has been conceptualized as being a pragmatic choice driven by the needs of families rather than individuals. In contrast, studies of refugee integration post-migration have tended to analyse integration processes through the perspective of the individual rather than through a family lens. Drawing from data collection using a social connections mapping tool methodology with recently reunited refugee families supported by a third sector integration service in the UK, in this paper the author makes a valuable contribution to addressing this theoretical gap. The author explores the ambivalent ways in which family relationships, and the care that flows between family members, influence emotional, and practical aspects of refugees' integration. Empirically the inclusion of accounts from people occupying different positions within their families, including from children, adds depth to our understanding of integration from a refugee perspective. Conceptually, the paper argues that a focus on familial relationships of care re-positions refugees not as passive recipients of care, but active and agentive subjects who offer care to others. The paper ends with a call for integration to be understood in a family way that fully encompasses the opportunities and limitations offered by familial care.

KEYWORDS
refugee, family reunion, care, integration, migration

1. Introduction

Across the UK, Europe, and the Global North, controlling and, in some cases, preventing spontaneous arrivals by people seeking international protection has become a major policy preoccupation. Responses to refugee mobilities range from the construction of physical walls to blockade borders (Garcia, 2019), to co-operation agreements with third countries to prevent departures regardless of the humanitarian consequences (Sajjad, 2022). In the UK context, immigration legislation has restricted refugees' legal and socio-economic rights (Mulvey, 2015), creating a policy environment that is purposefully hostile to migrants, most especially those entering the country through irregular routes to seek international protection (Griffiths and Yeo, 2021). People who overcome these hurdles and are recognized as refugees can face a new set of challenges as they try to settle in the new country context (Strang et al., 2018) including structural constraints that shape their experiences of integration (Phillimore, 2020).

Integration policies are nominally designed to assist refugees to "re-build their lives from the day they arrive" in their countries of settlement (Scottish Government, 2018, p. 10).

Political discourse around integration is strongly linked to concerns around social cohesion, with social and cultural changes occasioned by migration perceived as leading to division and discord (Casey, 2016). This discourse has been critiqued as being rooted in a post-colonial mindset, that assumes people are integrating into what is in fact an imaginary culturally and ethnically homogenous national community (Schinkel, 2013). Scholars have insisted on the importance of understanding integration as a multi-dimensional process, rather than a pre-determined set of outcomes. However, policy and practice interventions can still rely on gathering evidence of integration through measures such as levels of employment and education (Penninx, 2019). As a result, refugees can find their progress judged against metrics that fail to consider the fluid, non-linear nature of their lives and changing circumstances.

This paper does not, as Schinkel (2013) recommends, jettison the concept of integration entirely. Instead, in line with scholarship that recognizes and addresses its critiques (Spencer and Charsley, 2021), my aim is to expand its conceptual and empirical reach through exploring the role of the interrelated concepts of care and family in integration. Care, as a site of "intimate connection" (Caduff, 2019, p. 788) can facilitate integration (Käkelä et al., 2023). The obligations and complexities of organizing and providing transnational family care where one or more family members are living overseas have been well-documented (Baldassar, 2007; Näre, 2020). Yet, despite the family's central position as "a template for a safe social relations" (Caduff, 2019, p. 794), where care is present in integration discourse, it is usually understood as professionalized care received by refugees—through interventions taking place in health or social care, provided by the third sector or during research itself (Vera Espinoza et al., 2023). Intra-familial acts of care given and received by refugees in countries of settlement remain largely invisible.

In a similar way, the role of the family in the integration experiences of forced migrants is rarely explored in detail. While the same critique could be leveled across the field of migration studies, research with people migrating for work or family reasons has increasingly, though not uniformly, adopted a family-eye view. Cooke (2008) underlines the importance of understanding *all* migratory projects "in a family way" (Cooke, 2008, p. 255). This approach conceives of migratory decisions as the result of a process of weighing up costs and benefits for the whole family, not just in relation to the individual family members who cross international borders. Family has been recognized as an effector of integration: one of a multitude of contextual factors that influence integration (Spencer and Charsley, 2016). Research with refugees living in London and Glasgow, two large cities in the UK, confirmed that family has "a unique saliency in human relationships" and should be a central component of future integration research and policymaking (Strang and Ager, 2010, p. 597). Yet, for people who cross borders to seek asylum, as opposed to through routes such as work and spousal visas, an understanding of individual and family mobilities as being migratory projects can be somewhat subsumed by insistence on the traumatic and forcible nature of their displacements (Marlowe, 2010). Relatively little is known about the concrete ways in which being part of a family, and the everyday care this involves, can affect refugees' experiences of integration.

To address this gap, this paper presents data drawn from qualitative research activities undertaken with recently reunited refugee families living in the UK. Data were gathered using a Social Connections Mapping Tool methodology with a sample of refugee families living in cities where people seeking asylum are housed by the UK government. Participants were drawn from a cohort of asylum route refugees accessing family-focused integration services and were recruited through specialist third sector project partners. To frame the findings from the study, I begin by exploring the nexus between family, migration and integration; then outline feminist conceptualizations of care and how these apply in a migratory context. Taking the moment of family reunion as a pivotal event around which past, present and future experiences and aspirations for care collide and coalesce, I draw out accounts from sponsors, arriving spouses, and children to build a multi-layered view of the meanings they ascribe to giving and receiving care. This illustrates the ways that age, sex and family position shape how care impacts upon integration. I end with a call for care within the family to be recognized as a site where refugees are agents, rather than recipients, of integration assistance, and for intra-familial care to be foregrounded in future integration research and policy.

1.1. Migration, integration, and the refugee family

Perceptions of the role played by the family in the integration are not static. The European Union's Family Reunification Directive accords rights to family members of EU workers because "family reunification helps to create sociocultural stability facilitating the integration of third country nationals in the Member State, which also serves to promote economic and social cohesion" (EU Council Directive 2003/86/EC). This was indeed the initial approach to family unification migration taken by European countries in the post-war period. Allowing workers coming from outside the European Economic Area (EEA), who were primarily men, to bring wives and children to join them was seen as a positive way to ensure their integration into society (Bonjour and Kraler, 2015). However, in recent years, family members' capacity to integrate, as judged by measures including language proficiency tests, has been used to justify policies that restrict family migration (Strik et al., 2013). Increasingly migrant families are situated as problematic social units where harmful cultural norms are perpetuated, and where integration can be halted or reversed (Grillo, 2008).

In the specific case of refugee families, similar contradictions dot the policy landscape. Being officially recognized as a family is a primary criterion that qualifies refugees for resettlement schemes that enable safe passage to receiving countries. In this reading of what it means to be a refugee, being part of a (nuclear) family denotes vulnerability and people *at* risk, whereas being single, especially for men, is an indicator that you may be *a* risk rather than someone who is deserving of care (Welfens and Bonjour, 2020). It is on this basis that families are prioritized for resettlement, displacing the goalposts of refugeehood enshrined in the 1951 Refugee Convention, and re-positioning asylum as a humanitarian gesture rather than a human right (Fassin, 2005). If family arrivals are nominally more welcome than single men, this does not denote an unconditional acceptance of family as a factor supporting integration. Interventions to support family integration can have as their starting point the notion that family relations that are "one of the main barriers toward successful integration into the local society" (Olwig, 2011, p. 191). Doubt is cast upon refugee parents' capacity to care for their children in line with prevailing cultural expectations (Kouta et al., 2022). Perceptions of refugee families as being in need of assistance not only justifies government interference in their family lives but, in contrasting local family norms to those of arriving refugees, reinforces the cultural identity of receiving countries (Bonjour and De Hart, 2013).

Evidence from research with migrants and refugees themselves confirms that family unity—or lack thereof—has an important effect on people's ability to settle into new environments (Bonjour and Kraler, 2015). The existence of trusted social bonds, including familial relationships, is fundamental to people's ability to build deeper connections with other people or services over time (Strang and Ager, 2010). Knowing that family members are living in situations of danger and precarity overseas can mean that people feel "less able to establish and sustain relationships" in the country of settlement (Pittaway et al., 2016, p. 414). However, if family ties can provide "strength and solace" (Lokot, 2018, p. 560), familial relationships can also be sites of obligation, and, in severe cases, of abuse and violence. Migration, and the separations it occasions, can affect family relationships (Näre, 2020). Evidence suggests that subsequent moments of reunion can be fraught with difficulty as family members come to terms with the effects of separation (Rousseau et al., 2004). Young people have reported various challenges within the home: conflict with parents who object to them adopting the new cultural norms, pressure from parents who see their children's success as the main aim of their migration and the need to navigate unfavorable material circumstances in the early days of settlement (McMichael et al., 2011). The enforced nuclearization of refugee families by immigration policies that narrowly define family as parents and their dependent children means that families themselves may still feel incomplete. Important extended family members including grandparents and adult siblings can be prevented from crossing borders to live with or visit families who have been granted settlement (Grillo, 2008; Wachter and Gulbas, 2018). This paper provides further evidence of both the joys and difficulties of rebuilding family relationships in the months after reunion, and by extension of the ways that family, in its opportunities and constraints, influences integration for people settling in the UK.

1.2. Perspectives on family care and its role in migration

Feminist perspectives that suggest that care, in its practical and emotional manifestations, is a "building block of society," whose meanings and practices are rarely explored in detail (Innes and Scott, 2003, p. 5.1). In a wide range of social policy areas, manifestations of care are both neglected and ignored (Lynch et al., 2021). For example, while many social policies orientate toward "facilitating labor market participation for a range of socially excluded groups" (Innes and Scott, 2003, p. 3.1), this has been at the expense of policies that recognize and support the unpaid work of care and its contribution at micro (family) and macro (societal) levels (Yeates, 2011). Much of the physical and emotional labor of care is undertaken by women, either within familial structures or as employees in care industries. The relegation of care as an area of private rather than public concern is reflective of the ways in which women's experiences more broadly have traditionally been understood to lie outside the public, male sphere. This, Scuzzarello (2009, p. 66) argues, "depoliticizes highly political issues and retains structures of power that position women and care receivers outside the public realm."

At the nexus between care and migration, this does not always mean that women are materially disadvantaged. Women who migrate to provide care elsewhere face fewer obstacles than men in obtaining visas and regularization in countries of settlement (Calavita, 2006). However, migrant women can then face the challenge of navigating between caring for others and organizing transnational care for their own family members (Bernhard et al., 2009). The often invisible labor of transnational care can include financial remittances (Bernhard et al., 2009), maintaining virtual contact by phone or internet (Baldassar, 2007), social remittances involving sharing of new social and cultural norms between countries (Lacroix et al., 2016), and organizing visits home (Baldassar, 2015). If the capacity to provide these multiple layers of care can be considered a form of "social capital" (Baldassar and Merla, 2013, p. 7) care can also elicit emotions of guilt and obligation (Baldassar, 2015). This is especially the case for women who, before, during and after migration, are potentially expected to be primary carers for children and for older family members, in proximity as well as transnationally. Similarly, the work of "homemaking" in the new country environment, a process that involves dual processes of adaptation to new environments and retention of customs, connections and identity, is inherently gendered with women undertaking much of its emotional and practical labor (Boccagni and Hondagneu-Sotelo, 2023). This is not to say that men are excluded from all caring responsibilities. As the family members who are most likely to depart first for potential countries of refuge, men may face a specific and administrative burden of care. This is discharged through navigating the bureaucratic systems that will allow them to obtain leave to remain for themselves and then send for family who remain overseas (Näre, 2020). Fulfilling this role, and the separations it entails, can have a significant impact on their spousal and parental relationships.

Less is known about the ways in which family care interacts with processes of integration once families are reunited in receiving countries. The UK's policy framework for understanding integration—the Indicators of Integration Framework—mentions care only briefly: three times in the context of formal care offered by others (social or health care) and twice regarding the need for childcare so that adult family members can engage in economic activity outside the home (Ndofor-Tah et al., 2019). In this way, to the extent that it is considered at all care is positioned as something provided through professional services external to refugees' own family units; and primarily in terms of the potential for care-giving to impede progress in other domains. While this paper does not seek to deny the ambivalent nature of care's impact on integration, the framework does not appear to recognize acts of intra-familial care, nor accord them any integrative value. Yet, for the men, women and children who took part in this study, such care was central to their experiences as they prepared for reunion, navigated its realities and imagined their family's future life. This paper seeks to fill this gap and, in line with feminist perspectives on care, render intra-familial care more visible as a factor affecting integration for all family members.

2. Materials and methods

The findings outlined in this article are drawn from a research project that used a mixed methods Social Connections Mapping Methodology to explore the role of social connections in integration, building upon previous studies in the UK (Strang and Quinn, 2019) and Iraq (Strang et al., 2020). The methodology comprises (a) workshops using visual mapping methods to invite adults to discuss whom they or members of their community would turn to in three hypothetical scenarios (see below) and (b) a quantitative social connections survey. Constraints imposed by the COVID-19 pandemic led the team to conduct a series of additional semi-structured qualitative interviews in the period immediately after initial lockdown restrictions were lifted.

2.1. Sampling and limitations

The data outlined in this paper is drawn from the qualitative components of the methodology: 13 interviews conducted with adults and young people aged 12 and over living in Glasgow and Birmingham (13 families: 21 adults, 8 children); and eight social connections mapping workshops conducted in cities across the UK's four devolved nations (35 families: 61 adults). The choice of sites was determined by the places where the project's third sector partners were offering services to refugee families. This in turn reflects the location, at the time of the study, of the UK's principal dispersal areas—local authority areas where the UK government and its subcontractors allocate accommodation to people seeking asylum.[1] In one site the mapping workshop with families was supplemented by a workshop with six Peer Educators, who were volunteers from a refugee background working with our third sector partner. All participants were, at the time of the research activities, accessing or supporting the work of a specialist family reunion integration service provided by two voluntary sector partner organizations. The service provided support both to the sponsor refugee—the person who had first come, usually alone, to claim asylum; and their arriving spouse and any dependent children, granted visas under the UK's refugee family reunion regulations.

TABLE 1 Family mapping workshop participants.

Location	Families	Participants	Women	Men
Birmingham	4	11	6	5
Glasgow	2	4	2	2
Belfast	8	13	7	6
Leeds	5	8	5	3
Sheffield	5	8	5	3
Cardiff	4	5	3	2
Plymouth	4	7	4	3
Leicester	3	5	3	2
Total	35	61	35	26

Demographic information for workshop participants, all of whom were adults, is outlined in Table 1; Table 2 summarizes the profiles of the families interviewed during remote interviews. All names have been changed and pseudonyms used throughout to preserve participant anonymity. Ethical approval was sought and obtained from the Queen Margaret University Ethics Panel (REP 0190; REP 0222).

The cohort of research participants was drawn from the beneficiaries of a third sector-led refugee integration service offered to people who had qualified for family reunion under existing UK immigration rules. In allowing only reunion with spouses and dependent children aged under 18, these rules are heavily skewed toward the nuclear, heterosexual family. As a result, this paper focuses on the experiences of families constituting one or more biological parents reunited with one or more biological children and so cannot claim to represent the full range of experiences of diverse family groupings. The power dynamics inherent in research activities, and our profile as university researchers may have influenced answers given to us during workshops and interviews (Mackenzie et al., 2007). While the use of interpreters, translated information and a two-stage informed consent process mitigated this, participants may not have felt able to discuss all aspects of their experiences in the UK or may have felt obliged to present a positive image of their family life. Families living in areas, including in rural locations, not served by the urban sites included in the study and/or who had chosen not to accept the support offered by the integration service are not represented in this cohort. Finally, the remote interviews were conducted online and so researchers were unable to ensure that each family member could talk in a private space without their spouse or parents able to hear their accounts. As such, it is likely that negative experiences within the family were minimized or omitted.

2.2. Social connections mapping methodology

In mapping workshops, participants were presented with three scenarios and asked to discuss whom they would speak to or ask for help were they, or someone they knew, to face these hypothetical

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[1] The geographic distribution of people seeking asylum—and as a result of those who are recognized as refugees—has significantly changed since the study was completed due to the implementation of a "full dispersal model" in the UK whereby all local authorities must make arrangements to house people seeking asylum. Available online at https://www.emcouncils.gov.uk/write/Migration/Asylum_Dispersal_Factsheet_PDF.pdf.

TABLE 2 **Interview participants.**

Interviewee (all names have been changed)	Family composition	Gender of sponsor	Interviewees	Time in UK—sponsor	Time in UK—family
Tesfu	Single parent	Woman	Son	5 years or more	6–12 months
Karim Leyla Mahdi	Two parent family	Man	Sponsor (m) Spouse (f) Son	Over 1 year, <2 years	6–12 months
Mohammad Sana'a Hossam	Two parent family	Man	Sponsor (m) Spouse (f) Son	Over 1 year, <2 years	<6 months
Abdul Hekmat	Two parent family	Man	Sponsor (m) Spouse (f)	Over 1 year, <2 years	<6 months
Samal Dilnaz	Two parent family	Man	Sponsor (m) Spouse (f)	Over 2 years, <3 years	6–12 months
Reza Fatemeh Mehrdad	Two parent family	Man	Sponsor (m) Spouse (f) Son	Over 3 years, <5 years	6–12 months
Mustafa Alan	Two parent family	Man	Sponsor (m) Son	Over 3 years, <5 years	6–12 months
Khalid Rasha	Two parent family	Man	Sponsor (m) Spouse (f)	Over 2 years, <3 years	6–12 months
Kehinde Mary	Single parent	Woman	Sponsor (f) Daughter	5 years or more	<6 months
Massoumeh Maryam	Two parent family	Man	Spouse (f) Daughter	Over 1 year, <2 years	6–12 months
Ismail Alia	Two parent family	Man	Sponsor (m) Spouse (f)	Over 3 years, <5 years	Over 1 year, <2 years
Hagos Bethlehem Tsige	Two parent family	Man	Sponsor (m) Spouse (f) Daughter	Over 2 years, <3 years	6–12 months
Abdo Zahra	Two parent family	Man	Sponsor (m) Spouse (f)	Over 1 year, <2 years	6–12 months

problems. The scenarios were explored sequentially: (a) having no hot water at home; (b) looking for a job; (c) a child being unhappy at school. They were designed to elicit responses covering the categories of social bonds (close relationships with people you trust), bridges (weaker relationships with people occupying different social spaces), and links (relationships with organs of the state). The questions were drawn from previous research conducted with displaced people (Strang et al., 2020), and adapted to the UK context in discussion with our third sector partners who advised on relevance to the refugee families who access their services. As participants spoke, researchers drew the connections onto visual maps, using lines to illustrate the ways in which one connection could lead to another, for example if the initial connection could not assist with the problem, whom might they recommend that the family contact. These maps and contemporaneous notes taken by the team comprised the dataset from this phase of the research.

For interviews, the research team used a Wheel of Life visual tool[2] to facilitate discussions. Paper copies of the wheel were posted, translated if required, to participants in advance. An amended version, and information in age-appropriate language, was provided for children. Participants were invited to shade the wheel before the interview to indicate how fulfilled they felt in each area of their life. The researchers had envisaged that people would fill each segment according their level of satisfaction in this area of their lives, with a fully shaded segment indicating high satisfaction. However, some interviewees chose instead to color code their wheels. In the wheel shown in Figure 1, Hossam explained that deep blue represented "excellent," while the lighter blue was "less good." Each interviewee was encouraged to share their rationale for their choices of shading. The wheel then served as a prompt to allow interviewees to begin the interview with the part of the lives they most wanted to discuss.

Family members were offered the opportunity to be interviewed separately, however space constraints in family homes meant that most children spoke to the team with at least one parent present in the room with them. For the nine families where both spouses took part in interviews, all interviews were conducted jointly with both spouses speaking in the same room either consecutively or together. All but two interviews were recorded and sent for professional transcription.

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[2] This tool was adapted from commonly used life-coaching tools, for example: https://www.kingstowncollege.ie/coaching-tool-the-wheel-of-life/.

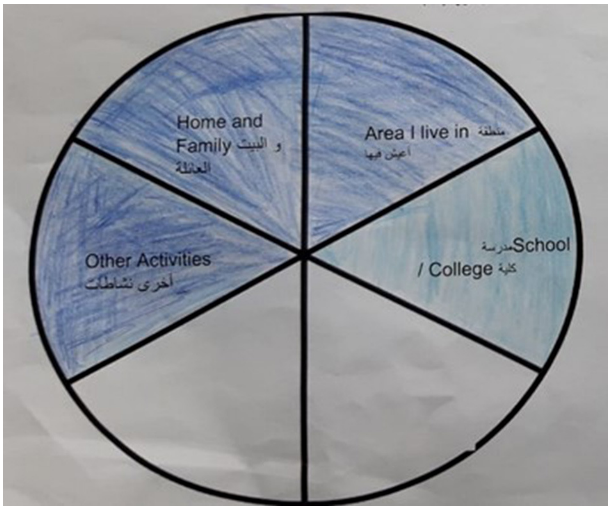

FIGURE 1
Completed wheel of life (Hossam, arriving child).

2.3. Analysis

Research notes and visual mapping diagrams were jointly reviewed after each workshop by the team. This produced a set of emerging codes, which were then used by the researchers to manually code the full set of diagrams and notes once this research phase was complete. Interview data were analyzed using an interpretive phenomenology approach (Matua and Van Der Wal, 2015). All transcripts or notes relating to each family were analyzed in turn, firstly by each individual researcher and then as a team. In this way, data gathered from each family was reviewed as a distinct phenomenon or case. After this initial analysis the team proceeded to a more traditional inductive coding phase. Each researcher manually coded an agreed sample of interview notes and transcripts. The team then met to compare their coding schemes. This informed the development of a joint coding scheme, which was then applied to the full dataset. Following this initial phase, the author undertook a subsequent round of analysis that focused on findings relevant to intra-familial care. This encompassed narratives relating both to experiences of caring *about* family—care understood to be a set of values and concerns; and caring *for* family—undertaking physical acts of care (Yeates, 2011). Relevant excerpts were extracted and analyzed using Dedoose software to inform the findings presented in this paper.

3. Results

While care was not the focus of the broader research project, acts of caring for and about family emerged strongly from our analysis as being central in participants' accounts of life in the UK and the social connections that they valued. In this family context, caring *for* included daily tasks like cooking, cleaning, and walking children to school. Caring *about* was expressed through the strong sense that family members were constantly "looking out for" each other (Yeates, 2011, p. 1,111) and, in the case of adult family members, taking decisions on housing, education and employment with the welfare of their dependants uppermost in their minds. I draw on the ethnographic work of Larsen (2018) to explore these aspects of intra-familial care across a temporal scheme encompassing the past (prior to family reunion), present (post reunion, at the time of the interviews), and aspirations for the future. Placing the moment of reunion as the pivotal event around which these time periods coalesce is a choice borne from the accounts of the families my colleagues and I spoke to. Our analysis confirmed that the moment of reunion was the culmination of many months if not years of planning and yearning, after which life shifted once more on its axis and began again. This gives voice to time's central role in integration and migration, confirming that time really is "of the essence" when seeking to explore and better understand integration as a process (Sheller, 2019).

3.1. Caring in the past

Caring in the past, defined for the purposes of this paper as the period prior to the moment when sponsors, spouses and children were finally able to reunite in the UK, was still vivid in the memories of many participants. Arranging, funding, and delegating transnational care is well-documented in literature on transnational family practices (Baldassar and Merla, 2013). The obligations involved in such care directly impacted on parents' decisions around other integration domains. One workshop participant explained that she had remained working for a company in the UK, despite evidence that she and other migrants were being discriminated against by the employer, for reasons relating to her family's welfare overseas:

> *"I needed to keep the job as I was paying for my children to come to the UK and for family back home."* (Alisha, sponsor and mother)

If the foundations of integration are rights and responsibilities (Ndofor-Tah et al., 2019), caring for family can impinge upon refugees' ability to demand that their rights are realized.

Sponsors' accounts confirmed that, above and beyond organizing transnational care, their decisions and actions in the UK were heavily influenced by considerations of how they planned to organize family care in future. These considerations were largely invisible from public view, but strongly shaped sponsors' accounts of the time prior to families' arrival. Mustafa explained that he had moved to a new city, despite strong social ties elsewhere, as he perceived that it offered better prospects for his arriving family members.

> *"I am always concerned about my family and the good quality of education for my children, so I decided to come to Glasgow."* (Mustafa, sponsor and father)

This was the case even where other cities or places offered opportunities for advancement in areas such as employment, because, as Mohammed explained, they were not suitable as places to raise a family:

> *"I went to London to search for a job because there is good opportunities there. And the rate of the hours—of working hours—is better than other cities. Yes, it's expensive, it's good for single people, but for family, I don't think that it's good, because it's very expensive and not easily to find the accommodation like that."* (Mohammed, sponsor and father)

Primrose, a workshop participant had left a full-time job to move from England to Wales. She decided to move when she heard news of her four daughters and knew that reunion was imminent. In moving, she was motivated by her feeling that Wales would be a better place to settle as a family. It is not then only the existence of family, or family-like connections in other areas that motivate internal migration (Stewart, 2011). Instead, decisions reflect the ways in which sponsors "think forward" about care from the moment that reunion becomes a possibility (Innes and Scott, 2003, p. 5.2). Moreover, decisions that may appear to negatively affect integration—for example, Primrose's decision to leave a stable job—can instead be understood as active steps toward a sustainable, family-focused future (Strang and Ager, 2010).

At an emotional level, care provided even in the more distant past continued to resonate in the present time. This was evident in Samal's account of his gratitude and love for his father. He became emotional when he spoke of his father and the care he had received from him.

> *"I always say that if there is a—there comes another Prophet after our Prophet it would be my dad because I think he's the greatest person. He did everything for us. [...] he sacrificed all his life only for us just so that we have a good life to live, and now whenever I talk to him he cannot stay on the phone [...] because he just starts to cry because he misses us so bad. I just wish that if possible 1 day I can go back to see them again."* (Samal, sponsor and father)

This mixture of gratitude for past care, and guilt around current separation illustrates the ways that migration can disrupt assumed contracts of care within families, whereby younger family members benefit from care as children and then can reciprocate by caring for parents in old age (Baldassar, 2015). Being unable to fulfill that contract can lead to feelings of guilt and shame. Giving and receiving care in the past then shaped emotions in the present, affecting lives across borders. Even for families reunited on paper, the restrictive way that the family is defined in migration legislation, and related practices of "bureaucratic bordering" (Näre, 2020) can leave families feeling incomplete (Wachter and Gulbas, 2018). This is the case even once they have successfully navigated the paperwork, waiting times and dangerous journeys involved in family reunion (BritishRedCross, 2020). These accounts remind us too of the difficulties of drawing definitive lines between past, present, and future when exploring migration and integration (Sheller, 2019).

3.2. Caring in the present

If the absence of beloved extended family members was still keenly felt for some families, their previous separation(s) from family members who were now living together in the same household also had echoes in the present, despite long-desired reunion having finally been achieved (Bernhard et al., 2009). Kehinde explained that caring for her teenage daughter in the present was rendered more difficult by the 9 long years when her daughter had been in the care of others.

> *"I keep telling her that there's some things that you have to do. You don't want to do this job, but you can't just say you don't want to do everything. You just have to learn how to do it. [...] But I assume because I wasn't around to look after her, to know you know so, so many things that I trying to make her adapt to now [...] it's really hard. So, I know we'll get there."*(Kehinde, sponsor and mother)

Sana'a had remained with her children, assisted in caring for them by her own mother, while her husband navigated through the asylum process. Although they were now living together as a family, she felt that he was unwilling to fully share childcaring responsibilities, ascribing this to differences in attitudes between men and women. While in the same interview she spoke at length of her joy at being reunited with him, this was a source of frustration.

> *"The day before yesterday, I was having headache, I was telling their father to take them to the market. He said, "No, no, I cannot control them in the street." I said, "Why? I was controlling them for 2 years there alone and sleeping and wake up and everything. [...] You see, the men, they don't want to take responsibility like us."* (Sana'a, arriving spouse and mother)

Other parents expressed more everyday difficulties in parenting their children. Reza and Fatemeh, interviewed separately from their only son, expressed concern that he was spending increasing amounts of time in his room playing on a computer game. They explained that:

> *"We don't see him much, sometimes he just comes for dinner or lunch and again back to his room, so it's, kind of, everybody's problem now."* (Reza, sponsor and father)

As a result, these parents were considering seeking therapeutic family support. On the other hand, when interviewed separately to his parents, their son Mehrdad, explained that for him the computer game was a positive way to build and maintain social contacts with friends from home. These intergenerational discussions and dynamics speak to the complexities of building and maintaining positive relationships of care and of the ways that care can constrain as well as empower those who receive it, particularly children (Larsen, 2018). They are also far from unique to families with experience of forced migration (Livingstone and Byrne, 2018).

Other "dark sides of care" (Pratesi, 2017, chapter 5) that emerged were the ways in which parents' obligations to provide care for children constrained them in domains of integration such as work, education and building social networks. Kehinde had found herself unable to embark upon paid work despite her strong desire to become economically self-sufficient and support herself and her daughters:

> *"They* [employability support programme] *were like, "You want to work, but all your time you have, so which time do you want to have for your children?" Which hours you want to use to want to work?" I say, "I use the weekend," they say, "No, you can't use the weekend, so you have to stay with your children for that weekend you know." [. . .] because I want to fit in, I want to do something, I want to be able to provide for my children."* (Kehinde, sponsor and mother)

It was not just caring for children that constrained participants. Mary, a workshop participant, had arrived to join her husband, and both were of retirement age. But her husband had significant health problems. At the outset of the workshop, she explained that caring for him meant that she rarely left their house. In integration terms, this also meant that she could not rely on him for advice on settling in their local area. Instead, she took many of her questions to a nearby neighbor who luckily was willing to assist.

Sponsors often reflected on the sense of responsibility that they had for their family's integration as the person who had been longest in the UK and knew systems better than more recently arrived spouses and children.

> *"Actually the time was very tight, so I had only 15 min' break and at that time, so it's only—I was getting a chance to meet my classmates only but not other people. The reason basically is because I was feeding my kids, buying some food from restaurants, so I was running after college to my family."* (Hagos, sponsor and father)
>
> *"I am thinking of joining the Sudanese Community in Glasgow, but my time is very limited, being busy with my children, sometimes helping with the kids when my wife is going out."* (Mustafa, sponsor and father)

It is perhaps notable that for both men quoted above, care impinged upon but did not fully prevent other activities. They were, it seemed, engaged in care on more of a part-time basis—"helping when my wife is out"—than some of the mothers who raised similar problems. The obligations of care were, it appeared, more of a potential impediment to integration for women than for men (Innes and Scott, 2003).

Yet if care has its dark sides, acts of care contain integrative potential also. In line with Ryan (2018), parents were often able to build social connections outside the home when engaging in daily childcare activities, for example walking children to school and nursery or supervising them as they played outside. *"Taking our kids to the park and having the chance to play there"* (Bethlehem, arriving spouse and mother) was an activity that enabled all members of the family—men, women and children—to build social networks with others. The resulting ties contributed to families' sense of belonging and safety in their local areas. Families also recounted being able to share care outside their immediate families and spoke of mutual networks of support whereby they provided care to others' children, enabling all concerned to *"grow our kids together"* (Bethlehem, arriving spouse and mother). Care was a priority and had a value in and of itself, even when its realities impacted on other areas of life.

> *"My kids are the most important thing in my life so I just try my best to make them happy and overcome those difficulties that we face."* (Samal, sponsor and father)

This commitment to family was echoed by the children we interviewed. Despite some of the difficulties described by their parents, the predominant emotion expressed by the children we interviewed was the joy of being back together with their families:

> *"I'm so happy to see my mum and my sisters after a very long time. Like, so I get to know them more than before."* (Mary, arriving child)
>
> *"So, the most thing that makes me happy is we all, [our] family's reunited."* (Tsige, arriving child)

And if adults were sometimes frustrated by the ways that caring responsibilities prevented them from moving forward in other domains, some children saw things differently. Tesfu's mother had been able to find work outside the home, however he reflected that before COVID-19 lockdowns, this had meant that he, his sibling and his mother "rarely saw one another." He was pleased when lockdown meant his mother was able to spend more time with them, and went on to explain that being with his family had been enough even to overcome some of the constraints and boredoms of the COVID-19 lockdown:

> *"Surviving lockdown was not important, it had its difficult moments but it was just a temporary moment the whole world went through. The important thing is that me and my family are safe and were safe throughout lockdown. And the most important thing ever is the bond I share with my family. There is a lot of love."* (Tesfu, arriving child)

The dark sides of care are a strong reminder not to romanticize the giving or receiving of care, nor to assume that all families were happy and nurturing outside the confines of the interview space. However, care as narrated to us by refugee families had on occasion been enough to overcome the practical and emotional obstacles placed in families' roads by circumstances and world events.

3.3. Caring in the future

If the obligations and opportunities offered by intrafamilial care shaped families' current experiences of integration, these were also prime considerations when families spoke of their future aspirations. These were not framed around individual goals but were formulated with the whole family's future wellbeing and success in mind. Caring about children was expressed by parents' strongly felt wish that, in future, their children "*be better than us*" (Hagos, sponsor and father). The route to this, in parents' accounts and those of several children, was education. Caring about education and their children's progress within the UK system was fundamental to parents' aspirations for the future. This was also expressed through parents' willingness to advocate for the best possible education provision for their children, even where they were reluctant to independently challenge systems barriers in other domains (Baillot et al., 2023).

Care included a recognition of and support for shifting notions around the role of women and girls within and outside the family home. Adults from two families discussed the importance of helping their partners and children adapt to what they perceived to be more equal, less strictly defined gender roles in the receiving society. Khalid and Rasha, interviewed jointly, were one of the couples who talked in these terms. Having progressed in her English through online classes during lockdown, Rasha's goal for the future was now to *"work and help myself"* (Rasha, arriving spouse and mother). However, Khalid explained that he had told her many times that to achieve this, she would have to reduce the time she spent cooking for the family. This highlights the ways in which care is part of a wider, family-wide calculation whereby caring duties must be balanced with people's desire to achieve individual goals in other domains:

> *"I sometimes have thinking because the life here is different. It's not like our country especially she started studying and if she starts working full time, I told her this system* [cooking fresh dishes] *will not work. So especially sometimes some food it takes about 2–3 h to prepare, it's a long time."* (Khalid, sponsor and father)

Khalid's explicit contrasting of cultural norms in his country and those in the UK was echoed by Sana'a. Her daughter was trying to find a place in an all-girls school in the UK as she did not feel comfortable in a mixed-sex environment. Whilst sympathetic to her daughter's wishes, her mother felt that she would sooner or later have to adapt to prevailing cultural norms in the UK in this regard. As such, she was managing her child's expectations as best she could:

> *"I feel like she was enforcing us to put her in girls' school [...] I said, if it is she will not go to this school, she will go to another one. It's OK, it will be good experience, it will be hard at the beginning, but she'll get used to [...] Because like just think, if she will keep going in the girls' school, OK, in university, what she will do?"* (Sana'a, arriving spouse and mother)

For Sana'a, caring for her children was not limited to physical acts of childcare but included supporting them to understand and adapt to the prevailing norms in the new country context. Similarly, when workshop participants in Cardiff were presented with a hypothetical scenario around their child being unhappy at school, they felt that this matter did not immediately require care from professionals. Instead, they spoke of their role as parents in helping their children to build "resilience" that would enable them to cope with hardships in the future. Their view was that *"once they show their character, the bullying will stop"* (Peer Educator workshop participant).

Family members' active role in these moments of cultural and emotional adaptation contradict framings of family as a place where parents and their children may "actively decide not to integrate" (Casey, 2016, p. 103). Instead, caring for one's own family was directly related to nurturing ways in which the whole family could move from being recipients of help to actively contributing to the receiving society.

> *"now I just try to do everything in correct way to get the better life for my family [...] sometimes I hope my kids do better in the school and they can in the future help this country and like to repay all this help to this country."* (Khalid, sponsor and father)

This transformation is enabled through acts and values of care—in simple terms, the care parents and spouses gave to their family members in the present was a means to help those family members to adapt and become successful in the future. There is evidence that shouldering this burden of expectation can put pressure on young people whose parents frame familial success in this way (McMichael et al., 2011). Deeper exploration of children's own feelings about familial aspirations and how they navigate these over time would be ripe topics for further research.

4. Discussion

The accounts of families who took part in this study confirm that the emotional and practical impacts of care given and received flow across time and space in ways that confirm the fluidity not just of care but of integration itself (Tefera, 2021). Foregrounding refugees' experiences of care and caring remind us too that refugee families share commonalities with all families in the ways that the obligations and logistics of care can constrain life on one hand but provide deep emotional connection on the other (Innes and Scott, 2003). This is true also for the ways that care can have a differential impact across the family. While men did discuss care, and—for sponsors in the study—felt the weight of their caring duties—it appeared to be women whose activities outside the home were most circumscribed by caring commitments. Again, this is not confined to people with experiences of forced migration—in many contexts it is women who, in their role as wives and mothers, shoulder the greatest burden of the obligations and duties of care (Innes and Scott, 2003; Baldassar, 2007; Bernhard et al., 2009; Scuzzarello, 2009).

Of course, caring for and caring about one's family members (Yeates, 2011) may be rendered more difficult by the specific circumstances of people's forced migrations to seek protection from harm. The moment of family reunion is pivotal precisely because it is often the culmination of months if not years when families have navigated separation, bureaucratic processes and sometimes extreme physical danger (BritishRedCross, 2020). Organizing and managing care across borders during separation is frequently an invisible labor being undertaken by refugee sponsors even before families arrive (Bernhard et al., 2009) confirming that a transnational understanding of care is required to fully encompass refugees' experiences of settlement. Even whilst physically separated, people's choices, conditioned as they are within the structural constraints of systems of immigration control and welfare (Phillimore, 2020) are made not with only their individual futures in mind but with the needs, circumstances, and future welfare of their families as a prime consideration. This may involve making choices that could from the outside appear to undermine their own integration (Strang and Ager, 2010). Failing to take family into account when working with people who initially present as single adults is to render invisible the familial context which conditions many of their choices and decisions.

Once families arrive, providing care is a time intensive activity. While superficially it may seem that this care impedes progress across other domains, accounts from families themselves clearly indicate that giving and receiving care has value in and of itself. Children's accounts, which are often omitted from integration research, do indicate that those who receive care in the present feel safe and at home. This complements previous findings to the ways in which receiving care from professionals in the third sector can have a positive impact on integration experiences (Käkelä et al., 2023). Importantly, a focus on care given by refugees, rather than care that they receive, repositions them as active subjects who are shaping the world around them rather than passive recipients of help. In this way, bringing intra-familial acts of care from the private realm to the public plays a role in pivoting away from images of helplessness and victimhood and the negative impact that these can have in the real world (Pupavac, 2008; Wroe, 2018).

The present though remains intimately connected to the past. Previous separations from arriving family members, and ongoing separation from extended family can temper joy at reunion with emotions of sadness and guilt (Baldassar, 2015). Shifting family roles can bring frustration as well as happiness. Seen from a child's eye view, acts of integration such as gaining paid employment outside the home can reduce the quantity or quality of care they receive from parents. Women may remain tied to obligations of care and struggle more than men to build lives outside the home. Care certainly has its dark sides (Pratesi, 2017) and should not be over-romanticized (Caduff, 2019).

Refugees' aspirations for the future make clear that it is not only in the private realm that care can be given effect. Intra-familial acts of care can carry forward into the public realm, demonstrating that "interdependency with close others" is not a recipe for non-integration (Scuzzarello, 2009). Instead, it can be a platform from which refugees can go on to build independent lives and, in the words of families themselves, give back to society. In this vein, building an ethics of care into integration policy as Scuzzarello (2009) suggests, is not an ideological stance. Rather, these findings suggest that it is a far better reflection of the reality for refugee families settling in the UK for whom the family unit motivates, facilitates and shapes integration pathways. Looking at families' future aspirations through the lens of care helps us too to understand how the very existence of hope for the future is a vital emotional underpinning to refugees' own narratives of settlement and integration. As Larsen explains:

> *"The envisioned future for their children ascribes meaning to the parents' present everyday lives and thus has an integrating effect, here understood in terms of an inner personal integrity in the form of a sense of existential meaning and coherence in a life within one's present surroundings."* (Larsen, 2018, p. 118)

Given the well-documented pressures of settling in a new country context after navigating what can be a complex and brutalizing asylum process (Mulvey, 2015), the emotional importance of being able to provide intra-familial care and of feeling that this will bring the family to a brighter future is critical to refugees' own notions of successful integration.

5. Conclusion

> *"Migration research should embrace the family as a central component of migration [...] family migration should move front and center in discussions regarding migration in general."* (Cooke, 2008, p. 262)

In this paper, I have argued that, for refugees as for people taking alternative migration routes, it is not only migration but integration that should be understood "in a family way." Even refugees who arrive alone are in many cases seeking protection not only for themselves as individuals but for their families who—even if they themselves never cross a border—may eventually rely on social and financial support sent by the individual. For refugees who do reunite under family reunion, integration pathways are shaped not only by well-documented structural constraints but by the care they actively provide in the present and hope to provide in future. This care is not an adjunct to integration. The obligations inherent in undertaking acts of care shape opportunities for progress across other integration domains. As such, familial care plays an ambivalent role in integration and its constraints may be particularly hard to overcome for women upon whose shoulders the greatest burden of care continues to rest. This said, it is important to note that what may appear to be a step backwards in one domain can in fact be a move toward refugees' own aspirations for stable, familial future. These same obligations of care often contain opportunities too, for example parents who through traveling to nursery and school meet other parents with whom they can build positive relationships in local areas. Caring about family, from afar and from within the household, is the motivator for a multitude of decisions taken at different junctures. Losing sight of the role of family in these decisions is to fundamentally misunderstand their meaning to refugee families. On this final point, exploring integration through the lens of familial care is an important way to foreground refugees' status as agents of integration rather than passive recipients of integration assistance. Care given by non-familial others can, as I and colleagues outline elsewhere, play a key practical and emotional role in integration (Käkelä et al., 2023). But giving care within the family is a realm where refugees can exercise decision-making and their own skills. While aware of the dangers of over-romanticizing the family and remaining cognizant of the risks that less powerful members of family can face, including of intra-familial violence and abuse, the accounts of the families in this cohort provide a welcome antidote to images of refugee helplessness. Instead, in considering them as family units, we see that receiving and giving care within the family is a crucial ingredient to building hope for the future. Bringing care to a central position in understandings of integration is not designed to mask its ambivalent nature. Instead, it supports feminist perspectives that ask that the work involved in caring for and about family members, in all its complexity, be brought more strongly into the light of public debate rather than confined to the shadows of the home.

Data availability statement

The datasets presented in this article are not publicly available due to the potential for identifying vulnerable participants (refugee families). Requests to access the datasets should be directed to lkerr2@qmu.ac.uk.

Ethics statement

The studies involving humans were approved by Queen Margaret University Ethics Committee. The studies were conducted in accordance with the local legislation and institutional requirements. Informed consent was sought from all participants, including, for children aged under 18, from their parents/guardians.

Author contributions

HB is the sole author of this paper and agrees to be accountable for the content of the work.

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Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Migrant-focused inequity, distrust and an erosion of care within Sweden's healthcare and media discourses during COVID-19

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Despite initial suggestions that the COVID-19 pandemic affected everyone equally, it quickly became clear that some were much worse affected than others. Marginalization—including poverty, substandard accommodation, precarious or no employment, reduced access to healthcare and other key public goods—was clearly correlated with higher rates of both contagion and fatality. For Sweden, COVID-19 inequality could be seen along clear racial and socio-economic lines, with some of the first high death rates seen amongst Somali communities, where individuals had contracted the virus through unsafe employment as taxi drivers transporting wealthier Swedes home from their winter holidays. At the same time, actors on the extra parliamentarian far-right in Sweden were quick to blame the country's relatively high per-capita fatality rate on persons born outside Sweden working in the healthcare and care home sector. Media frames affirming racial stereotypes grounded in cultural racism circulated across the ecosystem of alternative media in the country. In both healthcare and the media, we see growing forms of exclusion disproportionately affecting migrants. Such intertwined exclusions in Sweden, as the article argues, are a sign of a wider disintegration of Swedish society in which individuals lose trust in both the core institutions as well as across different parts of society. Drawing on Davina Cooper's understanding of the relationship between the state and other public institutions with individuals as based on "touch," the article explores how exclusionary practices impact this relationship. Our key argument is that, whilst ostensibly such practices often most materially hurt minority groups (e.g., migrants), they are indicative of—and accelerate—a broader disintegration of society through undermining a logic of "care" necessary to sustain social bonds.

KEYWORDS

COVID-19, trust, migration, precarity, health, media

1. Introduction

Trust serves as the core indicator of a politically stable society, with Scandinavian countries such as Sweden scoring highest within comparable studies attempting to measure public trust levels (Rothstein and Uslaner, 2005; Freitag and Bühlmann, 2009; Bergh and Bjørnskov, 2011). Yet, today in Sweden, the pandemic provided evidence that trust is declining as a small but growing part of the population has started questioning the credibility of health guidance advising them to vaccinate (Fahlquist, 2018; Kokkinakis and Hammarlin, 2023). Vaccine hesitancy in Sweden, as elsewhere, intersects with other polarizing issues that drive a series of political cleavages undermining broader trust (Lazarus et al., 2021; Raffetti et al., 2022; Steinert et al., 2022). At the start of the pandemic in early 2020 commentators referred to COVID-19 as a "leveler," threatening every human regardless of wealth and power with media stories reporting examples of politicians and wealthy celebrities contracting the virus (Ali et al., 2020). As lockdowns were enforced and the virus played out, however, the narrative of equality unraveled as it became clear contagion and fatality rates were significantly higher amongst groups living on the margins of society (Cheshmehzangi, 2022). Poverty, substandard accommodation, precarious or no employment, and reduced access to healthcare and other key public goods were clearly correlated with higher rates of both contagion and fatality (Bentley and Baker, 2020; Orcutt et al., 2020). The effects of COVID were also very different depending on an individual's social status and precarity (Smout et al., 2022). Rather than being a leveler, COVID acted as a catalyst accelerating the effects of societal inequities normally experienced at a much slower and less visible state.

COVID emerged not in a vacuum but, rather, a period already experiencing excessive polarization with noted politicization of policy processes and knowledge formation in many parts of the world (Boräng et al., 2018). Where vaccine hesitancy coalesced in the form of social movements these mobilisations often contained a mix of demands and activists placed at opposite ends of the "Left-Right" political spectrum (Dubé et al., 2021; Sorell and Butler, 2022). Not only have anti-vaccine movements connected the so-called "Far-Right" and "Far-Left," but they have also hosted a range of lifestyle cultures on the fringes of the mainstream, including survivalist, spiritualist, and alternative healing (Halafoff et al., 2022). Rather than being focused exclusively on vaccines, therefore, anti-vaccine movements provided a vehicle by which those perspectives that had come to perceive themselves as outside the political and cultural mainstream could link their otherwise diverse and often opposed identities. Public denouncements of those individuals as "ignorant" or "selfish" risk being counterproductive when made by figures they perceive as part of an "elite" associated with the source of their self-perceived "oppression."

The World Health Organization (WHO) came to see the politicization of the vaccines roll-out as the greatest threat to preventing further deaths from COVID, emphasizing the urgency to develop communication strategies able to rebuild societal trust (WHO, 2020). The challenge for health bodies like the WHO, however, is that they have little capacity to handle phenomena like anti-vaccine movements when the grievances at play embody far more than just a debate about how best to respond to a health crisis. Where expert knowledge is questioned not for the veracity of its methods but for its perceived association with an "elite," the value of the main currency used by medical practitioners and policy designers—expert knowledge—to legitimate their public role declines (Dib et al., 2022). Competing ideas of how both to interpret the pandemic and its unequal effects upon individuals play out in the Swedish case. In this article, we therefore use the case of Sweden as a window onto understanding inequity and distrust as factors to consider in the broader context of the role of institutional and societal care relations. The ambition of our contribution is to bring attention to some of the exclusion mechanisms and processes of cultural and racial Othering in public discourse in Sweden, which might provide a useful backdrop for addressing the broader political and discursive struggles in the region, today and historically (see Deland, 1997; Ter Wal, 2003). Our reflections are based on ongoing work and preliminary results of case studies conducted within the framework of the Precision Health and Everyday Democracy (PHED) project and its Commission on the Future of Healthcare Post COVID-19 as well as ongoing research on the production of extremist discourse in response to the pandemic by far-right actors and its projection into the digital mainstream and mainstream political discourse conducted at the Institute for Futures Studies in Stockholm in collaboration with TSAS.[1]

Sweden was an outlier during the height of the pandemic as an advanced European economy that, in contrast to other Western states, opted for a voluntarist approach toward social distancing and other controls elsewhere imposed by the state. At the same time, Sweden initially experienced higher per capita deaths than comparable welfare states, particularly amongst elderly populations within nursing homes (Mishra et al., 2021; Rizzi et al., 2021). For many engaging with Swedish public institutions there was a sense that the pandemic did not exist (Strange et al., 2021). For example, foreign students faced legal precarity where universities moved teaching online and the Swedish Migration Agency reacted by seeing any failure by those students to attend on-campus as a violation of their residency conditions and therefore grounds for deportation (Gemma, 2020). COVID fatalities in Sweden followed societal cleavages most with respect to migration history, with a high prevalence of deaths amongst Somali communities in Sweden early in the pandemic's first wave (Rostila et al., 2021). Such deaths were followed by media speculation as to the causes, with some public commentators blaming the "culture" of the affected individuals. In this narrative, their death, albeit tragic, is nontheless related to a failure on their part to comply with consensus culture, and seemlessly adapt to a society of cultural homogeneity and high trust in authorities. As such, the immigrant or the refugee is, "an essentially ambiguous figure suspended between victimhood and malevolence," and one who is at one and the same time in need of protection and threatening to the community to which they have been accepted (Chouliaraki and Zaborowski, 2017, p. 616). Whilst popular in the media, cultural explanations overlooked the prevalence of precarious employment within areas with high immigrant populations of non-Europeans. For example, those affected neighborhoods included a disproportionate number of taxi drivers who contracted the virus driving wealthy holiday-makers home from their ski trips (Kjøllesdal and Magnusson, 2021). Those same residential areas also included the poorly paid professional carers working in nursing homes. Nevertheless, nursing home workers and other carers born outside Sweden were soon identified as the main culprit by far-right actors who blamed and demonized immigrants for causing the abnormalities in the country's high per-capita fatality rate just as a series of culturally coded conspiracy theories emerged among actors in the same far-right media milieu in which the high death rates in Swedish nursing homes were presented as an intentional "geronticide" or "senicide" (the intentional killing of the elderly) committed by migrant workers (MSB, 2021). In this sense, national discourse both

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[1] The Canadian Network for Research on Terrorism, Security and Society, 1-MS-002: Violent threats and internal security, Swedish Civil Contingencies Agency (MSB).

echoed and exacerbated the extensive international media attention Sweden reveived in which immigrants were predominantly made invisible or irrelevant (Irwin, 2020). As pointed out by Christensen (2022) international news pieces about Sweden and its lax or "light touch strategy" (both positive and negative) fixated on the relative openness of society using accompanying images from central city areas, often showing crowded restaurants and cafes or shopping areas full of young people, "while rarely (if ever) noting how this 'openness' was reliant upon lower-paid workers such as cleaners or kitchen staff, often with immigrant background, who lived and commuted from parts of the city never shown or discussed in the articles" (Christensen, 2022).

Media discourse at large but most prominently that produced within the country's extensive online ecosystem of alternative news media, thus tended to erase or co-opt the inequitable impact of COVID in Sweden by subsuming it within a growing anti-migrant discourse in which the individuals' suffering was framed as being a consequence of their migration into Sweden and bringing a "culture" from abroad, as the article will discuss. To draw out the processes through which inequity revealed by COVID has emerged and been co-opted for a regressive politics explicitly intent on further inequity in Sweden, the article is structured as follows. It begins with an outline of inequity within Swedish healthcare during the pandemic, with emphasis on problems within health communication as well as healthcare access that disproportionately affected individuals along racial lines. Drawing upon secondary data and a synthesis of literature emerging on this issue, this section points to the experiences of regional health carers working with migrant populations and their feeling of being ignored by higher-level decision-makers who pushed for a "one-size-fits-all" model for healthcare ignorant of the barriers that prevented people with poor housing and precarious employment to follow health guidance for avoiding COVID.

The article then synthetises the emerging body of research on media and the pandemic to examine how COVID-19 was narrated as a highly mediated event within social media and framed in alternative and mainstream news media. Social media achieved new prominence globally during the pandemic due to social isolation and, in Sweden like elsewhere in Europe and the States, can be seen to have been important to conveying racialised narratives of otherness stigmatizing migrants as "dangerous" due to their lack of trust in public authorities or having a flawed and "culturally specific" response to the pandemic. Paradoxical and racialised media frames in which migrants who became victims of the pandemic were reframed as "aggressors" and "foreign bodies" failing to follow the guidelines of health authorities, obscured the inequities migrants faced whilst creating political obstacles for any government attempts to support those who were most vulnerable to the pandemic or working hard to maintain the Swedish healthcare system within nursing homes. Whilst these exclusionary practices will have most materially hurt those minority groups immediately impacted, the article considers them in a broader political context through drawing on Cooper (2019) understanding of the relationship between the state and other public institutions with individuals as based on "touch." The authority of the state can be felt in a myriad of ways, as elaborated below, with consequences for the social bonds constitutive of society. Our approach posits that health systems and media systems, and the structural and discursive exclusions they may produce, are intricately linked even as they represent distinct ways of being "touched" and as such of being included (or excluded) in a broader horizon of care. Our key argument is that the practices evidenced in Sweden during COVID-19 are indicative of—and accelerate—a broader disintegration of society through undermining a logic of "care" necessary to sustain social bonds and in which there was a shift in how individuals felt touched by the State.

2. Being touched by the Swedish state

The below analysis draws heavily upon the work of critical political and legal scholar Davina Cooper for her reconceptualization of the State and its relationship to individuals as based on "touch." That is because the state is never a fixed or physical entity but, rather, a concept that has material meaning based on how it is felt (Cooper, 2014, p. 65–66). The notion of touch does not necessarily equate to one of care but, nevertheless, highlights the various ways in which individuals feel the impact of the state on their lives that can take many different forms. The state can touch individuals in many different ways, as reflected in the variety of regime-types with stable democracies felt to be distinct from highly restrictive authoritarian states. At the same time, neoliberal states have a much more diffuse and thinned touch where individuals experience the provision of public goods as being dependent on a much more *ad hoc* and unpredictable network of agencies and non-state actors. Whatever form the state's touch may take, touch is the baseline for individuals' experience of the state and its societal role. Drawing on Cooper (2014) three aspects of touch were most visible in Sweden during the pandemic: (1) touch is reciprocal, impacting both parties even if in different ways; (2) touch can be both emotional and physical; and (3) touch is imbued with power and, whilst it may sometimes subvert relations, typically it reinforces existing structures. Since touch is a dynamic process that is never fixed, the same can be said as regards the relationship between the State and individuals. Relating back to the role of trust in society, touch provides an overall way of thinking through both how individuals experience the state but also the dynamic within that relationship. In Cooper's perspective, the state needs to be seen as an assemblage of institutional mechanisms, forms of political representation, public goods provision, rights protection, policing, and many other aspects that vary over time. It is also something highly mundane in which touch is felt largely as an everyday phenomenon through "jobs, membership, leisure activities, festive spaces, schoolbooks, accreditation, and recognition" (Cooper's, 2019, p. 15). Touch is often material but, also, for Cooper the dynamic in which the state can be experienced in alternate ways points to the role of imagination in thinking the state differently. Writing on the role of prefiguration in politics—the political significance of acting "as if" things were different—Cooper asks:

> [W]hat if state actors take up and manifest conceptions of the state as caring, responsible, solidaristic and activist? What can imagining the state in these ways, and acting as if these ways were true ways, do? (Cooper, 2020, p. 898).

Her 2019 book "Feeling like a state" tackled this question directly by relating to examples where the state has been imagined differently to be at the center of progressive politics. She also relates to examples where the state withdraws its touch by refusing to provide care, resources, services to individuals. Importantly, the state is not taken as a reified concept but, rather, as "a way to orient our discussion of public governance toward questions of form, scale, and ethos" (2019, p. 23). The notion of the state is therefore not necessarily limited to one side of the traditional "state/non-state" binary but, rather, may embody a much wider series of relations and actors that as an assemblage touch individuals. The state works as a nexus of authority by which individuals are touched, which goes beyond just a one directional impact since, for Cooper, touch is reciprocal in that the one touching is also impacted by that contact. In welfare states like Sweden a touch of "care" has been central to the social bonds constituting society, coming from a historically two-way relationship in which labor movements were key alongside top-down policy implementation in establishing certain principles around provision of healthcare as well as solidarity within societal discourse. Yet, how the Swedish state touches individuals has shifted. In what follows, the article considers how Sweden's healthcare and media touched migrants during the pandemic. Whilst much of the media is private and the majority of Sweden's healthcare system is state-funded, from the conceptual lens we borrow from Cooper it can be seen that individuals feel both as part of the "State" touching their lives as they impact how it feels to be living in Sweden.

3. The structural basis of inequity within Swedish healthcare

Sweden's healthcare system offers a generous provision of medical care to those with legal residency on an equal basis to national citizens, though for asylum seekers coverage is limited to urgent treatment only (Mangrio et al., 2018, 2020; Mona et al., 2021). Varying levels of healthcare access mean that, on an experiential basis, Sweden as a state takes multiple forms, in which citizenship status is perhaps the most obvious way in which some are denied care. Healthcare access for migrants continued during the pandemic, comparing favorably to other European countries such as the United Kingdom where, for example, during the first wave of the pandemic asylum seekers were forced into prison-like accommodation with poor sanitation and no possibility to socially distance with the result that many caught COVID (Dalingwater et al., 2022). When compared to other countries Sweden has historically stood out for having taken a humanitarian perspective toward migrants but it has undergone a political shift since the 2014 election when an anti-immigration party first won considerable mandates in the general elections (Rydgren and van der Meiden, 2018). As already established, early in the pandemic there was evidence of higher contagion and fatality rates in Sweden amongst those born outside the country compared to native born individuals. Based on an inquiry we organized with healthcare practitioners, activists, and researchers—the PHED Commission on the Future of Healthcare Post COVID-19—in Autumn 2020 (Strange et al., 2021), the pandemic period identified two significant areas of inequity within the Swedish healthcare model that detrimentally impacted those with a migrant background.

The first aspect was the temporal delay in communicating essential health information—such as how to socially distance—to those outside the middle-class mainstream of Swedish life. Like many countries, Sweden was slow to make information available in languages beyond the official native tongue. This was despite the easy availability of translation resources within a rich country with a linguistically diverse population capable of providing that translation. More crucially, those familiar with the healthcare needs of migrants criticized the central health authority's approach as based on a narrow conception of life in Sweden that ignored the practical obstacles faced by individuals living in substandard accommodation and with economic precarity. Poor health communication is one of the main barriers to achieving universal health coverage, limiting not only access to healthcare services but also undermining individuals' understanding of their own health needs (Maibach and Holtgrave, 1995; Dutta, 2007; Maldonado et al., 2020).

Sweden is noted for having taken an exceptionalist approach to the pandemic, relying on voluntary compliance with guidelines rather than imposing social distancing and self-isolation via punitive measures due to the perceived long-term costs compared to the effects of the immediate pandemic. Sweden stands out as unusual, though, not just for taking a long time to impose restrictions but also a much less risk-averse approach toward pandemic-related health guidance. This was seen in the comparatively low use of face masks, for example. Health carers working with migrants experienced difficulties where there were significant disparities between Sweden's national healthcare guidance and the stricter approach advocated in the international media followed by their patients. This has been shown in a study by Mangrio et al. (2022) drawing on interviews with health and social care workers serving migrant populations. One such example was changing guidance regarding the at-risk status of someone being pregnant. Swedish health guidance was slow at defining pregnancy as a factor impacting at-risk status. Health carers working with migrants faced a contradiction between the national guidance they were required to convey to patients with the more risk-averse information those individuals received from the non-Swedish media on which they often relied for their understanding of the pandemic. The situation was made especially challenging where national guidance shifted over time and health carers appeared uncertain and ignorant in front of migrant patients. For health carers this undermined their authority with those patients, who turned even more to non-Swedish sources of information. More problematically, divergent perspectives on how to respond to COVID meant that some migrants chose to keep their children out of school despite Swedish guidance not to do so. By following what they saw as increasingly more credible non-Swedish guidance, migrant parents became stigmatized as "deviant" and "bad parents" for undermining their children's education and acting contrary to the national approach (Mangrio et al., 2022).

In the Scania region of Southern Sweden with a relatively high proportion of newly arrived migrants, the regional healthcare system was actively working to improve translation of health information for different migrant groups (Strange et al., 2021). A common theme expressed by those working with migrants and primary healthcare in the region, however, was that the national level was disinterested in the needs of a diverse population. There were very few opportunities to report problems back to the central level such that, despite Sweden's regional system for healthcare, the pandemic was managed centrally top-down with the region left to try and make-up for errors and holes in the system, such as an initial lack of interest in reaching out to migrant groups. The centralized structure of Sweden's response to the pandemic disproportionately impacted individuals with a recent migration background due to being most likely to be living outside the mainstream of an otherwise affluent society.

Sweden is a highly digitized society with a strong reliance on e-governance systems, including for healthcare, which can be accessed through having a Swedish "Bank-ID." To have such an identity requires a Swedish bank account (Holmberg et al., 2022). As Sweden adopted an increasingly restrictive approach to the pandemic as the first wave matured and adopted some of the lockdown policies already implemented elsewhere, primary healthcare services including general practitioner consultations moved over to digital systems. The rapid shift was highly problematic for some of the most vulnerable groups in society, particularly non-European migrants, who were not only less likely to possess a Swedish Bank-ID but due to having come from authoritarian regimes were reluctant to communicate sensitive information via digital technologies susceptible to surveillance (Strange et al., 2021).

The mix of poor health communication, centralized top-down decision-making, and digitalisation of healthcare with no accommodation for a diverse population constitute a form of structural inequity. For those migrants directly affected structural inequity was felt with reduced healthcare access and options to maintain their wellbeing. The disproportionate impacts of the pandemic on migrants were seen across Europe and globally (WHO, 2022). In Sweden, rapidly changing health guidance that shifted from contradicting to belatedly supporting international media challenged societal trust overall. However, migrants who relied heavily on non-Swedish news sources are likely to have been impacted more significantly by finding themselves positioned as "deviant" if they followed guidance that differed from that provided by the national health authorities. Whilst trust relations between society and state were challenged globally with disproportionately negative effects on migrant populations, the Swedish case stands out for the effect this had within a country in which, whether supportive of those policies or not, many viewed their government as "migrant-friendly." Where those structural inequities were largely hidden from the broader population, and migrants felt a heightened sense of distrust in authorities, the higher fatality and contagion rates amongst some migrant populations were hard to understand for those living within the affluent mainstream. Not seeing the structural inequities that made it harder for those migrants to protect themselves from COVID, it was easier to turn to explanations around the behavior of those individuals.

For more than a decade, Swedish politics has been dominated by a fear that the far-right anti-immigrant Swedish Democrats would enter government. As seen elsewhere, that fear has empowered a shift of the Social Democrats—traditionally Sweden's dominant party and in government during the pandemic up until September 2022—toward an increasingly anti-immigrant stance within its own policies (Oxford Analytica, 2022). That context was significant for the vaccine rollout where initial plans to prioritize some migrant groups due to having been most affected by the virus were dropped due to public outcry by the Swedish Democrats. Vaccine rollout in Sweden has been affected by the same structural problems and forms of exclusion described more generally within the healthcare system. Booking of vaccine appointments involved use of multiple apps, several of which were available in only Swedish and English or, sometimes, only the former. Non-European migrants were also less likely to vaccinate due to having developed lower trust in Swedish healthcare guidance (Tankwanchi et al., 2021). A study focused on Sweden identified a strong correlation between being a victim of racial discrimination and heightened vaccine hesitancy (Savoia et al., 2021). The complex character of racial discrimination and vaccine hesitancy means we should be wary of suggested direct causation, but nevertheless such studies underline the importance of examining the potential links between forms of societal violence and trust levels. The pattern of limited healthcare access and well-being for some migrant populations in Sweden has accelerated where combined with societal distrust. Reduced capacity to comply with health guidance amongst those vulnerable groups has furthered not only their own distrust in the healthcare system, increasing their likelihood to choose to ignore guidance, but also marked them out as "deviant" and subject to distrust from other groups in Swedish society. As an extreme event, the pandemic does not in itself provide evidence of a decline in general healthcare access for migrants in Sweden. The pandemic does not provide evidence of an overall decline of the Swedish state's "care" role since there is no directly comparable event. However, in the struggle over how much the Swedish state should adapt to individuals' needs, we do see a shift in which the Swedish state withdrew from that form of attentive and adaptive care within its touch. Equally, as the next section outlines, we see other aspects of its touch having strengthened through actively marking individuals out as different to the majority population—not by acknowledging their needs, but rather seeing their "difference" as a problem. A vicious circle has accelerated and spilled over into media discourses, as discussed in the next section.

4. Mediated touch and the cultural and racial othering of media discourse

The COVID-19 pandemic has been described as the first truly global, digitally mediated event felt everywhere. Not only is it one of the most reported news stories ever, it is also "the first epidemic in history in which people around the world have been collectively expressing their thoughts and concerns on social media" (Aiello et al., 2021, p. 1). For people in quarantined societies, social media turned into the prime channel of information and interaction and "a rigid and noxious polarization" has dominated much of public discourse (Bisiada, 2021, p. 2). Throughout the pandemic, media discourse was driving polarization and reproducing existing structures of social injustice, including racial inequities unearthed and aggravated by the pandemic. Across the world, we saw an uptick in online hate speech during the pandemic (United Nations, 2020) along with a surge in media discourse stigmatizing migrant communities (see e.g., Caiani et al., 2021; Poole and Williamson, 2021; Avraamidou and Eftychiou, 2022). Sweden was no exception to these tendencies. Albeit media provided community and support for many people during long periods of social isolation, it was also a source of divisive and stigmatizing discourse which framed the pandemic along ethnic and cultural lines. Such discourse was propelled not only by the country's extensive web of alternative far-right media but also, even in less blatant ways, by mainstream news media.

Given the media's role as an authoritative entity in society in general, and even more so during the pandemic, from the perspective of Cooper we may consider it one of the crucial ways in which individuals and communities were "touched" by the "state." This was particularily evident in the early phases of the pandemic in which information and guideline transmitted directly from state authorities via public service media or sponsored content pushed into social media feeds were paramount. During the first waves of the pandemic in particular, as people found themselves confined to their homes and spending considerable time in front of screens, the individual-state encounter was largely mediated. Public service media served as the primary source of information and recommendations from the state communicated to the general public through daily live-transmitted press conferences, short videos with expert advice and other educational content on SVT, extensive news coverage etc. In this sense, public service institutions seeking to nudge people's behavior in a certain direction were one of the main ways people were "touched" by the state and its attempts to reduce mobility, encourage social distancing and promote vaccination campaigns. Indeed, research shows that news coverage played an important role in shaping public opinion, social norms and ultimately individuals' health-related actions in a context where Swedish authorities relied on voluntary compliance with public health recommendations (Garz and Zhuang, 2022).

But beyond public service institutions disseminating up-to-date and accurate information, promoting public health measures etc, news media more generally also *framed* the pandemic in important ways by providing the public with schematic interpretive packages (Gamson and Modigliani, 1989) with which to understand the nature of the public health crisis, its scale, causes, effects and potential solutions. COVID-19 spread unevenly in particular residential areas and disproportionately affected communities with a high number of residents with migrant backgrounds. These facts were widely reported across Swedish news media early on and fervently discussed in social media. In some of this media discourse, groups with migrant backgrounds were blamed and framed as "problems" in ways that testify to the discursive boundary-work of them/us along racial lines produced by media (Titley, 2019). In the initial waves of the pandemic, discursive processes of Othering that centered the racialised "migrant body" surfaced in Swedish news media and social media commentary. This too has been the case in international press about Sweden's controversial and hotly debated approach to the pandemic, framing immigrants as "the hidden flaw in Sweden's anti-lockdown strategy" (see e.g., Rotchild, 2020) often part of a more general framing of Sweden as the "worlds cautionary tale" (Goodman, 2020). Such discourse matters. Previous research indicates that media play a central role in the processes of stigmatization of residents in the "vulnerable neighborhoods" (Ericsson et al., 2000; Backvall, 2019) that became portrayed as hotbeds for COVID-19 transmission. As a proxy for the state in many people's lives, by touching individuals in ways that they feel differently recognized it has accelerated fragmentation.

A wealth of previous research has demonstrated how media tend to frame people with migrant backgrounds as causes for various social problems, for example by construing entire neighborhoods as "problem-places" and no-go Zones (Titley, 2019). The pandemic certainly provided ample opportunity for such scapegoating and Othering discourses to be perpetuated. Across various national contexts, media coverage of the pandemic has been characterized by problematic language that is consistent with racialization of illness and color-blind racial frames constructing COVID-19 as a highly racialized virus (Lyons et al., 2020). In some countries, public debates and media discourse about COVID-19 negatively racialised Asian communities and perpetuated Sinophobia (Zhang and Xu, 2020; Li and Nicholson, 2021; Wu and Wall, 2021). Research coming out of the US is showing how news media tended to report on racial disparities related to COVID-19 as an outcome of the "bad" health behaviors on the part of Black individuals thus ignoring the structural inequities and mechanism of exclusion behind the high numbers of morbidity and mortality affecting Black communities (Turchi and Melton-Fant, 2022). Similarly focusing on the US, Bonilla-Silva (2022) argues that the media framing of racial disparities in the early phases of the pandemic perpetuated public perceptions of Black individuals as unhealthy by nature or because of personal lifestyle choice. In a study of UK news coverage, Poole and Williamson (2021) show how the UK press often took "a culturalist position signaling overt religiosity and cultural practices as evidence of the social (and so health) threat that Muslims posed, and through constant attentiveness to their potentially regressive behavior," they were portrayed as not only a danger to themselves and their communities but as threats to national security (p. 273). In doing so the media reinforced hegemonic discourse that has developed since 9/11 by drawing on and reworking longstanding tropes in which "marginalized groups are 'othered,' subject to moral panics, and accused of refusing to integrate" (p. 275).

In the Swedish context, the racialised media discourse around the pandemic also invoked the figure of "disobedient" migrant bodies in the suburbs (on far-right media framed as "No Go Zones") focusing on the failure of the Somali community in particular to follow public health guidelines, rather than treating them as a group in need of care. We see an early example of this frame in a widely circulated debate article by MP and leader of the Christian Democrats, Busch in the Swedish Daily Aftonbladet published in April 2020 in which she encourages the country to have the courage to speak plainly about "the problems of the suburbs" (Busch, 2020). With a focus on the seemingly insurmountable cultural differences, lack of trust and illiteracy of this particular black *and* Muslim minority population, the article echoes historical scripts about a lack of integration and adherence to the (formal and informal) rules and norms of Swedish society. In an op-ed published in the same news paper, also in the early days of the pandemic, three members of the far-right party the Sweden Democrats cautions that elderly care is being turned into an "integration-experiment" arguing that the health of elderly people was put at risk for the sake of integrating uneducated immigrants with poor Swedish language skills (From Utterstedt et al., 2020, see also Gustavsson, 2020).

The more general framing patterns, which these examples epitomize should be understood in the broader context of an increasingly hostile social and political climate toward immigration and the "Muslim Other" since the 2015/16 European border crisis (Askanius, 2021; Ekman and Krzyzanowski, 2021) and the last years' perpetual campaigns of far-right parties and groups promoting ethnonationalism and repatriation rather than integration, and policies actively working to disrupt possibilities for social connection and belonging for migrant minorities. Another important factor is the growing mistrust in traditional media among the Swedish population in particular with regards to reporting on issues related to migration which has provided a breeding ground for a flourishing scene of alternative "immigration critical" media in the country (Holt, 2016)—by far the biggest in Scandinavian comparisons (Ihlebæk and Nygaard, 2021). And indeed, the disobedient or infected "migrant body" took center stage in Swedish media discourse on the pandemic, most blatantly in the hyper partisan news coverage produced by this extensive network of alternative media but such ideas were also to some extent reproduced by mainstream media perpetuating culturalist explanations to first mortality rates and later vaccine hesitancy. Examining conspiracist and racist narra-tives circulating across the Nordic countries, Dyrendal (2023) found that migrant workers and ethnic minori-ties were among those most often presented as spreading the disease, and that these groups were represented either as part of a concerted malign effort to spread the virus or as spreading the virus "because of their culture" (p. 270).

These observations are in line with previous studies showing how historically infectious diseases are often represented as a threat from "outside" and construed around ideas of the mobile body as a threat to the larger social body (Kraut, 1994). The significance of such constructions is clear when contrasted against an imagined alternative in which, rather, the mobile body was seen as something to care for and preserve. Previous research tells us that when a pandemic threatens a global population, "the new fear of a floating population that moves as mobile migrants, passing mobile germs, fuels the media practices of boundary building of nation-states" (Kaur-Gill, 2020, p. 3). For example, a discourse analysis of the Canadian media coverage of the H1N1 outbreak, reveals that contamination "risk space" was centered around "mobile citizens" as particularly dangerous "pandemic subjects" (Maunula, 2017). Similarly, a study of media framing of the H1N1 pandemic in the UK context reveals the role of the traveling body as a central actor in media discourse (Warren et al., 2010). The blame game and scapegoating we saw unfolding in discussions on social media and in both mainstream and hyper partisan alternative media linked to the far-right is therefore best understood as a continuation of a set of longstanding mechanisms of exclusions—material as well as ideational. These are processes which extend beyond the case of Sweden and the current pandemic, but which in the specific context of Sweden and the COVID-19 pandemic had particularly damaging consequences.

The media framing and broader public discourse of the pandemic might not be formally part of the Swedish state, but in Cooper's broader understanding of the state such discourses are crucial to how people feel their relationship to the state. In this case, that media has been central in thinning the state's caring role. The stigmatizing or hateful discourse circulating online along with the more general and less blatant forms of scapegoating in mainstream media reporting provide an important backdrop to understanding a sense of being undeserving of care by the healthcare system and excluded by society at large. The role of the media—whether legacy or alternative online media—impacts how it is to experience living in Sweden and what to value in society such that, keeping with Cooper's approach to the "state," we see the media as in some cases part of the Swedish state in other cases. Crucially, these aspects play into and amplify the more structural mechanisms of exclusion in Sweden today and alter how the state touches individuals.

5. Declining trust and a Swedish political crisis

At the time of writing Sweden is undergoing a seismic shift in its politics as the far-right party Sweden Democrats capitalize on their position as the second largest party in Sweden's parliament after the September 2022 national elections. Whatever legislative changes occur, the most immediate change is in Sweden's self-perception, the norms of political behavior deemed appropriate within the country's mainstream discourse, and how individuals feel touched by the state. In the first year of the pandemic there was evidence that trust amongst the Swedish public remained high (Helsingen et al., 2020), though it was becoming polarized along ideological Left-Right lines (Hassing Nielsen and Lindvall, 2021).

At the start of the so-called "refugee crisis"—a European Union political crisis as its Member-states failed to coordinate a measured response to the Syrian civil war—in 2015, Sweden stood out for its initially open-arms approach toward welcoming those fleeing the conflict. However, within a few months the governing Social Democrat-Green coalition made a very public "U-turn" toward the path pushed by the anti-immigrant Swedish Democrats and for the first time in many people's living memory imposed strict border controls on the Öresund bridge. The Öresund bridge had been a symbol of regional unity for both the EU and Scandinavia, linking Denmark and Sweden in what many in Southern Swedish municipalities had labeled the "Greater Copenhagen" economic zone that had helped spur significant innovation and growth within an area of Sweden often overlooked nationally (Hansen and Serin, 2007; Hansen, 2013). Sweden's radical policy shift in late 2015 came at a high economic price for its Southern regions which had most benefitted from the closer economies ties with the Danish capital as new border controls came into effect and disrupted cross border commuters and the ability of its growing technology sector to retain and attract employees (CPH Post, 2017).

Media reporting on the 2015 policy shift has presented it as an "emergency solution" to a "crisis" as Sweden's social services were overwhelmed by the influx of refugees that followed the government's initial welcome. Yet, at the time there was a debate as to whether the crisis was less to do with whether Sweden could afford to host refugees and, rather, more to do with a worsening fear that in welcoming refugees the then government risked greater political support for the anti-immigrant Swedish Democrats. For example, at events in Southern Sweden where most refugees arrived there was substantial mobilization by civil society and a claim heard at public meetings that the "crisis" was rather to do with Stockholm's perception rather than the reality of the situation.

The summary of these events provides part of the context to understand how health inequity in Sweden has become viewed within mainstream discourse. Another part of that context has been declining public trust due to reforms dated to the mid-1990s. Despite Sweden's self-image as a social-democratic country with a strong welfare system a series of both Left and Right-wing controlled governments have successively restructured public policy decision-making along market-oriented lines. New Public Management (NPM) models were adopted in Sweden and Denmark, for example, but whereas public servants in the latter often implemented such policies only superficially, their Swedish colleagues followed them much more directly (Hall, 2013). This can be seen in many areas of Swedish society and has restructured public policy to be increasingly technocratic and removed from political oversight or accountability with the result that Swedes have slowly lost trust in the systems once seen as key to making their country distinct (Hall, 2013). Such reforms mark a significant shift in the social bonds constituting Swedish society. The events of 2020 marked what Elander et al. (2021) describe as a "perfect storm" as policy uncertainties grew around not only COVID but also migration and climate change. Although none of those three policy crises are unique to Sweden, how they are positioned in Swedish political debates is arguably unique given how all three have historically been areas where Sweden's political elite have marked themselves as international pioneers and the country as "exceptionalist" compared to other states (Schierup and Ålund, 2011). We might even consider the September 2022 elections in which the issue of migration was largely blamed in media debates as a cause of growing gun violence as a reflection and an extension of this broader long term governance crisis in the country.

That individuals experience the state differently is, of course, not surprising, and certainly not unique to Sweden. What does make the Swedish state notable, however, is the shift it has undertaken in the last 10 years from an outwardly welfare-oriented and migrant-welcoming state to become something new as became evident in the pandemic and has been reinforced by its new government. If read superficially, these developments largely concern only migrants and their integration within Swedish society. Yet, drawing on Cooper, the overview of both healthcare and media discourses in Sweden during the pandemic indicates that how the Swedish state touches individuals has moved away from care. By marking an increasingly larger part of the resident population as subject to withdrawal from care and, in some cases, a "threat" to be managed the Swedish state has taken on an entirely new form of touch toward individuals. The social bonds making Sweden have shifted and, consequently, what it is to live within Sweden has altered. Not only did the Swedish state withdraw by refusing to acknowledge a diverse population impacted by the pandemic differently than an privileged elite with secure employment and safe housing, but also vulnerabilities were treated as threats and the fault of those worst affected by the pandemic rather than justification for enhanced care. Cooper's perspective allows us to look beyond individuals' citizenship status to, rather, understand what otherwise look like exclusions affecting only migrants as part of a broader shift in the social bonds constituting Swedish society in which individuals are now touched differently by the state. Although these exclusions may not be directly felt by those with formal Swedish citizenship, the pandemic period in Sweden evidenced an exercise of different ways by which the state touches individuals, including a general withdrawal from trying to understand how people live different lives.

6. Conclusion

Globally, despite high-level warnings that migrants living in precarious life conditions were both particularly vulnerable to COVID and political stigmatization that might worsen pandemic control measures (UNHCR, 2020), the pandemic has disproportionately impacted migrants with citizenship status playing a significant role in determining health outcomes (Shaw, 2021). Although in many cases the disproportionate impact on migrants has been due to explicit obstacles to health access, the Swedish case demonstrates how exclusion can often be much more passive but no less dangerous. In practice, structural inequities might be seen as more detrimental through being much harder to challenge as well as link to its consequences. Being harder to see, structural inequities in Sweden have been ignored within mainstream debates that have instead been dominated by cultural explanations of migrant deaths. Vaccine hesitancy as a symptom of societal distrust places migrants in a doubly dangerous situation through being both less likely to vaccinate but also vulnerable to stigmatization as being socially irresponsible and a "threat." There is urgent need to understand the exclusions that lead to societal distrust, as well as levels of trust between different groups in society, that undermine health equity. Through Cooper, relations of care both within the public healthcare system and the media are understood as mechanisms by which the state and society touch individuals. That touch can take place in many forms, leading to varying levels of exclusion or inclusion with consequences for the overall level of trust and sense of belonging within the territory. The Swedish case evidences a disproportionately negative impact on migrants lacking formal Swedish citizenship, yet by considering it in the context of the broader social connections and importance of care in constituting "Sweden" as a societal entity, the shift in how the state touches individuals in Sweden impacts all of society. The approach developed here helps us understand the role of everyday micro-violences and their role in restructuring the relationship between individuals and the state, a shift that goes beyond any specific form of exclusion, in contributing to social disintegration.

Author contributions

TA wrote the section on Sweden's media discourse. MS wrote the section on healthcare. All authors contributed equally to the research presented in the final text.

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"When a bad thing happens…you are better only when you are home:" alienation and mental health challenges experienced by Congolese and Somali migrants in Johannesburg, South Africa

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This article explores the link between migration and alienation and its impact on the mental health and wellbeing of Congolese and Somali asylum seekers and refugees—two of the largest populations of displaced migrants in South Africa. Drawing on ethnographic research in Johannesburg, we highlight the various ways alienation is both imposed upon and experienced by migrants and argue that systemic *dis*integration, or acts of alienation, can be seen as deliberate and active policies and practices that are instrumental in excluding asylum seekers and refugees from everyday life. The experiences of marginalization and othering narrated by Congolese and Somali migrants highlight ways in which alienation and *dis*integration from critical social connections including family, community, and familiar contexts fundamentally impact wellbeing and mental health as well as strategies of care-seeking, and other forms of relational resilience. While conceptualizations and metrics of integration may in some ways capture the fallout of disintegration, such as access to livelihoods, housing, education, and healthcare, we suggest that this does not adequately assess the profound damage by acts of alienation on crucial relationships. The alienated psyche of innumerable migrants in South Africa results in the feeling that "when a bad thing happens…you are better only when you are home." This pain, or feelings of alienation, we argue, are a crucial aspect to our understanding of alienation and in turn, highlight the importance of alienation as an apt analytical tool through which experiences of asylum-seeking in South Africa can be understood.

KEYWORDS

alienation, integration, displacement, refugee, Somali, Congolese South Africa, mental health

Introduction

In Johannesburg, South Africa asylum seekers and refugees[1] face multiple forms of stigma, discrimination, and alienation when negotiating integration and daily life. Since its

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[1] We use refugee, asylum seeker, migrant, forced migrant interchangeably because these are the local terms used, which reflects the complexity of perceptions and lived realities of "life seekers" or "people on the move."

first democratic election in 1994 and the adoption of a progressive and protective legal framework to protect human rights—including the rights of migrants—South Africa has been perceived as a place of safety and opportunity for asylum-seekers and refugees from across the African continent. The majority of these migrants have gravitated toward urban spaces such as Johannesburg (Misago et al., 2015; Walker et al., 2017; Schockaert et al., 2020).

However, despite the fact that South Africa is built on and shaped by historical and contemporary regional and circular migration, many asylum seekers and refugees face multiple barriers to regularizing their stay in the country, accessing employment, and basic services such as education, healthcare, and social support (Hassim et al., 2008; Amit and Kriger, 2014; Vearey, 2017; Gandar, 2019; Walker, 2021). The South African government has placed greater emphasis on securitizing the border, simultaneously painting non-national as a threat to national security and a burden on state resources. As a result, migrants increasingly experience hostility, threats, and alienation (Walker and Oliveira, 2020). Therefore, although many migrants find ways to navigate and negotiate strategies for survival, including informal work and tapping into support networks, this xenophobic discourse persists, which enables the state to push (and justify) the active and deliberate exclusion or "disintegration" (Collyer et al., 2020) of migrants and refugees. This is done through policies and practices aimed to restrict migrants' rights and curtail movement, which ultimately creates and re-enforces feelings of alienation.

Recognizing that historically alienation has been identified as an important lens to exploring and explaining the process of separation—from one's work, one's purpose, and ultimately one's sense of power—in this paper we contend that the concept of alienation is an apt analytical tool through which experiences of asylum seekers and refugees living in Johannesburg can be understood.

In this article we focus on asylum seekers and refugees from the Democratic Republic of Congo (DRC) and Somalia—two of the major source countries of forced migrants into South Africa (second and third to Ethiopia) (Moyo, 2021). The research informing this article is a part of a larger multi-sited project (including Johannesburg and Nairobi), which explores the relationship between displacement, gendered violence, and mental ill-health for internally displaced persons (IDPs), refugees, and asylum seekers who face multiple barriers to accessing healthcare.[2] Looking at Congolese and Somali migrants in Nairobi, Kenya and Johannesburg, South Africa meant that we could explore the experiences of two of the largest displaced population groups in Africa and compare them across two different cities. In Johannesburg particularly, Congolese and Somalis are a part of well-established communities that have been living in Johannesburg for many years and groups of new arrivals have come to the city in recent years in search of safety and support. Through qualitative research with the diverse groups of Congolese and Somali refugees and asylum seekers in Johannesburg, we aimed to better understand the interrelationship of migration and health, including mental health, as determined by the broader context of xenophobic violence.

In this article we draw on this research to interrogate how alienation from critical social connections including family, community, and familiar contexts fundamentally impacts wellbeing and mental health as well as strategies of care-seeking, and other forms of relational resilience.

Despite alienation's important place in social theory with a long history in Marxian and Hegelian thought (Seeman, 1959), there is little recent scholarship linking migration and alienation. Various isolated forms of research through film (Gürkan, 2017) and literature (Khan, 2021), or the analysis of policymakers' failure to capture migration policy (Scholten, 2020), have provided some sense of how alienation can impact and shape migrants' lives, we contend that they do not fully apply to or capture the ways we conceptualize alienation.[3]

Drawing from the development of the term alienation and locating this within the complex context of migrant lives in Johannesburg, South Africa, we contribute two interrelated aspects to understanding alienation as it relates to migration: acts of alienation and feelings of alienation. Acts of alienation include the processes of *dis*integration and othering by the state and society. This includes the role of policies, practices, and discourses of (re)producing and imposing *alien*ation through the creation and reification of migrants and refugees as the "other," that is, the alien. Acts of alienation lead to the estrangement to customs, family, and an existential loss or incomplete sense of belonging—the feelings of alienation. Noting that these forms of enacting and embodying alienation are intersecting, our findings suggest that alienation is felt particularly through three key areas of life: in gender roles; relationships with family, and through religiosity and faith-based spaces.

Structure of the paper

In what follows we begin with an overview of the methodology of the research that informs this paper. We then focus on "acts of alienation" through which we present Johannesburg as a city of stark inequality and shaped by policies and practices of exclusion, which enforce deep feelings of alienation such as denied access to documentation and health care. We then explore the complex feelings of alienation amongst Congolese and Somalis through their narrations of challenges faced in the key spheres of gender roles, family, and faith. In doing so we show how systemic *dis*integration, or acts of alienation, are the deliberate and active policies and practices in South Africa that are instrumental in excluding asylum seekers and refugees from accessing basic services and employment, which profoundly impacts their mental health and wellbeing.

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[2] The support of the Economic and Social Research Council (ESRC) (UK) is gratefully acknowledged.

[3] We identified only one scoping study linking feelings of alienation to migrants' lived experiences, which recognizes the complexities of defining alienation (Yang et al., 2022).

Methodology

The fieldwork for the project was conducted between 2020–2022 at the time of the COVID-19 pandemic and as South Africa implemented a series of strict national lockdowns to prevent the spread of the virus. When we had initially planned the research, we had envisaged an ethnographic study which would incorporate a series of interviews and focus-group discussions with Somali and Congolese asylum seekers and refugees in two areas of Johannesburg. However, due to the pandemic and the unpredictability of the situation we found that initially interviews had to be online and, only after some time could interviews be conducted in person.

Interviews had to be carefully planned due to enforced social distancing and researchers and participants could not interact "naturally" but instead had to be vigilant with every step. In addition, the impact of the COVID-19 pandemic meant that many potential participants had been forced into greater states of precarity with a loss of income and challenges in accessing support (Oliveira and Walker, 2021; Vearey et al., 2021; Mutambara et al., 2022). Therefore, while the pandemic itself created a new lens to examine migration and mental health (Walker and Vearey, 2022), it also pushed many of the most marginalized and othered groups into deeper poverty, isolation, and desperation. This is a point that should be recognized as central in this research and as raising questions about doing research during times of crisis.

Despite the practical challenges of research during COVID-19, overall we managed to conduct 123 semi-structured interviews, with 83 adult participants from the Congolese community (44 males and 39 females); and 40 adult participants from the Somali community (25 males and 15 females).[4] The interviews aimed to explore experiences of health and mental health including access to healthcare, understandings and perceptions of mental health, and alternative strategies for care (where the public health system is not/cannot be accessed).

As lockdown was lifted in South Africa, we were able to conduct most of the 123 interviews in-person as long as they were outside. These took place outside participants' homes, open spaces of lodges, and sometimes sitting on pavements beside busy streets. As many of the migrants interviewed were undocumented, access to informants was difficult at times due to the fear of being exposed and suspicion of the researchers' intentions.

Access to participants therefore was based on the researchers own social networks and negotiated through trusted local organizations and faith-based spaces. Both the fieldworkers are migrants (one from the DRC) and understanding the challenges of living as a non-national in South Africa including documentation and access to services was important to developing relationships of trust. It also helped particularly with awareness and sensitivity toward the anxieties and concerns of migrants about participation in the study specifically, and life in South Africa generally. That said, it remained difficult for the fieldworkers to form connections and trust and willingness to talk could not be assumed. All of these challenges, including the ones created and, exacerbated by the Pandemic are reflections as to how alienation impacts migrants and refugees in South Africa—as we go onto discuss.

The interviews were conducted in a mixture of languages. The Somali participants' interviews were either in English or Arabic with an interpreter to assist. The Congolese participants' interviews were in Lingala. All interviews were recorded (where consent was provided) and written as notes (where recording was not possible). Interviews were then transcribed and analyzed using thematic analysis and coding to identify key themes.

Acts of alienation

In South Africa migrants are often accused of stealing jobs from locals, burdening the public healthcare system and other public services, and blamed for high levels of crime and violence (Amnesty International, 2018; Vearey et al., 2022; Palmary et al., 2014b). Data shows that the overall cross-border migrant population in South Africa is estimated to fall around 3 percent of the overall population. Although 3 percent reflects a global norm, non-South Africans (particularly from other African and South Asian countries) are routinely portrayed as "flooding" into the country. Resonating with nationalist rhetoric across the globe, concerns about border security, national-sovereignty, and protecting citizens have been used to justify increasingly restrictive migration governance in South Africa (Amit, 2015; Landau, 2017). In fact, a country once lauded for its progressive and human-rights based constitution is now reconsidering its stance on allowing asylum seekers to self-settle rather than being interned in refugee camps (African National Congress, 2022).

The majority of migrants arriving in South Africa head toward urban spaces such as Johannesburg. The city hosts migrants from within its borders, across the Southern African Development Community (SADC) region, and further afield (Jinnah, 2010; Makandwa and Vearey, 2017; Misago, 2019). Stats SA estimates that at the mid-point of 2021 there were about 3.95 million international migrants in South Africa out of a total population of 60 million in the country (Ogunnubi and Aja, 2022). While a rich and diverse mix of people and communities, the city of Johannesburg is also mapped by inequality. Considered as the economic hub of the country and still referred to by many as "the city of gold" (Palmary et al., 2014a) due to the opportunities for employment (mostly within the informal sector) and improved livelihoods, Johannesburg is more often known as a place of violence and insecurity.

This originates from the enduring impact of apartheid's politics of "ghettoization" of urban spaces marked by unequal disparities of wealth and extreme poverty (Palmary et al., 2014a, p. 103). This not only makes acceptance and/or integration for migrants into communities a challenge but intensifies the competition and tension between different communities and groups, particularly in marginalized areas. The resultant high levels of xenophobia increase the discrimination and violence that non-South Africans face and lead to an acute sense of alienation—from safety, from being accepted and from feeling a sense of belonging in Johannesburg (Walker and Oliveira, 2020).

Socio-economic precarity and marginalization impacts the mental health and wellbeing of asylum seekers and refugees.

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[4] Each participant verbally consented to interviews and audio recordings and the study was approved by the [University 1].

Although the South African Constitution and National Health Act provide for the right to free primary health care for all, refugees and asylum seekers are often prevented from accessing healthcare including mental health services.[5] Discrimination from public healthcare facilities in South Africa is routine (Walker and Vearey, 2022) and this exacerbates and extends the ubiquitous feelings of alienation amongst migrant communities.

As a country, South Africa continues to face challenges in the provision of public mental health services while experiencing an escalating crisis with a high prevalence of mental disorders linked to social determinants like poverty, violence, and substance abuse (Burns, 2015; SACAP, 2019). Although neuropsychiatric disorders are ranked third after HIV/AIDS and other infectious diseases in their contribution to the burden of disease in South Africa, there is not only underfunding of mental health services but also enormous inequity between provinces in the distribution of mental health services and resources (Docrat et al., 2019a,b).

There is also a lack of public awareness of mental health and widespread stigma against those who suffer from mental illness (Walker and Vearey, 2022). This means that many feel a reluctance to acknowledge mental health challenges or to even try to seek care (Walker and Vearey, 2022).

"*Little Mogadishu*" and "*Gambela*"

For Somalis and Congolese who are forced to cross many countries and borders to reach South Africa, the physical and psychological distance from home is felt acutely. The United Nations High Commissioner for Refugees (UNHCR) (2021) estimates that approximately 13.2% of the Somali national population have fled Somalia due to conflict, climate shocks, and resulting widespread poverty, and it is estimated that between 21,000 (Jinnah, 2017) and 32,000 (Alfaro-Velcamp, 2017) have settled in South Africa. Meanwhile, of the estimated 800,000 Congolese who have fled abroad (Gusman, 2018), many have crossed into South Africa with the help of smugglers commonly known as *Tindikeurs* (Tshimpaka and Inaka, 2020). Although there is little documentation on the migration of Congolese (Steinberg, 2005, p. 1), it is estimated that about 60,000 Congolese citizens live as asylum seekers and refugees in South Africa (Alfaro-Velcamp, 2017).

Somali and Congolese communities are not homogenous and both groups are diverse in terms of religions, ethnicity, gender, sexual orientation, region of origin, age groups, and periods of arrival, which impact ways in which they settle and live in South Africa. However, despite these differences, most Congolese and Somalis are concentrated in certain inner-city urban spaces. Somalis tend to gravitate toward the suburb of Mayfair in Johannesburg, commonly referred to as "*Little Mogadishu*" (Jinnah, 2010), while many Congolese live in Yeoville, an inner-city fringe suburb of Johannesburg with a public market nicknamed "*Gambela*" in reference to one of the popular markets in Kinshasa.

For both, Congolese and Somalis, the precarious processes of migration, settling, creating social ties, and attempting to make a new life are reflected in the renaming of these areas in which they live: "*Little Mogadishu*" and "*Gambela*". While such challenges are faced by different migrant groups across South Africa, these particular spaces mark the role and establishment of communities in South Africa while also demarcating their difference—and alienation—from surrounding society. Both groups tend to engage in a variety of businesses such as owning *spaza* shops (small retail outlets selling household necessities); clothing shops, restaurants, internet and telephone shops; and some engage in informal trade as "hawkers" selling goods on the streets. The majority of this work is precarious but when going well can pay rent, school fees, and support basic needs.

Denied documentation as a tactic of alienation

Documents—particularly legal state documents like visas and permits—have been increasingly recognized as enabling a sense of security, legitimacy and, accessing services (Willen, 2012; Cooper-Knock and Owen, 2018). Central to "the relationship between people and papers" (Tarlo, 2001, p. 87), state documents are embedded in the micro-politics of everyday life in South Africa. As Freeman and Maybin point out, "documents tell stories... because they embody the political processes by which they were produced" (Freeman and Maybin, 2011, p. 11). For asylum seekers and refugees, the status of documents—whether one is "documented," waiting for documents, or deemed "illegal" due to a lack of documents—can communicate a sense of security, safety, belonging, and/or alienation. We lay out the situation of documentation in the country and how this affects the lives of our informants.

Without documentation and a means to regulate their stay in South Africa, asylum seekers and refugees are excluded from participating further in everyday life and taking steps toward better security and wellbeing. For Congolese and Somalis in South Africa, as with many other migrants, documentation lies at the center of almost every challenge faced and is one of the most reported obstacles relating to daily living such as poverty, barriers to healthcare, education and employment opportunities. This produces a strong sense of alienation (Amit and Kriger, 2014; Schockaert et al., 2020).

Barriers to accessing documentation can be traced directly to South Africa's Department of Home Affairs (DHA) and its system which (often intentionally) presents non-nationals with numerous barriers to accessing legal permits (Amit and Kriger, 2014; Amit, 2015; Alfaro-Velcamp, 2017) and undermines efforts of regularization and integration.[6] The DHA is rife with bureaucratic

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[5] Section 27 of the Constitution provides that everyone has the right to access healthcare services, including reproductive health. Section 4 of the National Health Act provides that the state must provide pregnant and lactating women and children under six, except members of medical aid schemes and their dependents, with free healthcare (The Republic of South Africa, 2003; South Africa, South Africa, and Department of Justice and Constitutional Development, 2015).

[6] The COVID-19 pandemic exacerbated the crisis of documentation. The closure of the Refugee Reception Offices (RROs) as part of the lockdown

inefficiency and corruption and asylum cases are faced with years-long backlogs with lengthy appeals. In fact, the rejection rate reached as high as 96 percent for all asylum cases in 2019 (Amit, 2015; Schockaert et al., 2020; Moyo, 2021). The majority who apply are left in states of limbo for years, unable to move their cases forward or find out their status due to a DHA crippled by corruption, poor management, and an increasingly restrictive and securitized approach toward migration (Amit, 2015; Landau, 2017; Gandar, 2019).

Even when refugee status or other documentation is regularized, refugees, and other migrants find their permits contested and rights to employment, health, and education denied. Police harassment is also frequent (Crush and Tawodzera, 2017; Walker, 2021; Walker and Vearey, 2022). While those who remain undocumented face multiple forms of discrimination, insecurity, and threat, even those with documents do not experience security and stability. The efforts of *dis*integration effectively criminalizes all asylum seekers and refugees regardless of their status of documentation. In this way the mere identity of being an African or Asian, cross-border migrant, asylum seeker, or refugee of lower economic status renders one an alien.

Ovidy, a Somali man interviewed in Mayfair in Johannesburg, describes how documents alienate and impact asylum seekers who have not managed to regulate their documentation:

> *The people who are facing challenges are the asylum-seekers. Refugees have their documents, if they know their language they can fix their problems, but those who cannot fix their problems are the asylum-seekers because asylum-seekers don't have IDs. That ID allows a person to register a business, allows them to go to a hospital, allows the right for business or cars. So, the asylum-seekers are those who are facing problems. The refugees are better than the asylum-seekers (Interview Ovidy, Somali man, Oct 2021).*

This quote illustrates the challenges faced even when in possession of an asylum-seeking permit—due to its temporary and impermanent nature. Asylum permits must be renewed every 3–6 months, often involving a lengthy and expensive process for asylum seekers as they have to travel to the Refugee Reception Offices, spend hours- even days queuing and routinely leave without having completed their renewal. In most cases, employers are reluctant to hire asylum seekers for these reasons and may even dispute the validity of the documents claiming that asylum seekers cannot legally work in the country.

Bomba, a Congolese man, explains these challenges further:

> *Refugees and asylum seekers are made illegal not because they themselves want to, but the system does not allow them to keep the document up to date for a longer or shorter time. Sometimes the documents we have whether refugee status or asylum seeker permits are rejected especially when you apply for a job. The employer's requirement is that you must only possess a green ID. Document issue is very complex in South Africa (Interview Bomba [Congolese man], October 2021).*

The precarity and uncertainty for those without (regularized) documents means increased exposure to discrimination and exclusion. Located at the core of "acts of alienation" to asylum seekers and refugees, to be rendered "alien" in this way significantly impacts wellbeing and mental health.

This is captured most starkly in the following statement by a woman whom, since her arrival in South Africa in 2002, has not been granted refugee status and faces consistent difficulties in renewing her temporary permit:

> *In any case for the documentation, I cry morning, noon and night and I am not the only one in this situation... Recently, I went to Home Affairs, and they confiscated my document on the grounds that my file had never been found since I arrived in this country in 2002. They asked me to start afresh with a new file. I had to give R1700 to this officer to help me. I cried because I didn't have that money. . . . . I finally gave him R1000, and he gave me a three months extension. When these months expired, I went back to the Home Affairs, and they asked me for R2000 to renew my permit. As I had no money, they refused to help me, and I never went back until COVID-19 started. I did the online renewal for myself and my child. My paper was renewed but my child's paper has not been renewed until now. They only returned us to the 3 months or 6 months permits (Interview Jane, November 2021).*

This emotive response demonstrates the extent of powerlessness enforced on migrants as the attempt to access documentation as a means to increase and improve their security and integration in South Africa. The extent of the callousness of these policies and practices of exclusion is matched by the extent of distress expressed by Jane and the subsequent deep feelings of alienation. This next section explores these complex feelings of alienation amongst migrants and refugees in Johannesburg further through the key spheres of gender roles, family, and faith.

Feelings of alienation

> *When a bad thing happens here then you are better only when you are home. So, you miss home especially when bad things like violence happen. When you have the ID, you go to hospitals or somewhere, instead of being treated the same way, you are treated otherwise, you know. On those occasion, you will feel like down, and you miss home, sweet home (Interview Pedro [Congolese man], Sept. 2021).*

Pedro, a Congolese man described his feeling of marginalization, exclusion, and rejection—with being "treated otherwise" as a key indicator of the entrenched sense of alienation. This alienation is often in relation to "bad things" or distressing experiences that happen in different areas of their lives. The experiences shared by Congolese and Somali migrants, like Pedro

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regulations, meant that foreign nationals could not apply or renew refugee permits, asylum permits, and residence permits during the pandemic.

highlight alienation as a result of acute levels of desperation due to poverty, unemployment, and poor mental health. As the above quote suggests, the absence of a sense of security, integration, and belonging increases a sense of alienation and with this, the desire and longing to return "home" also intensifies. In the following, we consider alienation in relation to the shaping of gender roles, and family relations, and religious and faith communities.

Alienation and gender roles

Holding social esteem in one's family and social networks is closely tied to gender expectations around finances. What follows are excerpts of stories shared by the Congolese and Somali migrants we spoke with about the effects that alienation from gender roles have on peoples' relationships and sense of achievement. While understandings and expectations around gender are not wholly homogenous in any society or community, amongst many Congolese and Somalis the traditional cultural ideas of gender continue to identify men as the providers and breadwinner for women who stay at home and care for children (Lwambo, 2013; Johnson-Agbakwu et al., 2014; Perrin et al., 2019; Mulumeoderhwa, 2022). For these communities living in South Africa—not being able to adhere to these traditional roles and the alienation of men from secure employment can have a significant impact on their wellbeing and mental health.

According to Jinnah (2016), many migrants possess desired skills in the professions that are scarce in South Africa (Crush and Peberdy, 2018). However, the majority are unable to use their skills due to a lack of employment opportunities and their documentation status, which prevents entry into the formal economy of work. As a result, many end up working within the informal economy—a broad and diverse space where different trades and skills can be utilized—but also lacking in financial security and protection from workplace dangers and exploitation (Khan and Lee, 2018; Schockaert et al., 2020).

The narration by a Congolese woman of how she had to "force" her husband, a skilled graduate, to join a security company for the family's survival reflects this difficult situation in which many find themselves:

> *My husband is a university graduate but does not work. Since he came to this country, he only uses the asylum seeker permit. Even I, who arrived after him, already was granted refugee status. At first, he didn't want to be employed as a security guard because he thought that job was humiliating and not commensurate with his skills, and moreover he was discouraged by the low pay, but since I forced him, he finally accepted to do it for the survival of the family (Interview Amelia, a Congolese woman, Nov. 2021).*

In capturing the challenge of finding work and the sense of "humiliation" faced by a university graduate working in a low-skilled job, this quote speaks to the way in which gender roles are undermined and enforce a sense of alienation from status, family role, and self.

This also links back to the role of documentation. The temporary nature of asylum permits not only limit or prevent access to skilled and educated migrants accessing skilled employment but are also a part of specific policies and practices of exclusion and disintegration (Collyer et al., 2020).

Participants in the study shared accounts of a perceived loss of economic power by men due to unemployment or employment in "unskilled" positions and how this impacted gender norms in their households. This was also influenced by the pandemic whereby many breadwinners suffered a loss of employment without a social safety net (as initially migrants were excluded from the support grants provided by the state at this time). In some instances, women took over the breadwinning role as they found ways of making an income, and this further affected men's sense of their gender role and responsibility.

However, some participants also pointed out that women's new leadership roles challenging the traditional division of labor did not necessarily improve their status within the families or in the society. As a result, rather than seeing this change of roles as positive, some women also considered it disrupting their own understandings of gender roles (Chesley, 2017).

As a result of these cultural shifts through a lack of secure employment and status, some participants also reported tensions between couples and in some cases domestic violence. This was described as a result of men feeling "belittled" or "threatened" and therefore seeking to "reassert" control in some way. Reports from participants referred to women facing violence in their homes and communities and others being rejected and shunned:

> *My partner used to insult me profusely in front of the children and even the landlord. He would always come home drunk and start abusing me. Our son was very affected by our daily quarrels and started accusing us at school. When the child woke up at five o'clock to get ready for school, that's when Dad would start with his insults toward me. We used to fight a lot and sometimes he would come and destroy the staff (sic) I was selling* (Pinky, Congolese woman, Nov. 2021).

This quote by Pinky illustrates the violence emerging from a context of socio-economic alienation triggering rapid changes in gendered roles which permeates through families and communities. One young Somali pointed out that this has been a particular issue for many young couples:

> *We got a problem as Somalis around here, we have youths and some couples who are homeless because of COVID, and some men resort to drug abuse, and it has resulted in fighting among young couples as to who should provide for the family to survive and that is an important matter that our elders are concerned with (Interview Taiwo, a Somali youth, Oct 2021).*

Like violence, the use of drugs by men to numb the emotional and psychological burden can be related to the restrictions on their ability to provide and take care of the needs of their families as well as remitting in their home countries. This "crisis" in gender roles, which can be seen in different ways as disruptive, can result in a sense of economic disempowerment and marks another form of alienation.

Alienation from family

Congolese and Somali migrants in this study also reflected on the disruption of family ties and on a sense of familiarity due to their precarious status and the ongoing risks they face in South Africa. While physically away from their loved ones, many Congolese and Somalis seek to remain connected to those in the home country in various ways including through customs and rituals (marriages, funerals, and other key events) as well as giving and receiving financial support. This section illuminates the importance of families for mobilizing care, the anguish of missing out on giving and receiving care, and the psychological safety and the complexity of emotions people feel around familial care obligations.

For Somali and Congolese refugees in South Africa, the support of the family is valuable and expected, even in very desperate situations across multiple borders. However, when unable to give care, this causes acute feelings of alienation and pain. Hawy, a Somali man described the impact of not being able to travel and attend funerals for loved ones on his mental health:

> *Yes, I am a sad man and in pain because I miss my mother. Since I came here in 2004, my father and my brothers passed away, I could not attend their burial. It is because I do not have proper papers (documents) to travel back home or to nearby countries such as Kenya or Tanzania to at least meet with my relatives. But when I see the news, I see that there is a lot of fighting from when I left there and there is a lot of blood coming from my home. But I miss my home a lot (Interview Hawy, Somali man, Oct 2021).*

The line "there is a lot of blood coming from my home" powerfully captures the sense of fear and loss which is entangled with the sense of alienation—from home, from loved ones, and from life and death. Hawy's experience also reflects the alienating significance of the huge geographic distance between South Africa and Somalia and DRC. Crossing multiple borders is costly, exhausting, and distressing, which makes the logistics of visiting family left behind extremely difficult, especially due to the state's acts of alienation and marginalization of migrants. In the quote below, Rafiq also demonstrates his ongoing anguish after missing out on the end-of-life care of his mother who lived in Kenya:

> *So, for the past 2 years I was trying to go to Kenya because my mother was sick but because of COVID-19 lockdown I could not, she passed away while I was trying. It was traumatic and still it's troubling me… Sometimes I want to sleep but I cannot, thinking and worrying all night and when day comes, I will not function properly, I only have my Somali elders and community who keeps comforting me" (Interview Rafiq, A Somali man, Nov, 2021).*

While the loss of a loved one leads to intense grief for family members, the ability to witness and go through the rituals and procedures of burial are critical for feeling connected and supported. As the quotes above highlights, migrants who are already disconnected from their families are devastated for being unable to participate in a burial and important stages of grieving through connection. Not taking part in burial and care rituals enforces a stronger feeling of isolation and disconnection from familiarity and customs resulting in poor mental health and existential alienation.

For Congolese and Somali migrants, there are complex obligations and feelings toward giving and receiving care. Sending money or gifts is another way migrants seek to connect to their loved ones in the home country, especially across such great distances. For many, the fulfillment of migration dreams is made possible by the concerted support of family members, and the resultant status and esteem that comes from this (Kihato, 2013; Dzingirai et al., 2014). Hence, for these migrants, sending money from abroad not only means keeping connections in the home country, but also means expressing appreciation and gratitude to the relatives who supported this project. Often migrants are viewed by their families as problem solvers (Torres and Casey, 2017; Lakika, 2020). While such responsibilities increase the pressure to maintain contact and familial ties, many of the participants described wanting to reduce or cut contacts due to fear of their precarious life being exposed. Unemployed, unable to earn a living and provide were all seen as a form of embarrassment and as negatively impacting family and social ties. This leads to increased isolation and alienation, contributing to poor mental health. Salamaleko, a Somali man, expressed this dilemma below:

> *Sometimes you prefer not to bother your family members back home when you have problems here in South Africa, but as a human being you have to think about all of this. About your friends and the problems, they can face, your family members about how you can be there for them, although it's very difficult and how you can be there for yourself and your prosperity. A person should worry… (Interview Salamaleko, Somali man, Nov 2021).*

A Congolese woman explained that after spending many years in South Africa, she was never able to provide for her parents, which is a key responsibility of the first-born of the family. This left her feeling disappointed in herself and anxious about how this is seen by her family too.

> *After 18 years in this country, I see that I have gone backwards a lot. I have nothing and I suffer too much. My little brothers and sisters who went to Europe have made a lot of progress and support our parents. However, I do not do anything if something happens in the family. My mother often calls me to tell me that my father is sick and as the firstborn I do absolutely nothing. My mother tells me that she always prays that my father will not die before I do something for him because I am the eldest. When she talks to me like that, I always feel pain and I have trouble sleeping. But she encourages me by always telling me to stop worrying that God will help me (Interview Julia, a Congolese woman, Nov. 2021).*

This quote speaks to the woman's sense of alienation resulting from her inability as the first-born to meet expectations to financially participate in family matters. Being physically absent from the family, she thought she could maintain contact through providing when the family faced hardship. However, her marginalization in South Africa has prevented this and disrupted important family structures and norms. As the eldest sibling, Julia is unable to support her younger siblings, leading to a loss of status in the family and feelings of inadequacy and isolation.

At the same time, Congolese and Somali participants also described being on the receiving end of family care and support in times of need. Unlike Salamaleko and Julia's experiences, others reported unconditional support from their families even when they failed to remit. In fact, in some cases families understood and encouraged them as one Somali woman indicated:

> *You came from a family then if you have a problem, you go straight to the family. The most important thing why I speak to my parents mostly is because they are the ones who brought me up and helped me to learn something in this world and they are the people who always help and make me happy when I speak to them even if I don't give them anything (Interview Amigos, Somali woman, Nov 2021).*

That her contact with her family "makes her happy" is notable in that it is a stark difference to the alienation from family that most of our participants describe. This is also shown in the experiences of Nadia, a Congolese woman whom despite being unable to send money to her family during her 18 years in South Africa, she has continued to receive financial support from her brothers and sisters in Europe. She has also felt encouragement from her mother in the Congo.

> *My brothers and sisters who live in Europe are the ones who always help me. Whenever I face financial challenges in terms of paying rent or school fees for my child, they always assist me financially. It pains me to be always dependent on them. I told them I wanted to go back to the DRC, but all of them, including my parents refused; they kept on encouraging me to remain here. If they were not there, I could become crazy because life is not easy in this country (Interview Nadia, a Congolese woman, Nov. 2021).*

These comments demonstrate an internal dissonance in Nadia's emotions from gift giving and receiving. Her family is a lifeline that she requires to survive in South Africa, yet this also contributes to a sense of guilt that she does not reciprocate the care expectations. Furthermore, her quote also illuminates the tensions that often exists between Congolese migrants and their families about the decision to return to the country of origin. As migration is often considered a source of investment and enrichment, advising their loved ones to return home after failing to achieve their migration objectives has often been the last option that families back home have ever thought about. In the case of Congolese, families often encouraged their loved ones abroad to remain there even amidst alienation and precariousness. The failure of a migratory project has often been a source of shame and frustration, not only for the migrants but also for the whole family. Sometimes people would discourage their loved ones abroad from returning to the country arguing that their precarious situation in the receiving country is better than the economic downturn of the DRC. This section highlights the complexity with which social relations operate across space. Families separated by migration and displacement stay connected through giving, yet even if the support reduces economic strife, when the gifts go unreturned alienation feelings are exacerbated.

Alienation and religious faith

Throughout the course of fieldwork, religion and faith were identified both as central resources and key sources of hope, which at times also enforced a sense of alienation.

In terms of hope, participants in both communities reported that when faced with uncertainty, their faith provided a source of strength. A Somali woman, for example, explained how the mosque was a place and source of comfort in times of loneliness—and alienation:

> *I mostly went to the Mosque and then there is a whole Mass that they are doing for, like, Islamic studies. That is the best things for me, always, to cure my heart or to cure my loneliness. If I remain alone in one place, I will be crazy" (Interview Mother J, a Somali woman. Nov 2021).*

This quote speaks to how alienation experienced as loneliness drives a need for connection and comfort—which is found spiritually through Islam and experienced literally in the routine of attending mass at the Mosque. A Congolese participant also reported prayer as a means of coping with difficult situations in South Africa.

> *Yes, I do pray. I nourish myself with hope and work on plan B, plan C so that my family doesn't fall victim of this violence. Yeah, the first thing, I pray, I nourish myself with faith and hope. I believe that if I pray, God can protect me and the rest of my family. At the same time one can ask for God's guidance about what to do so that one's family may not be a victim (Interview Pedro [Congolese man], Sept 2021).*

Pedro's reflections demonstrate the importance of prayer for him in addressing or alleviating the uncertainties of life in contemporary South Africa. Accordingly, participants also pointed to the role of faith-based organizations where Congolese and Somalis in South Africa seek support. Jinnah (2017) has highlighted the Somali religious solidarity support which their community members received. Congolese citizens often seek care from the countless Pentecostal churches in South Africa which originate from the DRC. These churches' teachings force their members to "say no" to stress which they believed was not godly. A female participant who belonged to one of the churches stated:

> *The church teaches us that stress is not good for the children of God. We must try by all means to avoid it. That's why when it affects me, I come back to what the church says that stress is not good for the God's children, especially committing suicide is strictly forbidden by the bible. If you commit suicide, you are going straight to hellfire. So, pastors always warn us that stress is evil and that we must avoid it. That's why I have become cautious, whether I have or not I always minimize stress (Interview Alice, a Congolese woman, Nov. 2021).*

Where a body of research has highlighted ways in which the church has played a key role in helping cross-border migrants to deal with their violent experiences and adversity in the host society, it is also evident that the emphasis on prayer and healing and interpretation of stress and mental health can be limited in addressing the challenges migrants face (Sommers, 2001).

Some participants, reflected on the nuances of religion and faith. They identified that religious communities are not always a direct response and answer to suffering and referred to the need for more concrete and sustainable responses, especially to acute socio-economic needs. As one of the female Congolese participants explained,

> *That one whether you like it or not will affect you. Right now, I've got nothing to eat while my children want to eat, but I don't have. You know that we are approaching the end of the month, like me I have to pay rent on the second, but until now I don't know how to start and where the money will come from. In this condition, whether you like it or not you will be stressed even if you have God. Somehow, we think, and God has given us knowledge and a brain to think. You will always think, you know. You feel like you want to break down, but you say God, support me (Interview Jane, a Congolese woman, September 2021).*

Our participant shows her recognition of the complex and challenging situations that she faces—which she feels require more than simply prayer. As she notes, God has given them "knowledge and brain to think" about how to improve their conditions, but the socio-economic deprivation experienced in South Africa is a psychological burden that needs a different response. This point is important not only in highlighting the multiple ways in which care can be sought—often simultaneously—but also that these strategies are shaped and textured by the changing socio-political context in South Africa.

Participants also noted that religious leaders sometime take financial advantage of followers—particularly women in need of spiritual guidance and support. Others noted that pastors were less concerned about the challenges their congregants faced, but rather drew from "prosperity gospel" principles, insisting on money through the parable of "sowing a seed" as one participant explained.

> *When the pastor is asking too much which I don't have, it stresses me too much. I, myself, still struggle to meet my own needs and those of my family, but the pastor doesn't care. He only pesters me to give money. It becomes another source of stress. We don't receive any support from the church. Even if I have a problem the church doesn't do anything to assist me (Interview Emma, a Congolese woman, Nov. 2021).*

This quote illuminates the complexity the care and demands come with religious institutions in South Africa. In seeking support from the church, they are confronted with another reality in which the church turns solace into stress, which is further fueled by pressure for money and other demands. Emma points out a conflictual situation in which the members struggle to make ends meet while the pastor betters his own financial position to the detriment of his congregants. The participant expressed concern not only about the level of financial exploitation here but about what this meant for them in terms of fulfilling their perceived financial obligations to the church—a symbol of their commitment to the church. As a response, she underlined that the church's response to the challenges people face cannot only be based on prayer and contributions from congregants, they must also take heed of their socio-economic needs. This points to the alienation felt when seeking community, purpose, and comfort and instead finding judgement and exploitation.

Therefore, while many acknowledge the support of the church in dealing with their ever-present stress, others (particularly Congolese participants) also identified a negative impact religious social connections have due to judgment, labeling, suspicions, and different interpretations of what people are going through. Many individuals described states of pervasive precarity and desperation as leading to a sense of general suffering—resulting in people feeling unable and/or unwilling to support one another, or what Omata (2017) calls "shared destitution." This links directly to the subjective experience of alienation—of being cut off from ties or threads of security and solace—even when the expressed intention is otherwise. For some participants, the practices within religious institutions and spaces—that ostensibly intend to provide support and community—can actually increase a sense of alienation both physically and existentially.

Conclusion

This article explores the link between migration and alienation with the impact on the mental wellbeing of Congolese and Somali asylum seekers and refugees in South Africa. We document and explore the various ways alienation is both imposed upon and experienced by these migrant groups. As we have shown, systemic disintegration, or acts of alienation, are the deliberate and active policies and practices in South Africa that are instrumental in excluding asylum seekers and refugees from accessing basic services and employment while in turn impacting their mental health and wellbeing. This study's findings show that like many asylum seekers and refugees, Congolese and Somalis' face many obstacles which affect aspirations for a better life and increase their experience of being othered in South Africa. In other words, the state and society in South Africa actively impede possibilities of integration and care. However, specific to the Congolese and Somali communities are the spaces in which they live and work; "*Little Mogadishu*" and "*Gambela*" offer to some extent a sense of community and connection, yet on the other hand set the communities apart and increase the sense of alienation.

The article shows how several intersecting issues—accessing documentation; the breakdown of familiar routines; customs, and family ties; extreme poverty and socio-economic marginalization caused by the lack of decent employment—converge to trigger trauma, frustration, and ultimately pose a serious burden to the mental health of migrant populations. While conceptualizations and metrics of integration put forth by Ager and Strang (2008) may capture the fallout of disintegration, such as access to livelihoods, housing, education, and healthcare, it does not adequately assess the profound damage that acts of alienation does to the crucial relationships and psyches of innumerable migrants in South Africa.

This pain, or feelings of alienation, we argue, is a crucial aspect to our understanding of alienation.

In the absence of formal mental health care, migrants seek and provide alternative social connections for care. While religion, family and community support are looked to as ways of seeking help for poor mental health, these areas are also identified as creating greater burdens and stress, deepening feelings of alienation. The paper also shows how Congolese and Somalis' efforts to navigate structural challenges by adopting alternative means of survival can sometimes lead to an increased sense of isolation and alienation which one participant expressed in these words, "When a bad thing happens…you are better only when you are home."

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving human participants were reviewed and approved by the University of Edinburgh Research Ethics Committee and the University and the Human Research Ethics Committee of the University of the Witwatersrand. Informed consent was obtained from the participants for both participation in the research and for the publication of potentially/indirectly identifiable information. The consent was documented within the digital recordings. All names used in the article are pseudonyms to protect identities.

Author contributions

RW: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing—original draft, Writing—review & editing. DL: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing—original draft, Writing—review & editing. TM: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Writing— original draft, Writing—review & editing. CB: Conceptualization, Writing—original draft, Writing—review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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"Now we start to make it like home": reunited refugee families negotiating integration and belonging

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This paper highlights the importance of local and individual context in either facilitating or hindering processes of integration for reunited refugee families settling in unchosen areas. It adds to understandings of integration by analyzing the day-to-day active and processual nature of place-making, from the perspective of families. The findings are based on qualitative interviews with 13 refugee families—21 parents and 8 children aged between 12 and 18, who had recently been reunited in two large cities in the UK: Glasgow and Birmingham. The paper explores the local conditions families identified as conducive to settling in their local area and argues that the process of attaching to their new locales was mediated through the social connections they made. The article contributes to knowledge by demonstrating how families exercised agency and resilience in place-making in unchosen spaces, through the people they met and the relationships they developed. Further, it critiques the tendency to denigrate "exclusive" bonding ties, particularly between co-ethnics and pays attention to the role of friendship in routes to belonging in unchosen spaces.

KEYWORDS

integration, place-making, belonging, refugee, families

1 Introduction

This article builds on definitions of integration as a multi-directional, multi-dimensional and relational process with social connections at its heart (Ager and Strang, 2004; Ndofor-Tah et al., 2019) and as a dynamic process which incorporates economic, social and spatial dimensions (Kearns and Whitley, 2015; Spencer and Charsley, 2021). It argues that place and identities are co-constituted in spaces, between people, and calls for a re-linking of the relational and affective aspects of integration to the sites where social interaction happens. Drawing on Massey (1991, 2005), the article demonstrates how refugee families negotiate the process of integration through relational place-making. It describes the routes or integration pathways which family members carve out through their everyday interactions in new and unfamiliar spaces, toward a sense of feeling at home in an area. The theory of place-making is not only relevant to the social and spatial dimensions of integration, but also to the affective side of integration; how feelings of belonging are negotiated. The article explores place-making from the perspectives of people already granted refugee status who are at a very particular transition point in their personal and familial integration pathways, having been recently reunited in the UK. Specifically, it focuses on recently reunited refugee families' daily negotiation of place-making in unchosen places. It analyses the opportunities and constraints to develop friendships, how the families exercised choice in the people and spaces they attached to, and the meanings attached to these relationships. Places are not just the sites where social relations happen, but rather identities and places are co-constructed by the people who live there, forging a sense of attachment to locales through social interactions in shared spaces. The making of place is crucial in the process of actively negotiating the spatial and social dimensions of belonging. In the words of Massey:

> "[W]hat gives place its specificity is not some long internalized history but the face that is constructed out of a particular constellation of social relations, meeting and weaving together at a particular locus." (Massey, 1991, p. 7)

The author adopts a political lens in analyzing the everyday processes of weaving together of people in spaces; recognizing that place-making happens in uneven spaces and that the opportunities to access the spaces of interaction are not equally available to all people. Amin (2002, p. 959) refers to this as the "micropolitics of everyday social contact and encounter." Boccagni and Hondagneu-Sotelo (2023) conceptualize the dynamic and contested process of negotiating belonging in spaces as "homemaking" and argue that this constitutes a new analytical category from which to unpack and understand the contexts in which people, spaces and time intersect. Echoing Yuval-Davis (2006) they highlight the differential social locations of actors in this relational process (see also Wessendorf, 2019). However, this article retains the concept of place-making, drawing on later iterations of 'Massey's de-essentializing theory of space and place which also highlights how unequal social relations are played out in the everyday politics of place-making. She argues that power imbalances are played out relationally:

> "through a myriad of practices of quotidian negotiation and contestation; practices, moreover, through which the constituent "identities" are themselves continually moulded" (Massey, 2005, p. 154)

It is the contexts in which unequal social relations are played out and the agency exercised by refugee families in negotiating belonging in new locales, *despite* the constraints and lack of freedoms to choose where to live and who to interact with that this article is concerned with. Following feminist scholars such as Lenette et al. (2013) and O'Reilly this article aims to pay:

> "empirical attention to the everyday lives of migrants in order to understand and make visible the processes of mobility and immobility" (O'Reilly, 2018)

Further, the paper explores the affective side of integration, paying attention to the meaning attached to friendships in new locales, and how these relationships shape narratives of transnational belonging or feeling "at home". It draws particularly on Yuval-Davis (2006) who argues for a multi-faceted analysis of the "politics of belonging" including at the level of who and what people identify with, and the emotional attachments they make. Rather than making assumptions about the form, function and meaning (Baillot et al., 2023) of friendships made in the UK, particularly on the basis of nationality and ethnicity, the author argues that, the basis for homophilus "identifications" (Yuval-Davis, 2006) cannot be assumed but are rather "an observation that had to be explained" (Barwick, 2017). In conceptualizing belonging as the affective side of integration the article seeks to explore: who people interact with; in what spaces; and how they negotiate their relationship, based on which common and distinct aspects of their identities. Ultimately, we need to understand the meanings people attach to relationships vis-à-vis their feelings of belonging to particular physical and social locales.

For refugees, the practice of transnational place-making, place-attachment or "emplacement" (Schiller and Çaglar, 2013; Nelson et al., 2019; Wessendorf and Phillimore, 2019) must be understood in the context of displacement; a liminal state of "being attached to several places while simultaneously struggling to establish the right to a place" (Brun, 2015). People granted refugee status have been forced to migrate from their home countries and are then doubly displaced in the UK through the dispersal system and, later through a series of moves between emergency and temporary housing arrangements until they are able to secure permanent housing.

Lack of choice over where to live, homelessness and poverty are built into the UK housing and welfare systems asylum seekers and refugees have to navigate at several transition points in their integration pathway (Mcphail, 2021). First, at the point of claiming asylum, when people are dispersed on a no-choice basis from London and the Southeast of England according to the national dispersal policy, introduced under the 1999 Immigration and Asylum Act. Originally entered into by voluntary agreement with participating Local Authorities in England, Scotland and Wales, the dispersal scheme recently became mandatory and was widened to include all Local Authorities (Home Office, 2022). Updated Home Office guidance on accommodation allocation emphasizes the overarching principle is to allocate housing on a "no-choice basis". It states that any consideration of location requests to be housed near to friends, family or children's schools should not "outweigh the public interest of allocating accommodation on a "no-choice basis" outside London and the Southeast and in areas of the UK where the Home Office has a ready supply" (Home Office, 2022, p. 9). Asylum seekers are often housed in areas with poor quality housing stock, limited services and social infrastructure, and far from existing support networks (Kerlaff and Käkelä, forthcoming; Hill et al., 2021).

The second key transition point in the housing journey comes once a person is granted refugee status and is subsequently served "notice to quit" their current asylum accommodation within a 28-day "move-on period" during which they are expected to secure follow-on accommodation, usually in the social or private rental sector. While, in theory, recognized refugees have freedom to choose where they live, the reality is that few have the resources to afford them this luxury and will at this point have little choice but to register as homeless. Most asylum seekers are not allowed to work and are therefore reliant on asylum support, currently £47.30 per person per week, barely enough to live on, let alone enough to allow them to save money. Further, there is substantial evidence that the 28 day move-on period gives insufficient time to secure onward accommodation or access welfare benefits, putting newly granted refugees at risk of homelessness and destitution (Provan, 2020). Despite this, the UK government have just announced plans to reduce this "move-on period" to just 7 days (The Guardian, 2023).

The third transition point for reunited refugee families comes at the point of arrival of the family joining the sponsor in the UK when larger accommodation will usually be required. Most local authority areas, Birmingham being one of them, only activate their homelessness prevention duties once the family have arrived in the UK and won't accept an application for homelessness accommodation from the sponsor prior to his or her family's arrival (British Red Cross, 2022a). Glasgow, in contrast, will accept a claim a few days before the family arrives. Further, reunited families face a "destitution gap" in the intervening period between the sponsor's individual Universal Credit claim being canceled, and a new joint claim being processed (British Red Cross, 2022a).

The process for seeking accommodation in the UK for those who have come through the asylum route is depicted in Figure 1 (reproduced from Mcphail, 2021, p. 10). It should be noted that this figure does not reflect changes to this process which are currently being implemented under the UK Nationality and Borders Act 2022 and the Illegal Migration Act 2023. The initial lack of choice over where to live, and imposed financial insecurity as an asylum seeker, have a ripple effect on the housing allocation process after being granted refugee status, and again when family join sponsors in the UK and larger accommodation is required. Further, many families face overcrowding when they are reunited when the transition to more suitable accommodation can take many months after the family's arrival.

Homelessness is embedded in the system refugees have to navigate and multiple moves cause further disruptions and ruptures in the integration process (Hynes, 2011; Meer et al., 2019). Multiple moves between emergency and temporary accommodation can undermine the family's efforts to progress their integration pathways in other areas such as children's education and building social networks.

This cycle of exclusion requires refugees to constantly negotiate a sense of security and belonging in the face of ongoing rupture, liminality (O'Reilly, 2018; Vidal et al., 2023), stasis and insecurity (Brun, 2015; Horst and Grabska, 2015). This paper looks at the "opportunity structures" (Phillimore, 2021) that restrict refugee families' choice in where to make their new homes in the UK, and the resultant impact on their integration journeys. It explores how the families we interviewed exercised agency and resilience in negotiating a sense of place and belonging in the cities they were housed in, despite both the structural constraints on their integration pathways, and the additional ruptures imposed by the COVID-19 pandemic.

2 Materials and methods

This article is based on findings from a mixed methods study conducted from 2019 to 2020 with people who were accessing a family reunion integration service provided by two third sector organizations. The service provided support both to the sponsor refugee—the first parent to arrive, usually alone, and to their arriving spouse and any dependent children. The terms sponsor, spouse and child are used throughout the remainder of the article to differentiate participants and family pseudonyms are used throughout. The service was explicitly designed to deliver interventions across the domains of the Indicators of Integration framework (Ndofor-Tah et al., 2019). This included work to support families to re-build bonds between them, and to foster bridging connections with local communities (Baillot et al., 2020).

It draws on data from semi-structured interviews with 13 families, including 21 parents and 8 children aged between 12 and 18, all of whom had recently been reunited in two large cities in the UK: Glasgow and Birmingham. These locations were selected in agreement with practice partners as the families in these sites were being supported by family project workers to whom interviewers could pass on any concerns for safety and wellbeing. None were recorded· The interviews were conducted remotely over Zoom or by telephone during July and August 2020 due to strict physical distancing restrictions imposed as a result of the COVID-19 pandemic. Professional interpreters were used when requested. A schedule was used to guide the interviews and accompanied by an adapted coaching tool "the Wheel of Life" which was used to offer greater control to participants in guiding the conversation to the areas of their lives they wanted to speak about, and as a visual tool to facilitate the conversation. Different wheels were adapted for children and adults, to reflect the different priority areas of their lives. Interviewees were posted the visual tools in advance of the interview, with a set of coloring pencils, translated information about the interviews, and instructions on how to complete the wheels. They were asked to fill the wheels in according to how fulfilled they felt in each area of their lives, and to add any areas of life that they felt were missing from them. A filled in wheel is shown in Figure 2.

Some spouses were interviewed together and others consecutively, depending on preference and practicalities. The research team had originally anticipated interviewing family members individually, but seven out of 11 couples opted to be interviewed together. This, alongside the fact that physical distancing measures were in place and most family members were all in the house at the time of interview, could potentially have limited the opportunity for individual family members to speak completely openly. Informed consent was explained verbally before the activity and translated information sheets, including a child-friendly version were provided. Verbal consent was obtained at the outset. Ethical approval was granted by the Queen Margaret University Ethics Committee (REP 0222).

2.1 Analysis

An interpretive phenomenological approach (Matua and Van Der Wal, 2015; Noon, 2018) was used to inform both the collection and analysis of interview data; prioritizing understanding how each individual and family unit made meaning of their own experiences of settling in the UK from an emic perspective. The interviewing approach and use of the visual tool prioritized "deep listening" (Laryea, 2016) which goes beyond "active" listening in explicitly checking with interviewees that our interpretation of what they were telling us reflected their intended meaning, whilst in dialogue with them. In this way, we attempted to move beyond relying on a "flat" reading of the subsequent transcript as the principal means of interpretation. All transcripts or notes relating to each family were analyzed in turn, firstly by each individual researcher and then jointly with the two other fieldwork researchers and the Principal Investigator. In this way, data gathered from each family was reviewed as a distinct phenomenon or case. After this initial analysis the team proceeded to a more traditional inductive coding phase. Each researcher manually coded an agreed sample of interview notes and transcripts. The team then met to compare their coding schemes before proceeding to a second manual coding phase using the agreed coding framework.

The sample of families were drawn from the same family support programme and were geographically spread across different postcode areas in the two cities. Analysis of interviews focused on interviewees' emic perceptions of the home and area they were living in (at neighborhood and city level), without exploring the characteristics of the specific neighborhoods from an etic perspective. This was for both practical and conceptual reasons; it was not practical to explore the particular context of each postcode area where they lived and was also deliberately *not* our intention to make assumptions about the areas based on "some long internalized history" (Massey, 1991, p. 7), but rather to understand how interviewees themselves perceived the character of the areas they were living.

3 Results

3.1 Context—time, place, and person

This section first contextualizes the social and physical locations of the people we spoke to, describing their position in the family, how they came to be living in Birmingham or Glasgow, and for how long they had lived there. Seven of the families we interviewed were living in Glasgow, while six were based in Birmingham (see Table 1). Sponsors had been living in the UK from anywhere between 1 and 10 years at the time of interview and had lived in Birmingham or Glasgow for anywhere between 6 months and 5 years as reflected in Table 1. The table reflects the time sponsors had lived in Glasgow or Birmingham, rather than their overall time living in the UK in line with the article's primary focus on the process of place-making at the level of the neighborhood and city.

Six people had lived exclusively in Glasgow or Birmingham, five having been directly dispersed to the cities following their arrival in the UK. Five male sponsors had chosen to live in either Glasgow or Birmingham: two had chosen to move to Birmingham, and one to Glasgow after they were granted refugee status. One had originally chosen to come to Glasgow to study and had subsequently sought asylum and stayed on in the city once granted refugee status. A fifth male sponsor was offered a choice by the authorities to relocate to Glasgow from London after he was granted refugee status and was homeless, staying with friends in London. It is unclear from the interview whether a sixth male sponsor was dispersed to Birmingham after 6–12 months living in Newcastle or made a choice to move there. Finally, one female sponsor had spent several years living in Manchester before being dispersed to Glasgow when she applied for asylum accommodation support.

All of the arriving spouses and children had been in the UK for a year or less and had come directly to join their sponsors living in Glasgow or Birmingham. In one case, the whole family were initially housed in a town outside of Birmingham before being moved to more central temporary accommodation.

In terms of family composition, all but two of the families interviewed were two-parent families in which the father had come to the UK in advance of his wife and children. The two families with female sponsors were both single mothers, one of whom arrived in the country prior to her 2 children, and the other of whom was in the country with two of her children, and recently reunited with her third child after being separated for nearly 10 years. Five families were originally from Sudan, four from Iran, two from Eritrea and the remaining two families were originally from Palestine and Nigeria.

To offer some comparative context of the size and demographics of the two cities: Birmingham is the second largest city in the UK and widely recognized as a "superdiverse" city "soon to become a majority minority city" (Birmingham City Council, 2023). The city has a population of over 1.1 million and the wider metropolitan area of Birmingham has a population of 3.8 million. In the 2021 Census, 48.7 % of Birmingham's population identified as having a white ethnic background, 31% as Asian and 10.9% as Black. This compares to the City of Glasgow which has a much smaller population of just over 635,000 and the wider area of Greater Glasgow and Clyde which has an overall population of slightly more than 1 million (National Records of Scotland, 2022); similar to the population of Birmingham city. An estimated 88.5% of Glasgow's population identify as having a White ethnic background and 11.5% as having a Black or Minority Ethnic (BME) background. While not as ethnically diverse as Birmingham, Glasgow's ethnic profile has changed significantly since 2001 (when the BME population was 5.5%), likely due in main part to the dispersal of thousands of asylum seekers since that time (Walsh, 2017). Glasgow is also nearly 3 times more ethnically diverse than Scotland's overall population which is currently recorded at 96.0% White and 4.0% BME (National Records of Scotland, 2022).

Only one family in the interview cohort were living in suitable, sustainable accommodation at the time of interview, and 15 children out of the 36 who were old enough to be in education were not yet formally registered in school or college—in part due to their arrival shortly before the country went into lockdown in 2019, and also due to waiting lists for schools in Birmingham.

3.2 Reunited in unchosen spaces

Regardless of whether the family came to be living in Birmingham or Glasgow as a result of the sponsor's choice or out of circumstance (due to the fact that the sponsor had been dispersed there on a no-choice basis during the asylum process), none had any significant choice in the area or accommodation in which they were housed. All of the families had accessed housing through the homelessness system which offers little to no choice in the allocation of accommodation. All but two families were living in temporary houses and flats at the time of interview and without exception, all of the families living in Birmingham had initially been housed in emergency accommodation (hostels or hotels) for anywhere between 2 weeks and more prolonged periods of up to 6 months before being moved to their current temporary accommodation. Monitoring data collected by the family reunion support service indicates that

TABLE 1 Interview participants.

ID	Country of origin	Family composition	Gender of sponsor	Interviewees	Time in city—sponsor	Time in city—family	Housing situation and self-assessed suitability	Family pseudonym
B4	Sudan	Two parent family	Man	Sponsor (m) Wife Son (11–14)	6–12 months	0–5 months	Temporary Unsuitable	Family Malek
B5	Sudan	Two parent family	Man	Sponsor (m) Wife	6–12 months	0–5 months	Temporary Unsuitable	Family Biar
B6	Iran (Kurdish)	Two parent family	Man	Sponsor (m) Wife	2–5 years	6–12 months	Temporary Suitable	Family Zandi
B12	Iran	Two parent family	Man	Wife Daughter (15–18)	2–5 years	6–12 months	Temporary Unsuitable	Family Moradi
B14	Eritrea	Two parent family	Man	Sponsor (m) Wife Daughter (11–14)	13–23 months	6–12 months	Temporary Unsuitable	Family Berhane
B15	Sudan	Two parent family	Man	Sponsor (m) Wife	13–23 months	6–12 months	Temporary Suitable	Family Gai
G2	Eritrea	Single parent	Woman	Son (15–18)	2–5 years	6–12 months	Temporary Unsuitable	Family Tesfay
G3	Iran	Two parent family	Man	Sponsor (m) Wife Son (15–18)	13–23 months	6–12 months	Temporary Unsuitable	Family Heydari
G7	Iran	Two parent family	Man	Sponsor (m) Wife Son (11–15)	2–5 years	6–12 months	Permanent Suitable	Family Fikri
G8	Sudan	Two parent family	Man	Sponsor (m) Son (11–14)	6–12 months	6–12 months	Temporary Unsuitable	Family Arok
G9	Palestine	Two parent family	Man	Sponsor (m) Wife	2–5 years	6–12 months	Temporary Suitable	Family Hamdan
G10	Nigeria	Single parent	Woman	Sponsor (f) Daughter (11–14)	2–5 years	0–5 months	Temporary Unsuitable	Family Amaechi
G13	Sudan	Two parent family	Man	Sponsor (m) Wife	2–5 years	6–12 months	Permanent Unsuitable	Family Kuer

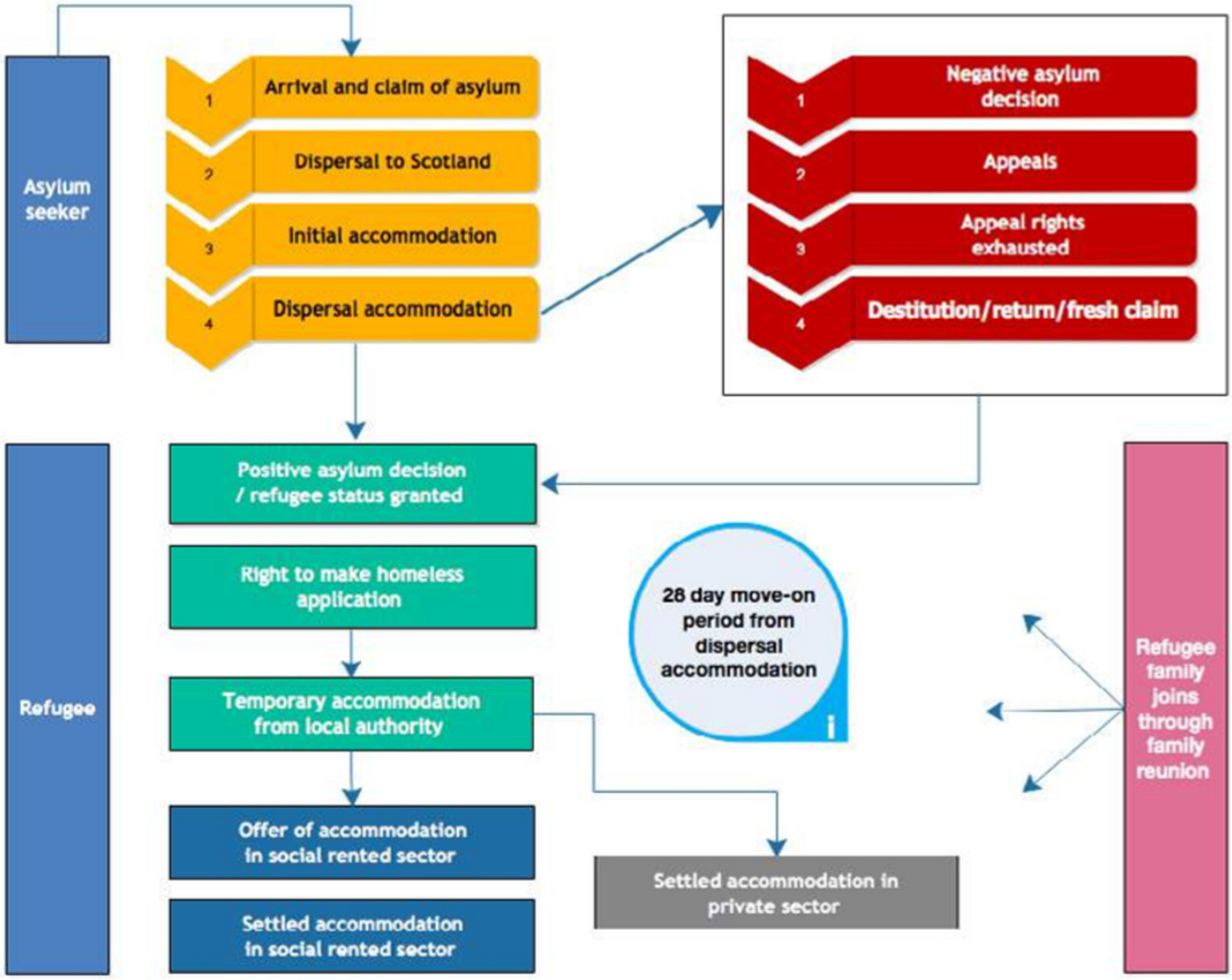
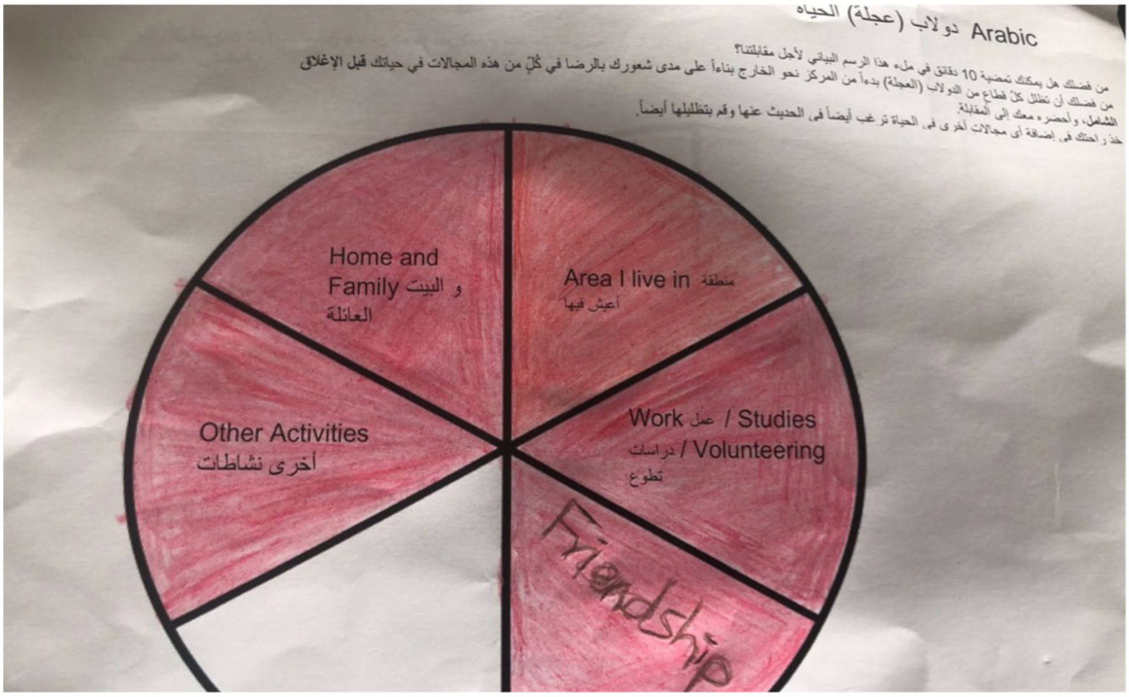


FIGURE 1
The housing process for people claiming asylum in the UK, reproduced with permission from Mcphail (2021, p. 10).

it took people accessing the service in the West Midlands 100 days on average to access temporary housing after initially being placed in emergency accommodation, compared to families in Glasgow who waited 4 days on average. In contrast to Birmingham council, Glasgow city council has a policy of providing temporary accommodation to the sponsor a few days before their family's arrival (British Red Cross, 2022b). Even those who had been in the UK longer and were more familiar with the housing system felt that they had very little or no choice in where they were housed, as in the case of Ms. Amaechi who had moved four times since living in Glasgow and was currently housed in permanent accommodation.

> *"I've got no choice. If I have my way, I don't know, anywhere they give me because we can't dictate, we can't say. Like when I got this house, you can't say no to your house. Whatever they give you, you have to just take it like that, you know."* (Female sponsor, Family Amaechi)

Although in theory, a person on the homeless register can challenge an offer of accommodation on the basis of it being unsuitable, they are encouraged to seek advice before refusing an offer as it puts them at risk of becoming "intentionally homeless", thereby risking their right to homelessness provision (Citizens Advice, 2023; Shelter Scotland, 2023). Mr. Biar chose to check out of the hostel he was housed in in Birmingham just before he met his family from the airport as he was advised the council wouldn't house them until they were in the country. He then presented at Birmingham City Council offices with his wife and four children, and the whole family were housed in another hotel for 15 days before being moved to temporary housing. Mr. Malek was offered the choice to relocate to Birmingham from London after he was granted refugee status, at a time when he was homeless and living with friends. However, he goes on to describe the lack of choice in where he was housed; first in a hotel where he lived for 3 months before his family arrived and then in a hotel room outside Birmingham where the whole family lived altogether in one room



Arabic دولاب (عجلة) الحياه

من فضلك هل يمكنك تمضية 10 دقائق في ملء هذا الرسم البياني لأجل مقابلتنا؟
من فضلك أن تظلل كلّ قطاع من الدولاب (العجلة) بدءاً من المركز نحو الخارج بناءاً على مدى شعورك بالرضا في كُلٍّ من هذه المجالات في حياتك قبل الإغلاق
الشامل، وأحضره معك إلى المقابلة.
خذ راحتك في إضافة أي مجالات أخرى في الحياة ترغب أيضاً في الحديث عنها وقم بتظليلها أيضاً.

FIGURE 2
The Wheel of Life Visual Tool, filled in by one of the families.

for 50 days before being housed in temporary accommodation in Birmingham.

> "*They book for me actually at housing option. It's not my choice, it's their choice, and they book for me one room for all my family […]. We are me and my wife and four children in one room and there is no kitchen, there is no washing machine—nothing like that.*" (Male sponsor, Family Malek)

Mr. Zandi similarly described the challenges of living in poverty and the associated lack of choice and control over housing:

> "*It was so difficult time for me because I did not have any money and they used to help me but when they came they moved us to a hotel. It was a two-bedroom hotel I think but it was really small for us. And what made me scared was that because it was the corona time and in the kitchen all the children used to touch everything, and I was so scared of my kids.*" (Male sponsor, Family Zandi)

Most sponsors were unemployed when their families arrived and reliant on welfare benefits—the expense of funding the family reunion process or supporting their family's move may have also sent some people into debt (British Red Cross, 2022a). Mr. Zandi's experience speaks to the insecurity experienced by refugees living in emergency accommodation and also to the fear associated with living in cramped conditions and using shared facilities during the COVID-19 pandemic. This resonates with the experiences of asylum seekers transferred to hotels during the COVID-19 public health protection measures (Vidal et al., 2021) an experience of rupture to daily life experience by the whole population:

> "*After my family arrived, we feel better, we feel more secure. And, now they're settled, my daughter started school but after lockdown, you know, so everything vanished, as you know.*" (Male sponsor, family Heydari)

In contrast to the circumstances for the majority population, the disruption from COVID-19 came at a time when many of the families had not yet had time to start their lives in earnest, and many arriving spouses and children felt they did not have enough experience of their new locales to comment on them. In the words of Ms. Fikri:

> "*It is difficult, I can't comment like [my husband] because [he] has been here for around four years, I just recently joined and also just after a few months' lockdown, so it's very difficult to comment or to judge.*" (Female spouse, Family Fikri)

Particularly for those families living in Birmingham, where many of their children had not yet been registered in school, much of their experience of life in the UK was characterized by "waiting": waiting for a response from the council about moving to larger accommodation, waiting for school place for their children, waiting for a GP appointment and waiting for a place at college.

> "*I'm just waiting.*" (Male sponsor, Family Zandi)

Despite the challenges of accessing the essentials in this early period of their integration journeys, the families expressed happiness at being safely reunited and, for some, lockdown was experienced as an opportunity to enjoy time together as a family. This happiness was expressed by some on the "wheels of life" where they had fully colored the "home and family section" or colored it in a bright color.

> "*My husband had been away from us for more than two years so to reunite again under the same roof and have a place to live in together as a family, especially my little daughter, she didn't know her father even before we came here. So, to reunite again and live as a family this is very bright, that's why we decided to colour it [the wheel of life] in brightly.*" (Female spouse, Family Kuer)
>
> "*On the "home and family", I coloured this full because I'm so happy to see my mum and my sisters after a very long time. Like, so I get to know them more than before.*" (Female child, Family Amaechi)

Alongside the happiness of being reunited, some families reflected on being separated from extended family back home and, in missing them, expressed the challenges of negotiating transnational belonging in new spaces while simultaneously experiencing the painful process of loss through forced displacement, and the joy of being reunited in a safe place.

> "*I'm really thankful just now but it's that I miss my parents and my sisters as I don't have any brothers, I have only three sisters but it's the fact that I know that I cannot see them, but it really makes me sad thinking about them.*" (Male sponsor, Family Zandi)

The impact on our research participants of loss in their settlement process—of having left behind loved ones in their home countries, and of having endured previous separation from family members—are discussed in more depth in Baillot (2023, this issue). In particular, Baillot discusses the practical and emotional implications of providing care for family members across space and time (in the past, present and future of the pivotal transition point of family reunion) on their opportunities to attach to new people and places. While recognizing the interrelated processes of loss of home and home-making (see for example Bunn et al., 2023), our research questions deliberately focused on participant's experiences of settling in the UK, and not on their experiences of loss and trauma in the process of displacement, unless they indicated a wish to discuss it.

3.3 Inclusive and exclusive spaces

Additionally, and often in spite of the negative experiences of waiting, insecurity and transience, interviewees commonly ultimately judged the character of an area by the people who lived there and the sense of welcome they had felt. This resonates with findings from Spicer (2008) on refugee experiences of places of inclusion and exclusion and on the impact of welcoming people and spaces on feelings of belonging compared to unsafe spaces that negated integration (see also Atfield and O'Toole, 2007; Darling, 2011; Baillot et al., 2020). For example, Mr. Malek had been moved multiple times during the asylum process between Lancaster, London and Liverpool finally ending up being offered to relocate to Birmingham where he was then housed in a hostel for 3 months before his family arrived. He did not feel at all safe in the hostel and describes it *as* "*not a place for families*". Unable to apply for homelessness accommodation city prior to their arrival, Mr. Malek, his wife and their four children had to spend several hours in the council offices on the day they arrived in Birmingham, eventually being sent to emergency accommodation where they shared one hotel room for 50 days, The hotel was in remote location several miles outside of Birmingham, in a town with seemingly little ethnic diversity. And yet, the couple liked the area because of the welcome they felt from the people who lived there.

> "*Nothing is there [...] but the people is very very good.*" (Male sponsor, Family Malek)
>
> "*I didn't see much black [people] there. But you can't imagine that how nice they are ... like you feel all of them know each other.*" (Female spouse, Family Malek)

A smile or gesture of warmth and friendliness was enough for some to feel welcome and accepted. This resonates with Barwick who describes how "friendly recognition" (Barwick, 2017, p. 418) is just one indicator of a "willingness to connect" (Barwick, 2017) on the part of more established residents and an essential factor in progressing the multi-directional and reciprocal process of place-making. It also resonates with respondents in Atfield and O'Toole's (2007) study who identified these small gestures such as greeting people in the street as important indicators of integration.

> "*From the smile I could tell people were friendly and warm, you know.*" (Female spouse, Family Heydari)

Conversely, when people felt a lack of willingness from neighbors to connect or worse: felt unsafe in their local neighborhoods; experienced anti-social behavior or tension from their neighbors; or racist attitudes and behaviors, this precluded them from feeling they could belong in that area. Mr. Fikri felt his neighbors were unwelcoming, saying:

> "*I feel like they [my neighbours] are a little bit conservative so it's not easiest to interact with them or make a kind of friendship or any kind of relationship with them*" and concluding "*it makes me feel like this is not the right place for me.*" (Male sponsor, family Fikri)

Ms Amaechi similarly says of a previous area she lived in that it was not "the right place to be":

> "*The people that lives there, they no, you know, it's not a good experience, the right place to be.*" (Female sponsor, Family Amaechi)

She goes on to compare the previous area to the area she currently lives in, somewhere she describes a lot of antisocial behavior and lack of amenities, but one she wants to stay in because of the people living in her building and nearby, demonstrating not only the importance of how crucial the opportunities to meet people and interact are to processes of place-making, but also how positive spaces of interaction can make all the difference within wider geographic areas that are felt to be unwelcoming.

> *"Wow, they are great people. The area I live is not a good area, but this particular building where I live, they are so good."* (Female spouse, Family Amaechi)

In contrast, the Moradi family were happy with their accommodation, but had not made any local relationships. Much of their experience since arriving in Birmingham was characterized by feelings of isolation, exclusion and "protracted uncertainty" (Horst and Grabska, 2015); neither of the children had been registered in school, the sponsor was unemployed, and they were waiting to be offered alternative, permanent accommodation. The mother and daughter we spoke to both described the area as somewhere where they felt the other residents to be people different from themselves, who they could not connect with.

> *"I love my home, but not the area. [...] There aren't many locals in our area. Mostly Pakistanis and Africans. They are loud, they drink a lot and they loiter a lot. It's not a very pleasant place to be."* (Female child, Family Moradi)

For many, the absence of conflict and threat was enough for them to judge the area to be "good" and somewhere they would like to stay.

> *"You know, before I heard [name of area] this area was trouble, but you know was totally opposite. This is a very, very good area, very happy, it's very quiet and we have got a very good relationship with the neighbour."* (Male sponsor, Family Karimi)

People's personal and familial circumstances were an additional factor in their opportunities to meet others and interact; English language proficiency, health and physical mobility were a big consideration for some interviewees, including Ms. Kuer who liked the area but was in unsuitable accommodation. Her health and mobility issues meant that she could rarely leave her flat, which was high up and only accessible by stairs, serving to enforce a degree of social isolation. Family Berhane wanted to move more centrally in Glasgow to be closer to the Eritrean community as they spoke little English and relied on them for practical support in navigating systems.

> *"See, the people from my community are very supportive. So especially in Birmingham, so if you've got any problems or if you face some issues, so they help you and support you with what to do. So especially because of the lack of the language I have."* (Male sponsor, Family Berhane)

Not enough is known about each families' socio-economic status in their home countries to draw any conclusions about how this impacted on opportunities to build social networks in their new locales, yet there were clear indications that not speaking much English was a clear added barrier to navigating the housing system. For more exploration on how the families in this research project navigated systems see (Baillot et al., 2023).

3.4 Places to meet

The reasons interviewees gave for either feeling like they could belong to an area or were "out of place" were not just based on experience but were also intrinsically tied to the felt opportunities to meet other people and embed themselves in local spaces and in "communities" of people. Closeness to amenities emerged as a factor underpinning how family members felt about the area they lived in. This was in part a practical consideration of being able to easily access essential goods and services such as schools, transport links, healthcare and shops. Under this lay a concern with being able to access spaces for interaction and opportunities for connection. For example, the Heydari family all expressed a wish to live closer to the city center; like many of the young people, the son was concerned with accessing central amenities such as leisure facilities. His mother articulated that it was not just the amenities in and of themselves, but the opportunity they offered to meet people:

> *"Probably, I'm not sure, but maybe just near the centre where there are more facilities, it would give us more opportunity to meet people or to socialise, even if we are somewhere near."* (Female spouse, Family Heydari)

This resonates with Feld (1981) focus theory that suggest the interactions between people are organized by the spaces and activities or "foci" that people structure their daily lives around, such as shops, schools and parks. For adults, the process of local place-making was negotiated through first meeting essential needs by registering with services such as schools, the GP and dentists, and then starting to embed in the area through interacting with people in the local shops and amenities or, in the works of Mr. Arok, "becoming customers":

> *"When I talk about the settlement, that means I got my children to go to school and we registered with the GP, with the dentist., we know about the area. There are important places we needed like the shops, and we started to become customers for some shops."* (Male sponsor, Family Arok)

Typically, young people were preoccupied with spaces where they could interact with other children and young people such as local parks and shared gardens or where they could engage in shared activities such as football clubs. Particularly in lockdown, some children were spending more time interacting with friends in virtual spaces, through video games.

> *"I'm a social person and through this game I'm socialising with the Iranian or maybe non-Iranian friends, so I just feel, you know, I'm socialising through this game."* (Child, Family Karimi)

The gendered interactions of the families in our sample with people and spaces are explored by Baillot (2023, this issue) who discusses how the invisible labor of caring performed by women in the private realm of their homes in some instances restricted opportunities for their interaction in public spaces, compared to their male counterparts. The mosque is one example where men may have had more opportunities to expand their social networks Mr. Arok suggests that the mosque was a particularly important place for him, as a man, to connect with other Sudanese people.

> "*Friday afternoon prayer is one of the most important prayers and it's a must for the man to go to do it in the mosque*" later adding "*this is a main window I used to get in touch with the Sudanese community or Sudanese people.*" (Male sponsor, Family Arok)

Our research highlighted instances of a re-negotiation of gender roles between reunited spouses in the UK, underscoring how gender relations and gendered spaces are also co-constructed differently across time and cultures (Massey, 1994). In addition to the gendered aspects, access to particular relationships and social networks were also different for male sponsors from their later arriving spouses by dint of having spent more time in the country as a single person without the day-to-day responsibilities of family life before their wives and children had joined them. Ms. Zandi reflects that she was not included in some of her husband's friendships and spaces where they interacted "outside" of the home:

> "*Yes, my husband a lot of friends but like most of them they don't have families so they're not just visiting us in our house, so they are just friends outside. They're only like men together.*" (Female spouse, Family Zandi)

Unwanted spaces were not only those that people felt to be unsafe or unwelcoming, but also those that did not offer opportunities to meet and interact with others.

> "*That place was really isolating—nobody to play with, it's only park, no libraries, nothing there.*" (Female spouse, Family Amaechi)

3.5 Navigating place-making through connections

This section turns attention to how families negotiated the process of adaptation to their new environments in Birmingham and Glasgow through friendships they made in the early stages (for arriving spouses and children) and at this transitional stage (for sponsors) of their settlement journeys. It highlights the different narratives family members employed in the process of place-making, according to their priorities and perspectives in making sense of their new lives and negotiating a sense of belonging.

People's aspirations to widen their social networks were dependent on the stage they were at in their personal and family integration journey, their needs and aspirations. Where some were focused primarily on meeting the family's immediate settlement needs and re-establishing bonds between themselves, others aspired to belong to a wider "community". These comfortable "easy" connections played a crucial role for many families in being able to develop deep trusting friendships which tied them both to people and spaces.

However, this "*step-by-step*" process is not a linear trajectory, and those who had been in the country longer spoke to the continued insecurity and ruptures in their housing journey, which in turn disrupted their children's education and the whole family's social networks.

> "*Leaving their school in Manchester, they were so sad and when they got here as well, they getting familiar with people and then we got moved again.*" (Female sponsor, Family Amaechi)

Friendships stood out as pivotal relationships which connected people to cities and neighborhoods and which influenced their desire to stay or leave, underlying the inextricable nature of space, place and social relations (Massey, 2005). The role of more formal relationships with organizations, and care experienced through them is explored in an earlier publication (Käkelä et al., 2023). These informal relationships offer insights into people's identities and the social and physical spaces where they saw opportunities to develop comfortable and trusting connections. Mr. Zandi articulates how familiarity with people and places had, over time, made him feel more embedded in Birmingham, saying:

> "*When I first came in here, I did not know anybody but now because I have lots of friends and I know people who were from Iran as well, so it makes me be more comfortable in here and I got used to the places, like I know how to go out and know the places.*" (Male sponsor, Family Zandi)

From a child's perspective, the son from Family Arok says simply that until he made some friends at school who also spoke Arabic and could help him learn in class:

> "*I felt I'm a bit a stranger because my language is different.*" (Male child, Family Arok)

This speaks to the axes along which people felt they shared similarities with others or the "bonds that tie" (Anthias, 1998, p. 570). Several interviewees strongly identified with people from the same country or who spoke the same language, referring to the comfort and ease of these friendships. Moving closer to the Sudanese communities in Birmingham and Glasgow were key drivers for the male sponsors from Family Biar and Family Arok in their decisions to relocate. Mr. Biar had chosen to return to Birmingham where he had originally claimed asylum before being dispersed to a small town near Newcastle and Mr. Arok had chosen to relocate to Glasgow from Belfast once granted status. Both had moved to the cities before their families arrived. For Mr. Arok, a friendship with someone from his own country was instrumental in his decision to move to Glasgow, again illustrating the relational nature of place-making. He says of the Sudanese friend he had met in Belfast:

> "*And sometimes there is like a chemistry between two people, so they get on well with each other and [name of friend] recommended for him to come to Glasgow. And what Arok noticed, the relationship between them and the communication is*

> *very easy and stuff, so he decided 'I want to be part of this group or this community'. So, he made his mind to come to Glasgow rather than going to Edinburgh.*" (Male sponsor, Arok Family)

Similarly, Mr. Biar had been drawn to move back to Birmingham to be part of the Sudanese network, saying:

> "*The first thing, we have a strong community in Birmingham. The time I have been there, I met a good network and friendship, and I like the city.*" Male sponsor, Family Biar)

It is likely also that both men were also considering the needs of their families in moving to Glasgow and Birmingham, although neither explicitly cited it as the main reason for their move. Mr. Arok in particular had moved to Glasgow just before his family arrived and also cited the "high quality of education" in the city as a factor influencing his decision. In fact, many relationships between families from the same country were facilitated by friendships between their children who played together in shared spaces. The Berhane family met another Eritrean family in the hotel they were initially housed in and became friends, attending the same church together and taking their children to the local park, demonstrating the intersectional aspects of their identities that drew them together: their shared nationalities being one; their shared faith another; and the fact of their shared circumstances living in a hotel with young children in common. Ms Berhane says:

> "*So even our kids, so they were taking them, we were taking them to the park, and they were playing together. And then they have built a strong friendship, even more than us.*" (Female spouse, Family Berhane)

However, not all interviewees were keen to connect with people from the same country or necessarily felt trustful of them as in the case of Mr. Fikri who preferred to spend time with Scottish friends, challenging the often-held assumption that shared origins or ethnicity are the basis for social bonds:

> "*I have friends from all the nationalities, but I feel more comfortable with my Scottish friends more than the people from my country.*" (Male sponsor, Family Fikri)

Axes of difference are as illuminating as commonality in identity formation in new places; the lines along which people perceived others to be "like me" or "not like me". Ms. Heydari had had limited opportunities to meet people before lockdown except through the church a few miles from where the family lived. However, members of the congregation were older than she was, and she couldn't therefore foresee developing friendships with the other women.

> "*So, I had the chance just to meet two or three ladies, they were lovely, we chat, but they were, kind of, not the same age range, they were very much older than me.*" (Female spouse, Family Heydari)

The reasons for those who chose to move to Glasgow or Birmingham are also instructive as to some of the narratives around which characteristics of people and spaces that made the cities attractive to them. Mr. Gai had chosen to move to Birmingham from a small city in the Greater Manchester area after being granted refugee status but prior to his families' arrival in the UK. The reason he gave for his decision was that he wanted to be in a more multicultural city where he felt he and his family would have greater opportunities and be less at risk of encountering racist attitudes and behaviors. In contrast to Mr. Biar and Mr. Arok, Mr. Gai had not explicitly moved to be closer to the Sudanese community and in fact said he hadn't found it as easy to connect with people in Birmingham compared to in Glasgow, where he had been located for a short while before being dispersed to a town outside Manchester, and where he still had a network of friends.

> "*When I was in the small city, [name], no opportunity, I was suffering from the racism, you know? It's a very small village or a city. Unfortunately, there is not many educated people and even they didn't have any clue what is a refugee. So, I don't know, we were just victim of racism. But here I chose Birmingham because it's a big city, multicultural, you know? Just it's like a culturally different people, so that's why I chose Birmingham.*" (Male sponsor, Family Gai)

Finally, Mr. Malek also from Sudan, chose to take the offer to move to Birmingham from London—he had originally arrived in London, then been dispersed to Liverpool and Lancaster before being granted status and returning to London to look for work. He had not identified Birmingham as a place to move to, but rather moved because he had been offered accommodation there. Comparing London to Birmingham, he concluded that the latter was better suited to families saying:

> "*For family I don't think it's good because it's very expensive and not easily to find the accommodation.*" (Male sponsor, Family Malek)

The desire to live in a multicultural area was common to a number of interviewees who felt it offered more acceptance and less threat. Ms. Zandi went further to comment on the freedoms offered in Birmingham, possibly comparing her experience to a lack of freedom she had experienced because of her gender, as a woman living in Iran.

> "*It's not like in my country there are some things that are forbidden, but here you're free to do whatever you want.*" (Female spouse Family Zandi)

Resonating with Mr. Arok's experience and again illustrating the role of friendship in place-making, she adds:

> "*It's a big city and I really love because I made friends, so I used more here, and I am starting to learn the locations and know where they are.*" (Female spouse Family Zandi)

Together, these findings illustrate the different frames of reference through which people negotiated pathways to belonging in Birmingham and Glasgow and the meanings they attached to their interactions with people in spaces. Despite the lack of choice over where to live, these practices of place-making are active and agentive in fostering a sense of belonging. Summing up how it is through meaning-making that people make spaces into "credible" places, Ms. Amaechi says of the area she lives in:

> *"it's only very credible because of the connection I have, that's why, because you need people, you can't live by yourself, you need somebody."* (Female sponsor, Family Amaechi)

4 Discussion

This article has sought to analyse how refugee families negotiate processes of integration in the early stages of being reunited and adapting to their new lives in the cities of Birmingham and Glasgow. Drawing on Massey's progressive concept of space and place (Massey, 1991, 2005), the author argues that the concept of place-making, similar to the concepts of "emplacement" (Schiller and Çaglar, 2013; Wessendorf and Phillimore, 2019) and "homemaking" (Boccagni and Hondagneu-Sotelo, 2023) provides a lens through which to understand how families actively make meaning of their new locales and negotiate transnational belonging through their everyday interactions with people in the spaces available to them. Considering their particular opportunities for interaction and the differential "social conditions, opportunities and exclusions" (Anthias, 1998, p. 564) offered in these spaces, the author demonstrates how the interviewees exercise agency and resilience in the active process of place-making, despite living in unchosen spaces.

Place-making adds to understandings of the relational processes of integration by re-contextualizing the interactions between people with their spatial environments (Lenette et al., 2013), and analyzing the processes by which identities and places are co-constructed through the interactions between people in spaces (Massey, 2005). The identities of the men, women and children interviewed were constituted and reconstituted (Spicer, 2008) in their new locales, according to the axes along which they saw opportunities for interaction and connection with others. Rather than falling back on assumptions that the pathways to belonging were necessarily predicated on shared origins or characteristics, the article has sought to analyse the "routes" rather than "roots" (connections to people through land, ethnicity or "cultural" heritage, see for example (Malkki, 1992) people traced in making sense of their new locales and negotiate a sense of belonging to them.

In tracing the interviewees' own narratives on their routes to place-attachment and belonging, the article has offered insight into how the participants negotiated transnational belonging as a process of recognizing commonalities and diversity (Anthias, 1998) through their friendships. The interviewees did not have choice over where they lived, but they did exercise agency and intentionality in choosing who to connect with in the spaces and places they lived in. Rather than assuming categories of belonging, the author explored how the families exercised choice in the people and spaces they attached to, within the constraints and opportunities of their new locales. Further, in contextualizing the inequalities in access to spaces, places and people, the author recognizes that these practices of place-making constitute an everyday "micropolitics" (Amin, 2002) of belonging. In doing so, the article pays attention to "boundaries of exclusion as well as boundaries constructed through identity and common experience" (Anthias, 1998, p. 569). This paper argues against analyzing the negotiation of identity and belonging through the lens of ethnicity, and for careful attention to the positionality of people in spaces, and their particular frames and contexts within which they negotiate their own pathways to integration at the level of the city and neighborhood.

The bonds that tie (Anthias, 1998) and the spaces in which they negotiated processes of place-making and belonging are forged through intersectional identities and experience, not always necessarily through shared origins. The findings contest the binary conceptualization in social capital of social bonds as exclusionary, and bridges and inclusive (Putnam, 2000) and adds to a growing body of literature which critiques the conflation of social bonds with ethnicity (Anthias, 1998; Barwick, 2017; Demireva, 2019; Baillot et al., 2023). Rather than essentializing people or spaces, the article has sought to critically analyse who people choose to build friendships with, and within which "opportunity structures" (Phillimore, 2021).

It recognizes the politics of place-making in exploring how belonging is negotiated by refugee families within the constraints and opportunities of uneven spaces and unequal relations. Despite the "architecture of exclusion" (Mountz, 2011) woven into the housing allocation process, refugee families negotiate connection, attachment and belonging to the neighborhoods and cities they are housed in but have not chosen, through the people they meet and the relationships they make. In practicing place-making, negotiating and navigating pathways to inclusion and belonging, the families exercise agency in spite of uncertainty, precarity and exclusion. In the words of Horst and Grabska.

> "Coming to terms with uncertainty, then, is often not about calculated risk taking but about coping through hope, waiting, negotiating, and navigating." (Horst and Grabska, 2015, p. 5)

Coming to terms with and navigating in spite of uncertainty is conceptualized as agency, understood as a "temporally embedded process of engagement informed by the past and oriented toward the future and present" (Emirbayer and Mische, 1998 cited in Vidal et al., 2023, p. 14). In paying attention to the day-to-day negotiation of pathways situated in "person-environment interactions" toward belonging the author also highlights the resilience (Lenette et al., 2013) of families in place-making. It draws on Lenette et al. and Vidal et al. in conceptualizing resilience as a "set of behaviors over time that reflect the interactions of people with their environment" (Vidal et al., 2023, p. 15).

5 Conclusion

Recently reunited refugee families are at a very particular transition point in their integration journeys, navigating the challenges of meeting the essential needs of the family, such as accommodation and benefits, education and healthcare. They are also negotiating the longer-term processes of place-making in unfamiliar and unchosen spaces. There is a political imperative to pay attention to the constraints and opportunities of the spaces within which they are housed and the contexts in which they are required to navigate insecure and unsuitable housing arrangements, poverty and disadvantage. There is an equal duty on those with power to recognize the agency and resilience with which the individuals and families practice place-making and progress toward transnational belonging, *in spite of* the multiple moves, ruptures and disruptions in their housing pathways and integration journeys. Further, there is an urgent need for the UK government to extend rather than reduce the move-on period for newly granted refugees and to co-ordinate an approach to housing people seeking asylum and refugees which supports rather than undermines their opportunities to integrate into local communities.

Data availability statement

The datasets in this article are not publicly available due to the potential for identifying vulnerable participants (refugee families). Requests to access the datasets should be directed to lkerr2@qmu.ac.uk.

Ethics statement

The studies involving humans were approved by Queen Margaret University Ethics Committee. The studies were conducted in accordance with the local legislation and institutional requirements. Informed consent for participation in this study was sought from all participants, including for children aged under 18, from their parents/guardians.

Author contributions

LK is the sole author of this paper and agrees to be accountable for the content of the work.

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Conflict of interest

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A long and winding road of referrals: investigating the relationship between healthcare and integration for Nairobi's urban displaced

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This article discusses what integration means in the context of forced displacement, focusing in particular on healthcare access of urban displaced people in Nairobi, Kenya. To do so, it uses a mixed dataset of survey data investigating health and healthcare access for displaced and host respondents in Nairobi's informal settlements Mathare and Kiambiu or Eastleigh South; key informant interviews with healthcare service providers working with displaced people; and finally a case study of a medical pathway taken by a displaced man living in a suburb to Nairobi. His journey demonstrates that documentation, information and language remain challenges specific to the displaced populations, and the importance of utilizing personal support networks, which will not be available to all patients. Notably, this patient's path to treatment brought him to clinics within Nairobi's informal settlements, where healthcare access is often inadequate for its own residents, including both locals and displaced. As such, it shows that where an integrated healthcare system falls short, it can be more beneficial for patients to navigate between the national system and support systems provided for urban refugees.

KEYWORDS
urban displacement, integration, healthcare, informal settlements, Nairobi

Displacement and healthcare in Nairobi's informal settlements

Kenya is home to over 500,000 refugees, out of which 92,778 officially live in the capital Nairobi (UNHCR, 2023). The majority are hosted in one of the two camp complexes: Dadaab and Kakuma. Despite recent legal changes through the Refugee Government of Kenya (2021) and a general policy direction toward "integrated settlements" where resources and services are intended to be shared between refugees and members of host communities, encampment remains the default for refugees in Kenya and under the recently enacted Refugee Act refugees will still be legally required to live in "designated areas[1]" with limited mobility (Owiso, 2022). Some refugees avoid the camps altogether and go straight to Nairobi, where they can apply for a mandate document from UNHCR instead of registering as a refugee in one of the camps. If they do register in a camp, they can only leave by applying for a "movement pass" from the authorities. Refugees can also apply for official permission to remain in the city as an urban refugee, which will allow them to bring their refugee ID and documentation to the city. This type of relocation is only granted for specific reasons, which can include health concerns that cannot be addressed within the camp (NRC and IHRC, 2018; Muindi and Mberu, 2019). Those who travel to Nairobi on a temporary movement pass and remain in the city without urban refugee status live without valid documentation, which makes them vulnerable to arrests and harassment (ibid).

This article focuses on refugees and asylum seekers living in Nairobi, with a particular focus on informal settlements like Mathare and Kiambiu, where many displaced people either live or go to access services. The UN defines informal settlements as "a group of individuals living in a dwelling that lacks one or more of the following conditions—the so-called five deprivations: (1) access to improved water, (2) access to improved sanitation facilities, (3) sufficient living area – not overcrowded, (4) structural quality/durability of dwellings, and (5) security of tenure" (UN-Habitat, 2016, p. 1). In Kenya, some estimates as much as 70 per cent of the population in Nairobi living in informal settlements (Mutisya and Yarime, 2011) and Mathare is home to just over 200,000 people according to the 2019 population census (City Population, n.d.).

During the British colonization of Kenya, Africans were restricted from living in the built-up part of Nairobi, but workers who came from rural areas needed some form of temporary residence in the city, which led to the construction of makeshift shelters on unoccupied land. After independence, many more moved from rural areas into the city to work as restrictions were lifted, which caused the informal settlements to expand rapidly (Wanjiru and Matsubara, 2017). In this sense these settlements were always home to migrants, initially Kenyan rural-urban migrants and today increasingly to cross-border migrants including refugees, who turn to informal settlements because of low-cost housing as well as social connections (IOM, 2013; Muindi and Mberu, 2019). Mathare in particular is home to refugees and migrants from a number of countries, but a significant population of migrants from Uganda has given one of the villages within the settlement where many of them work the nickname Kampala (Wanjiru and Matsubara, 2017). Eastleigh is predominantly home to Somali refugees (Carrier, 2017).

There are a number of health risks associated with living in informal settlements, as well as barriers to accessing healthcare (Arnold et al., 2014; Satterthwaite et al., 2018). A report from 2022 (De Falco, 2022) shows that private health facilities are more common than public ones within Mathare, while the public clinics suffer from understaffing and short opening hours, long waiting times and a lack of medical resources which often means patients have to buy medication from elsewhere. Quality-wise, however, the public clinics were well-regarded by informal settlement residents, but seeking care from inferior and more expensive private clinics was sometimes a necessity because of the much-reduced waiting time. Additionally, lack of public transportation (or inability to afford it) and poor road infrastructure can also limit the healthcare choices available to those living in informal settlement, depending on what is available within walking distance (ibid).

In theory, all refugees and asylum seekers in Kenya should be entitled to public healthcare through the National Health Insurance Fund (NHIF) which grants access to public healthcare facilities, but coverage is known to be patchy (Jemutai et al., 2021). For vulnerable displaced households in both refugee camps and cities UNHCR pays the regular insurance fee on behalf of refugees, but the majority need to cover this cost for themselves. The standard contribution for informal workers is 500 Kenyan shillings (around 5 USD) per month (UNHCR, 2022). In addition to public and private healthcare services, there are non-profit clinics run by NGOs or faith-based organizations, where services are usually provided for free (De Falco, 2022). In refugee camps, such clinics are funded by humanitarian aid and run by large NGOs including for example International Rescue Committee (IRC) and Médecins Sans Frontières (MSF) (Betts et al., 2019). However, resources are often limited within these clinics too, and refugees can be referred to hospitals outside of the camps if they need care that is not available in the camp (NRC and IHRC, 2018).

In Mathare, unaffordability and lack of medication in public clinics are issues that affect migrants and hosts alike, but there are also issues that are specific to migrants and refugees, such as language barriers and documentation requirements (Arnold et al., 2014; Muindi and Mberu, 2019). In this article we present an overview of quantitative data comparing displaced people and hosts living in Mathare and Kiambiu or Eastleigh South, which includes general health and healthcare access. We then present a case study of the process for a displaced patient accessing healthcare through clinics in the informal settlement Mathare, despite living elsewhere in Nairobi, and discuss this in relation to integration.

Data and methodology

This article uses a quantitative dataset with a random sample of 273 displaced people (including refugees, asylum seekers and economic migrants) and 131 Kenyan host respondents living in the informal settlements Mathare and Kiambiu or Eastleigh South. This data was collected in 2021. In addition to covering demographic information, the survey focused on livelihoods and wellbeing, the latter component importantly including both social connections and political representation alongside the usual indicators on physical health and basic needs. This data was collected from informal settlements as a complement to a broader camp-urban comparison[2] between Somali refugees in the camp Dadaab and in Eastleigh North and East, which are built-up urban neighborhoods in Nairobi. In addition to survey data, qualitative key informant interviews relevant to healthcare access have also been included

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[1] See Designated Areas within the Refugee Act (Government of Kenya, 2021).

[2] See project website for more information: www.protracteddisplacement.org.

here. These interviews were conducted in 2021 and included the following stakeholders:

Interview 1	National Council of Churches in Kenya (NCCK)-Jumuia hospital
Interview 2	Médecins Sans Frontières (MSF), Mathare
Interview 3	Mother and Child Hospital (MCH), Eastleigh

The two informal settlements where this data was collected are located on either side of the built-up part of Eastleigh. Mathare is located to the north and runs all the way along Mathare River. To the south is a smaller informal settlement built on what maps term "desert ground" next to Nairobi River, which is known as Kiambiu or Eastleigh South.

Finally, this article includes a case study of a medical pathway taken by a displaced man living in a suburb to Nairobi, which occurred in 2023. This was not a planned case study, but a situation researchers chose to document as and when it occurred, as an example of how an urban displaced person can utilize their networks and connections to access care that others in the same position would not be able to access. Importantly, as an urban displaced person accessing care through NGOs meant that the starting point was a clinic serving Eastleigh and the informal settlement Mathare, which was not where this patient lived. As such, it serves as a showcase of both barriers to healthcare and conditions within informal settlements, and further raises questions around how integration works in practice within such environments.

Understanding integration

The data presented in this article illustrates the health and integration context of Nairobi's informal settlements, complemented by a case study of a displaced person navigating an unusual healthcare journey, as a result of the lack of access through the regular integrated healthcare system. In order to place this into the context of integration, this section introduces relevant literature on the concept. This starts by looking at integration in high-income country contexts, as much refugee integration literature is focused on resettlement, to then turn to the East African context and how integration has been applied and studied there. Finally, it discusses the concept of local integration as a durable solution in refugee hosting states, which includes the role of humanitarian organizations in service provision which is also relevant to the case study we present below.

Europe and resettlement contexts

In high-income countries receiving resettled refugees and asylum seekers, integration is often high on the political agenda even though the concept itself is not necessarily clearly defined (Rytter, 2018). Ager and Strang (2008) have presented a conceptual framework for integration that has gained traction with policymakers (Strang and Quinn, 2019). Among their domains of integration are what they term *markers and means*, which covers access to employment, housing, education and healthcare. Achievements in this area are often cited as key indicators—or markers—of successful integration, for example within the UK Government's Indicators of Integration Framework (2019). However, it is not necessarily clear what the integration endpoint is. Official measures of integration are commonly done by comparing migrant populations against locals or hosts in key areas of markers and means, including education, employment, health and housing. By making local populations the benchmark, the assumption that follows is that migrant populations are integrated when they behave similarly or achieve similar outcomes to their non-migrant neighbors, which can be problematic. Using Rytter (2018), should increasing divorce rates among immigrants in Denmark be seen as positive for integration since they more closely match those of the local community? And are high grades among immigrant children reflective of cultural pressure, or of positive integration? Another question is *when* the comparison becomes arbitrary, and how many decades later migration can or should be treated as the main explanatory factor for any possible differences in statistics.

The focus on *means* in addition to markers or outcomes is intended to emphasize the interconnection between these areas, since an outcome in one area can enable further achievement in another (Home Office, 2019). These are well-known and self-explanatory connections, for example that access to housing can lead to better health, that education opportunities can lead to employment, and so on. An important part of acknowledging these as *means*, however, is that it highlights the role of governments and policymakers in enabling integration outcomes. It is not just up to migrant populations to adapt to their new environments and do what they can to achieve the best outcomes; they also need to be granted access and support to do so. This aligns with common understandings of integration as a two-way process between migrant newcomers and the receiving society, where both adapt to one another (Rytter, 2018). However, while receiving governments are expected to enable migrant populations to integrate, the two-way part of the concept does not appear to include changing on the part of local society as the focus remains on the actions of the migrant population. In this sense, it is worth questioning whether integration is just a government-supported form of its predecessor concept *assimilation*, which expected migrants to virtually blend in with their environments (Rumbaut, 1997).

In addition to the markers and means of integration, Ager and Strang (2008) focus on facilitators of integration, including language skills and cultural knowledge that can "remove barriers" (ibid: 177) to enable integration. Further, they consider citizenship and rights the foundation of integration. While full citizenship is not always an option for migrants, the rights granted to different migrant groups and to what extent they differ from those granted to citizens will of course have a huge influence on what migrants can achieve. Baldi and Goodman (2015) note that migrant rights are often conditioned on certain behaviors, through what they call *membership conditionality structures*. This can include for example compulsory language or culture training. In this way, states take an active role in "turning outsiders into insiders" (Baldi and Goodman, 2015, p. 1152). This can also vary for different migrant groups. In the UK for example, asylum seekers are actively excluded from integration processes and measures while their claims are processed, which often takes many years (Ager and Strang, 2008).

Finally, Ager and Strang's framework considers social connection, which they view as the "connective tissue" between the foundation of rights on the one hand and the integration outcomes on the other (Ager and Strang, 2008, p. 177). While policy makers and politicians often focus on outcomes (and, to some extent, rights and requirements), the social connections are perhaps the most important domain for migrants themselves. Social connections are important in determining to what extent migrants *feel* integrated and have a sense of belonging in the communities where they live. Building on Putnam's social capital theory, this domain covers social bonds, which connect individuals with a social group that they identify with; social bridges, which connect different social groups with each other; and social links, which connect individuals with state functions or services (Strang and Quinn, 2019). While the divide between bonds and bridges has been criticized as arbitrary and potentially restrictive in their definition social groups based on nationality and ethnicity, the third category of social links is an important arena for the two-way direction of integration, as individual refugees and migrants often struggle to build links to public services without support and outreach form the host society (Baillot et al., 2023).

This theoretical framework provides important insights into the integration concept and how it is commonly understood and applied. Firstly, it clarifies that from the migrants' own point of view, *appearing integrated* through behaviors and outcomes that are understood to be markers of integration does not necessarily equate to *feeling* integrated in the community. The latter is attributed to social connections that can also enable integration outcomes, and it is important to acknowledge that there is a separation between the two. Secondly, this framework highlights the role of governments and policymakers in enabling and supporting integration, both by ensuring the rights of migrant populations and providing services to them. While there may not always be political will to do so, it clearly paints a picture of the importance of removing barriers and helping newly arrived populations settle, which is an important contrast to the context of local integration to be discussed below. Finally, and most importantly, this literature underscores that integration is always measured and understood using the host population's attributes and behaviors as a baseline. This makes citizenship the only real endpoint for integration, as it is unclear *when* regular variations within a population would otherwise cease to be attributed to migration.

If integration in practice means displaced populations need to adapt to their surroundings, the environment itself will make a crucial difference. In the context of an informal settlement, where local populations already struggle with adequate service provision from the state, this raises the question whether being equal to the locals' state of deprivation is the best displaced people can hope for, or if there is a scenario of "reverse integration" where any additional support (discussed below) provided for displaced people can also benefit locals and offer improvements for everyone.

Local integration as a durable solution

In the context of resettled refugees, governments within the receiving countries are usually invested in providing support for social links as well as achieving integration outcomes and removing barriers. However, only 1 per cent of the world's refugees are resettled to high-income countries every year, and the majority live in low and middle-income countries within the same region (UNHCR, 2023). For these refugees, integration is not encouraged but actively prevented by authorities who want to avoid a situation where displaced populations remain permanently (Long, 2014). Many host countries opt to keep refugees confined in camps, separated from local populations and supported predominantly by humanitarian organizations and international funds (Slaughter and Crisp, 2009). Camps have well-known negative impacts on both individuals and their ability to support themselves (Crisp, 2003), and most refugees[3] today choose to live in cities. However, relocating to an urban area often equates to relinquishing access to humanitarian support provided in the camps, such as food and shelter. When it comes to covering basic needs and finding work, urban refugees are then forced to de-facto integrate with host communities in the cities where they live (Hovil, 2007).

When it comes to service provision, most countries (including Kenya) recognize the rights of displaced people to healthcare and (primary) education, but the way in which these are provided vary between states, depending on the extent to which host governments allow displaced populations to make use of national systems. If displaced people are not systemically integrated into existing systems providing education and healthcare (Bellino and Dryden-Peterson, 2018), international organizations can, to varying degrees, take on state functions that are not provided, which then creates a parallel system or "surrogate state" (Miller, 2017). While this form of state surrogacy is more common within refugee camps, it can happen in urban areas too where NGOs are present and have identified gaps in state-supported service provision. With a growing recognition of displaced populations living in urban areas from UNHCR, there has also been an expansion of non-governmental support for them (UNHCR, 2009, 2014).

Refugee support in protracted situations and urban contexts is often underpinned by a theory of changed that researchers at the Humanitarian Policy Group have termed "partial integration" (Crawford et al., 2015). This type of support recognizes that displacement will likely continue beyond the initial emergency support phase, but still works on the assumption that displaced populations will eventually return home. As such, it aims to include refugees within local systems and economies as far as possible, rather than duplicating services (Crawford et al., 2015, p. 20–22). Within Miller's model of state surrogacy, a partial integration support model could fall somewhere in the middle of the spectrum from abdication, where states resign all responsibility for the displaced population to international organizations, to partnerships where the organizations instead work together with states to provide services (Miller, 2017, p. 30-31). In the case of

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[3] While numbers are difficult to confirm, see UNHCR's Global Trend Reports for estimates.

healthcare provisions for urban refugees in Nairobi, as outlined above, UNHCR supporting refugees by paying their contributions to the National Health Insurance Fund (NHIF) would be an example of partnerships, while an NGO setting up and running a community health clinic would be an example of abdication.

Importantly, the partial integration model can still be temporary and dependent on external funding, while the support model termed de-facto integration accepts local integration (or onward or circular migration) as a durable solution. This type of support falls very clearly in the space of partnerships, as it builds on long-term inclusion of displaced populations in for example urban planning and local development strategies (Crawford et al., 2015, p. 22–24). In Kenya, the recent legal changes (see above) and accompanying county development plans that now do include refugees are a step in this direction, but in the case of Garissa and Turkana this is still limited to designated areas or camps (UNHCR Kenya, 2022).

Measuring de-facto and supported integration

Where integration in resettlement contexts is often to some extent supported by government actors, and formal local integration in countries of first asylum often resisted, there is another form of integration falling somewhere in between. As urban displaced populations are increasingly recognized by humanitarian and development actors, as well as by local authorities, attempts have been made to understand de-facto integration. In previous decades, when encampment was the preferred option for refugee support in countries of first asylum, refugees who chose to live in cities would in most contexts have to resign themselves from humanitarian support access, thereby creating their own integration under the radar (Harrell-Bond, 1986). Since 2009 UNHCR has an urban refugee policy and a model for supported integration. While not going as far as local integration, which to be considered a durable solution would include citizenship or permanent residency, de-facto integration may still be enabled by local authorities or certain forms of support for urban displaced populations.

Crisp (2004) describes local integration as "a process with three interrelated dimensions": the legal dimension, the economic dimension, and the social dimension (Crisp, 2004, p. 1). Attempts have been made to quantify, measure, and understand de-facto integration, where the legal dimension is reduced or altogether missing. Building on the theoretical framework from Ager and Strang (2008) presented above, Beversluis et al. (2017) have presented a tool called the Refugee Integration Scale (RIS) which was developed and tested in Nairobi. It was created from six integration- related themes (Beversluis et al., 2017, p. 112–117) gathered from qualitative interviews and focus group data: challenges of urban poverty; documentation and legal status; culture and community trust; livelihoods and education; personal and community security; and, finally, hope and control. The resulting scale measuring integration is made up of 25 statements, positive or negative, which are then calibrated into an integration score.

The most relevant of these statements is RIS 22: "I am permitted to access healthcare services for me and my family just as easily as our Kenyan neighbors" (Beversluis et al., 2017, p. 122). The corresponding thematic area (challenges of urban poverty) highlights issues with healthcare access, alongside other basic needs and services, are often shared between urban refugees and locals. Refugees may, however, be affected by additional barriers, caused by restrictions or even misconceptions that they as urban refugees have access to the same level of humanitarian support that is available in refugee camps.

This captures an issue also touched upon by Jacobsen and Nichols (2011) in their report on profiling urban displaced populations to support their needs:

> In low-income areas, where most refugees tend to live, it is important to determine whether and in what ways refugees are worse off than their neighbors, the local host population. In countries of first asylum, the urban poor face significant health, crime and poverty problems. Humanitarian programs can be seen as discriminatory when they target refugees whose neighbors may be equally badly off. Agencies need to justify—to host governments, to local people, and to donors—why they use resources to support one group and not others. If agencies can demonstrate that the target group is more vulnerable, or has special needs not faced by the larger population, targeting of resources can be more easily justified (Jacobsen and Nichols, 2011, p. 8).

Much like it is in resettlement and asylum contexts of the global north, integration in this context is measured in relation to the local population, which places a clear limitation on the extent to which de-facto integration can be supported, particularly by humanitarian and development actors focusing specifically on the displaced. Unless conditions are improved for locals too, there will always be a ceiling. Indeed, a displaced person who can access healthcare "as easily as their Kenyan neighbors" will not be particularly helped by that integration if the Kenyan neighbor also suffers from a lack of healthcare access and quality.

In this article, we focus on Nairobi's informal settlements as an example of a location where such a ceiling will exist. First, we examine demographic data of urban displaced people alongside hosts, in relation to their healthcare access, demonstrating small but noticeable disadvantages for the displaced. We then present a case study of a healthcare pathway taken by a displaced person in Nairobi, which took the route through the healthcare system in the informal settlement Mathare even though the person in question was not residing there. Together, this shows what healthcare integration in Nairobi's informal settlements can look like in practice, and how urban displaced people can use their personal networks to navigate the limitations of de-facto integration.

Empirical findings from Nairobi's informal settlements

This section uses the quantitative survey data collected in 2021 as a part of the research project Protracted Displacement in an Urban World. It aims to expand our understandings of healthcare access and issues within the informal settlements Mathare and Kiambiu or Eastleigh South, particularly for displaced populations. The data introduces indicators on healthcare access and explores the relationship between health and integration for displaced people.

Demographics

Our sub-sample[4] consists of 273 displaced (136 women and 137 men) and 132 hosts (72 women and 60 men). Displaced respondents came from five countries—Uganda, Tanzania, Somalia, DRC, and Rwanda—with the majority (68%) being displaced from Uganda. Only around 52% of displaced respondents identified as refugees, while the rest described themselves as economic migrants or asylum seekers.

Aside from nationality and migration status, displaced respondents shared many characteristics with host respondents. Displaced respondents were 34 years old on average, had a household size of 3.4 and 28% of these households were headed by women. These characteristics were very similar for hosts, who had an average age of 36 years, a household size of 3.8 and 28% of households headed by women. Marital status was similar between hosts and displaced. Just over half of the respondents were married, and around 30% were single.

There were more apparent differences between displaced and host respondents in income (see Figure 1). Both displaced and host respondents earned higher incomes in southern Eastleigh with 215 USD and 279 USD respectively. In Mathare the average monthly income was much lower, at 92 USD for displaced and 107 for host respondents.

Education levels were higher among hosts, 98% of whom can read and write compared to 82% of refugee respondents. Figure 2 below shows the differences in education levels between hosts and displaced samples. Overall, the populations were similar, but the host population had slightly higher proportion of people who had completed secondary or tertiary education. Within the displaced population the majority (55%) had primary education only, 31% had secondary education and 4% tertiary education.

Demographically, our sample populations of displaced and hosts in Nairobi's informal settlements share many attributes. There are, however, notable differences in literacy, education and income.

Health and healthcare access

Examining the perceived quality of healthcare in Mathare and southern Eastleigh, we find that hosts generally rated their own health slightly better than displaced respondents. However, both displaced and host respondents reported similar results regarding healthcare quality and availability. Around 89% of both samples indicated that healthcare services were available to them.

To put these findings into a wider context, we compared the responses of displaced and host respondents in the informal settlements with our displaced respondents in Dadaab camp and displaced and host respondents in the built-up part of Eastleigh in Nairobi. Optimal health outcomes (categorized as good and very good) were most frequently reported among the hosts (83%) in built-up Eastleigh, followed by urban displaced respondents in built-up Eastleigh (80%), displaced in the camp (77%), hosts residing in informal settlements (70%) and, finally, displaced respondents in informal settlement (66%). These results are indicative of the additional challenges displaced and host residents face in informal settlements.

When asked about healthcare access (see Figure 3 above) hosts in built-up Eastleigh had a near perfect score with 98.7% stating they did have access to healthcare, while the rate in the informal settlement was 89.4%. Contrary to the built-up urban area where hosts were slightly ahead, healthcare access in the informal settlement was the same for host and displaced respondents, with a slightly higher number of hosts (10.6%) stating they did not have access to healthcare, compared to 8.8% of displaced respondents. 1.8% of displaced respondents stated that they did not know, which was a response shared by displaced populations across all locations but not expressed by any hosts.

As public healthcare access is connected to the National Health Insurance Fund (NHIF) we have investigated access to social protection an additional factor. Disparities between hosts and displaced respondents emerge here, where 29% of hosts in informal settlements stated that they had access to social protection, compared to only 7% of displaced respondents. This could indicate that people rely on non-profit clinics more than the public healthcare system.

This section examined different health indicators, such as the general state of health and access to health care, highlighting better outcomes for both hosts and displaced respondents living in the built-up parts of Eastleigh. This underscores additional challenges faced by both displaced and hosts in informal settlements. Disparities between hosts and displaced is particularly evident within social protection access, which could indicate further differences in access to public health insurance that are not reflected in the healthcare access findings, likely because of non-profit clinics.

Integrated vs external healthcare in Nairobi

In addition to the quantitative data on the population in informal settlements Mathare and Kiambiu or Eastleigh South presented above, this section provides qualitative key informant interview data on healthcare access for the displaced population in Nairobi, and a case study of a displaced person navigating care access.

In line with the survey findings showing little difference in healthcare access between displaced and host respondents in informal settlements, interview data shows that the displaced urban population in Nairobi appears to be able to access healthcare in an integrated manner regardless of any perceived temporality of their displacement to Nairobi or Kenya, which includes healthcare facilities located in informal settlements. For example, the Maternal Health Clinic in Eastleigh supports

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[4] The original sample in Kenya consists of interviews with 382 displaced individuals in the Dadaab camp, 399 displaced in Nairobi and 156 hosts.

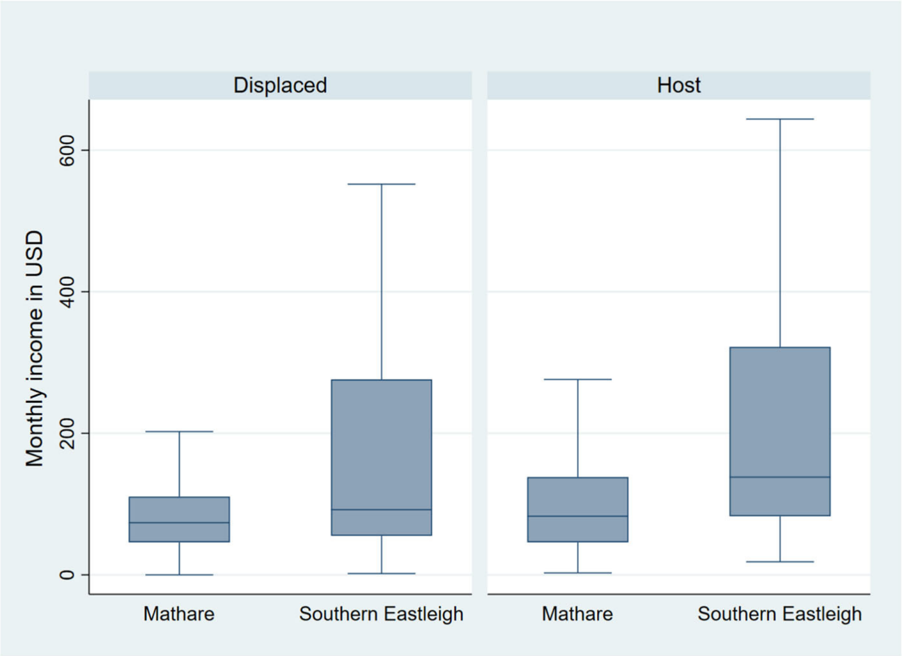

FIGURE 1
Monthly income in informal settlements.

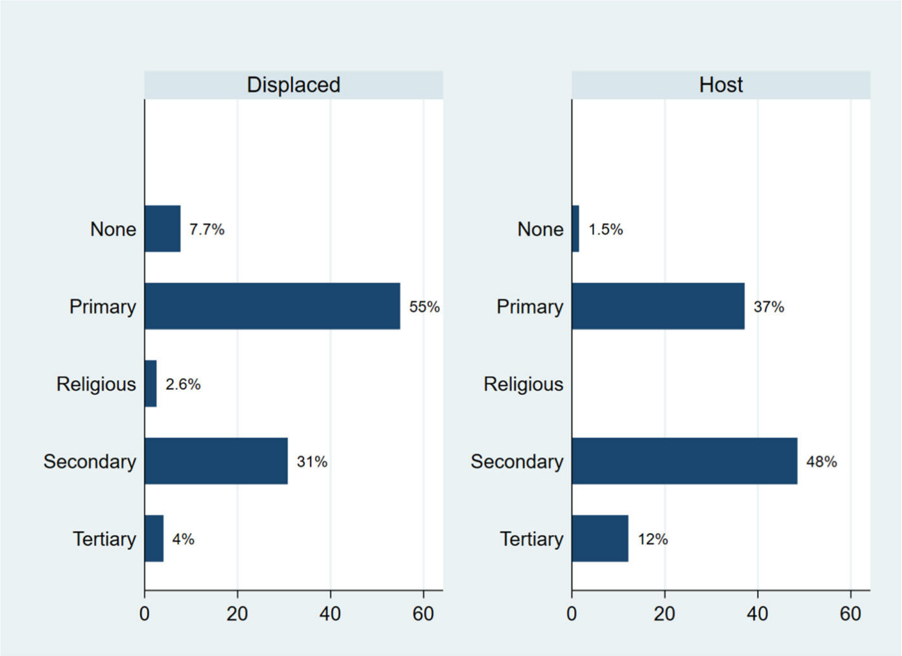

FIGURE 2
Education levels in informal settlements.

expecting families even if they are "transiting" from having prior antenatal care carried out at a different hospital and potentially also expected to also give birth somewhere else. A key informant (Interview 3) emphasized the importance of offering mothers a complete immunization profile regardless of whether the patient is expected to stay or not. In this respect, local service providers can in practice opt for supporting de-facto over partial integration despite the perception of displacement—and integration in Kenya—as temporary (Crawford et al., 2015).

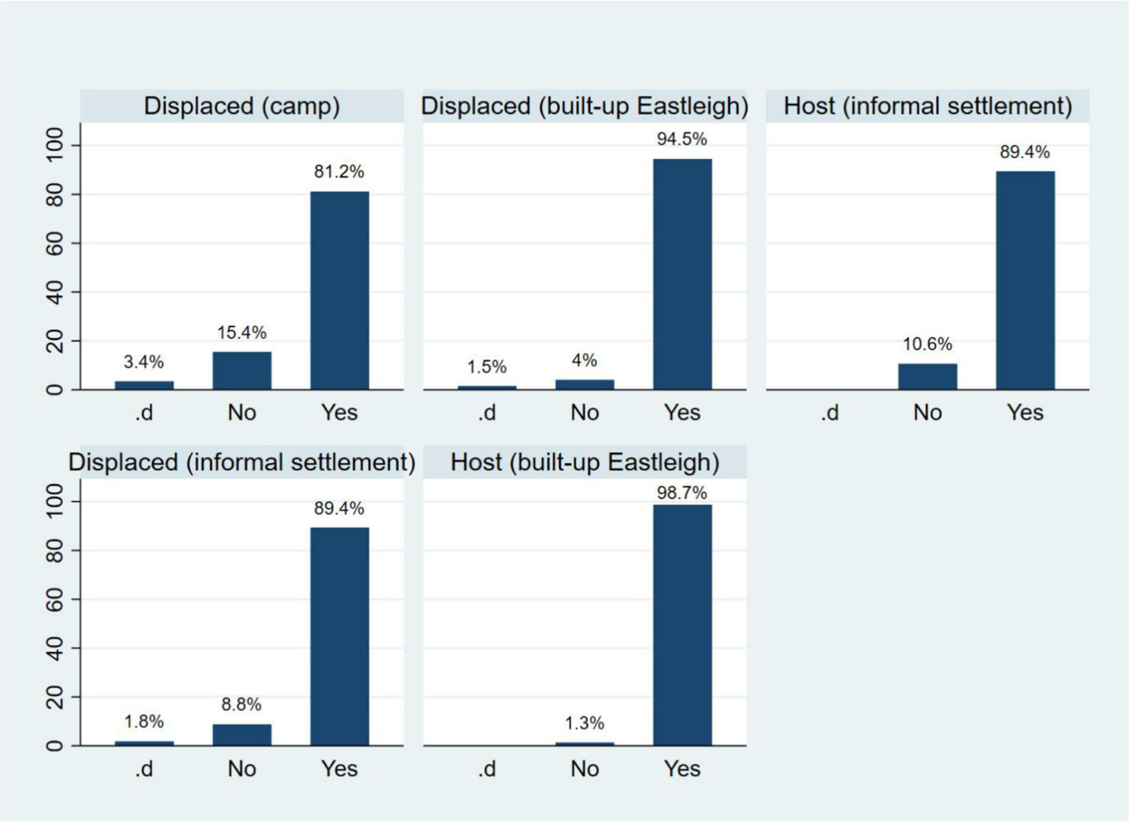

FIGURE 3
Access to health care in Kenya.

However, this type of integration is dependent on resources, which are supplied by the government but not always sufficient for all urban residents, including both hosts and displaced. In such cases, international organizations can step in, but there are examples of where humanitarian systems—or, in this case, funding—that aim to work in partnership to support integration end up causing friction between displaced and local populations in Mathare and southern Eastleigh. The key informant (Interview 3) described a situation where drugs were provided to both displaced and host populations, but when the medication ran out for the host population first, there was a perception that the displaced population was receiving preferential treatment. There were also examples of the displaced population being provided with different types of medication subsidized by funding from UNHCR, which was worth more than what the government-funded medication host population was given. This resulted in disharmony between hosts and refugees and a resolution within this clinic to have the same medication accessible to all regardless of the funding agency. The key informant said: "imagine someone is a refugee in your own country and he or she is living a better life than you" (Interview 3).

This sentiment expressed by a service provider within an integrated healthcare system demonstrates that this type of integration can in practice offer limitations for displaced populations in terms of direct service access. In the context of local or de-facto integration, this means that integration outcomes and enablers (or markers and means) (Ager and Strang, 2008) are not necessarily always enabled by an integrated healthcare system. In this case, support from the external system would likely have provided a better health outcome (i.e., higher quality medication) for the displaced individuals, but the primary consideration should be enabling access to all populations without preferential treatment of one population over another.

The case study below continues to provide a nuanced example of what the interactions between these two systems can look like for a displaced person in need of healthcare in Nairobi.

Case study: navigating referral pathways

This case study describes the complicated patient journey for a displaced man living in the outskirts of Nairobi. He was registered with a private clinic in his area of residence but needed advanced treatment for a condition that had gone untreated for a long time during his displacement, caused him a lot of pain and prevented him from working. He did not have information about how to access treatments offered outside of his home clinic, and they were not offering support with the referrals he needed. Left with no information about where to access care, he turned to his network for support and reached NGOs providing healthcare for

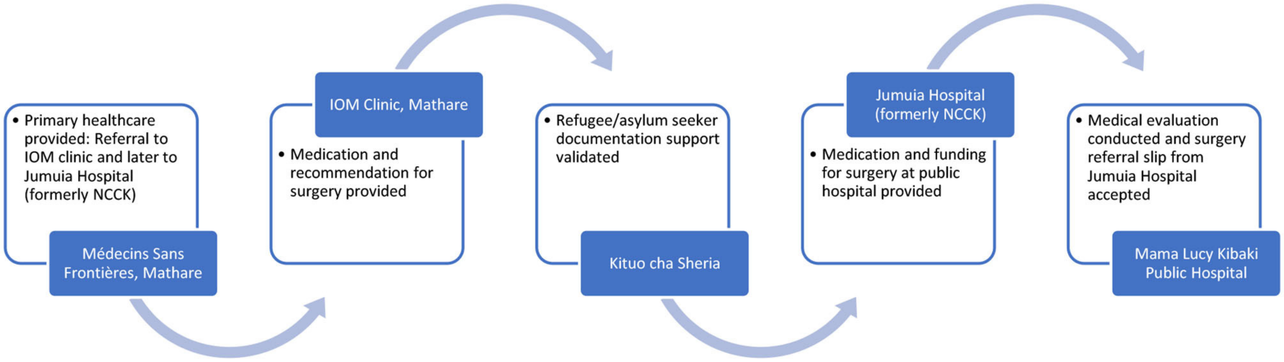

FIGURE 4
Diagram of the patient's healthcare journey: January-July 2023.

displaced people in Nairobi. Thus the long referral journey (see Figure 4) ensued.

In the first step of the process Médecins Sans Frontières (MSF), which serves both Eastleigh and the informal settlement Mathare offered an assessment of the patient's medical condition and provided free primary healthcare, which is within its organizational mandate for support for the urban population. MSF is focused on emergency care and does not require refugee or asylum seeker documentation in order to provide healthcare, since efficiency is a prime consideration. However, since this patient had been living with the condition for some time, it could not be categorized as an emergency case and MSF could therefore not support him any further. As a result, the patient needed a referral to a suitable medical facility. MSF referred him to an International Organization for Migration (IOM) clinic in Eastleigh, for further treatment.

At the IOM clinic, the patient was further assisted with medication for pain relief and recommended advanced treatment in the form of surgery, given the severity of his medical condition. No documentation was required at this stage either, but the IOM clinic was not equipped to provide the surgery and the patient was referred to Jumuia hospital (at the NCCK clinic) in Huruma. At this stage he required refugee or asylum seeker documentation, as one of Jumuia hospital's mandates is to provide services to registered urban refugees. The hospital is partially funded by the United Nations High Commissioner for Refugees (UNHCR) to implement its urban refugee assistance programme. At this stage, MSF got involved again to obtain a contact at Jumuia hospital for medical referral.

Simultaneously involved, was Kituo cha Sheria, a legal advice center. A paralegal officer and refugee community leader residing in the same locality and in similar refugee networks as the patient assisted in drafting a letter of support for the patient, which ensured that he had the required urban refugee status and documentation. Once the patient acquired the necessary documentary proof with the help of the organization, he was able to seek free medical drugs and assistance at Jumuia hospital and a full funding commitment for his surgery, which was not covered by NHIF. To this end, his final referral by Jumuia was to Mama Lucy Kibaki public hospital in Nairobi for surgery.

As demonstrated by this journey, medical access in Nairobi and is based on referrals depending on the severity of illness. Healthcare facilities are at six levels in Kenya, with the first five managed at a county level and the sixth level managed by the national government. The system entails moving patients from one level to the next using referral letters. Public hospitals are usually the main referral option for other service providers within the referral pathway. This was highlighted by the key informant from MSF who said: "[W]e usually transfer these patients to government facilities, because one, we are looking at quality services and also affordability" (Interview 2). Similarly, the key informant from NCCK stated: "We have partnered with various hospitals, for example Kenyatta National Hospital, Mama Lucy, Mbagathi, German Medical Center, Kijabe, Kikuyu. So what do we do, we just refer our clients there, because we have an MOU with them" (Interview 1). These statements have also been supported by interviews conducted within other projects the authors work on in Nairobi, where refugees have shared experiences of being referred from NGOs to public service providers.

However, this journey also exemplifies a referral pathway that involves various stakeholders outside of the public healthcare system that urban displaced people are supposed to be integrated into. For a displaced patient, required paperwork is one example of a potential roadblock, as well as lack of information around access and rights among healthcare providers, as was the case at the patient's home clinic. In this case, the journey through referrals toward the required surgery was long and winding, involving public and private (non-profit) parts of the healthcare system, as well as non-medical practitioners. Importantly in relation to integration, it required the patient to utilize his own networks, which are not available to all displaced patients. Secondly, going through non-profit providers aimed at urban refugees took this patient to clinics in the informal settlements, despite living in a much wealthier part of the city and having access to private care.

While the National Health Insurance Fund (NHIF) is available to Nairobi's urban displaced, refugees and asylum seekers without documentation are unable to access medical services through these facilities and are instead required to pay for any care provided with cash. This undermines effective and efficient access as the challenge with insurance policies is the claim procedure normally after service provision. Without patient documentation therefore, medical institutions are unable to later on claim from the respective health fund. Refugee or asylum seeker documentation is therefore a key challenge.

A key informant (Interview 3) stated that there is a lack of clear guidelines from the government around how to serve refugees and asylum seekers, both with and without documentation. The way it is, they struggle to provide care efficiently, simply "because this is not a Kenyan" and it is difficult for them to know for example whether they can file patients within their systems, and how to effectively follow up with them. Even in institutions like MSF that do not require documentation from displaced patients to serve them still face challenges in cases that require referrals, which limits their ability to fully support patients.

Medical practitioners within clinics based in Mathare and Eastleigh also highlighted the need for full-time language interpreters and or translators to assist them in service delivery to displaced persons, for example in form of recruiting community health promoters with diverse language skills to aid the referral process between various medical institutions. Currently, the system is dependent on community volunteers and individual service providers with the right knowledge, which means displaced patients can be left hanging in case of staff turnover or even temporary holidays. The key informant described how colleagues might "give up along the way due to the lengthy process involved" (Interview 3) in for example referring a patient for immunization to MCH, which would require a referral from NCCK. At the moment, there is no service provider that offers help for displaced people to navigate the entire system and overcome barriers caused by language and documentation needs.

Conclusions

This article has discussed what integration means in the context of forced displacement. De-facto and partial integration models in particular, which are in reality the only options available in many countries (Jacobsen, 2001; Long, 2014), present problems with rights and documentation in order to access services. Further, in any context integration appears limited to reaching the same level of service access as local neighbors, which in the context of an informal settlement is extremely problematic.

Our case study has demonstrated that even with integrated care on paper, when push comes to shove and care is urgently needed, access for urban displaced people is not easy. In this case it required a range of actors to invest their time and engagement on behalf of a single case, which in the long run is not a sustainable system. Further, it is interesting to note that our patient was referred to care providers in Eastleigh and Mathare, the latter being an informal settlement where locals struggle the most with healthcare access. While documentation, information and language remain challenges specific to the displaced populations, it is worth asking whether a local living in the informal settlements, without networks of international organizations working on their behalf, would have been able to access the same care through the same clinics.

Medical sociology literature defines *patient work* as "patients' participation in their own care" (Strauss et al., 1982, p. 978). It seems, in this case, that the patient could work his way *between* the national healthcare system and the non-profit healthcare system provided for the urban displaced. While an extremely complicated referral process, it is entirely possible that these two systems together grant patients better outcomes than the public healthcare system alone.

Data availability statement

The data analyzed in this study is subject to the following licenses/restrictions: at the end of the project datasets will be made available to researchers via the UK's Reshare Data Archive. Requests to access these datasets should be directed to Lucy Earle (Principal Investigator) lucy.earle@iied.org.

Ethics statement

The studies involving humans were approved by Ethics Committee within the Research Strategy Team, International Institute for Environment and Development (IIED). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

BM: Conceptualization, Writing–original draft, Writing–review & editing, Methodology. SAH: Methodology, Visualization, Writing–original draft. JW: Data curation, Investigation, Methodology, Writing–original draft.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Mental healthcare among displaced Congolese: policy and stakeholders' analysis

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The Democratic Republic of Congo (DRC) has been the subject of several armed conflicts for more than two decades, causing the displacement of millions of Congolese in and outside the country and impacting on their mental health and wellbeing. Mental healthcare interventions are a vital component for the displaced to holistically integrate into their new communities. This policy brief draws from a systematic review of various laws and policies as well as stakeholders' analysis to address the mental health issues of internally displaced persons (IDPs) in the DRC. In addition, we examine data from 32 interviews with various stakeholders at the national level and in 4 provinces of the DRC (Kasai Central, Tanganyika, South Kivu and Ituri). The findings show that while the DRC has committed to progressive policies and conventions the implementation of these policies and conventions, however, remains insufficient. There are also limited local and international stakeholders that provide forms of psychosocial support to IDPs and, effectively address mental health challenges in context. In addition, the provision of such care is limited by the scarcity of specialized and skilled staffs. These findings point to the need to strengthen mental health system governance. This should include scaling up of the integration of mental healthcare at the operational level, the training of community health workers in the screening of mental health issues and the sensitization of the IDPs and the host population to help them change their perception of mental ill-health.

KEYWORDS

internally displaced populations, mental health, DR Congo, migration, policy

1 Introduction

This policy brief brings together an examination of existing legislation that addresses health, mental health and internally displaced persons (IDPs) with findings from interviews with stakeholders working within the context of mental health.

In what follows we start by providing an overview to the background and context of the Democratic Republic of Congo (DRC) with a focus on the impact of sustained armed conflict on the mental health of IDPs. In doing so we also review the current policies and interventions in place to address mental health challenges. From the key findings we provide recommendations that are intended to guide stakeholders -government, United Nations (UN) agencies, local and international non-governmental organizations (NGOs)- to take necessary and tailored actions in order to strengthen their responses to mental health support and alleviate mental health issues among IDPs.

1.1 The DRC context and population displacement

The DRC is the second largest country in Africa with an area of 2 345 408 km^2. The DRC shares its borders with nine neighboring countries. Movement across the borders by choice (for work, education, family etc.) and forced due to the protracted violence and armed conflict that has crippled the country for more than 30 years is both regular and frequent. The fact that many people cross informally taking advantage of the largely porous borders reflects the mobility, relationships and connections across the region. However, it also means that the activities of armed groups and of the illicit movement of natural resources and goods are frequent (Schlindwein, 2020).

The decades of conflicts across the DRC have been fuelled by geopolitical and economical tensions with neighboring countries, primarily Rwanda and Uganda. The activism of armed elements and military operations have caused massive displacement of populations outside of the country (refugees) as well as within the country (internally displaced persons or IDPs). As shown in Figure 1, from 2010 to 2022, the number of IDPs have increased 8.8 times (from 498,230 in 2010 to 4,427,374 in 2022). This increase is explained by the escalation of armed conflicts in the east of the country with the M23 rebellion in North Kivu as well as the attacks by the Islamist group ADF-NALU from neighboring Uganda. Overall, in June 2023, the number of IDPs in the DRC has been estimated to be over 6 million; among the highest figures in the world (IDMC, 2023; UNHCR, 2023b). Most displacements were recorded in the eastern provinces of North Kivu (2,334,813), South Kivu (1,530,631) and Ituri (1,754,650). The inter-ethnic conflict between the Bantu and the Twa ethnic groups in Tanganyika have also caused the displacement of 350,958 IDPs. Nearly 20,000 IDPs remain in the Kasai region and other provinces near Kinshasa (UNHCR, 2023a).

1.2 IDPs and mental illness risk

Research shows that the rate of mental health conditions in conflict zones is more than double that of the general population (Charlson et al., 2019). Evidence also suggests that the negative impacts of conflict on mental health can be passed down through generations (Yehuda and Lehrner, 2018) and with psychological, familial, social, cultural and neurobiological transgenerational effects (Sangalang and Vang, 2017; Bezo and Maggi, 2018).[1] There are many possible reasons for why IDPs are at higher risk of developing mental health disorders. Mental illnesses among IDPs can result from multiple, often intersecting factors including direct exposure to the violence and destruction of war like (e.g., physical assault, the destruction of one's home, the disappearance or death of loved ones) and the stressful social and material conditions such as poverty, malnutrition, the destruction of social network or unemployment (Miller and Rasmussen, 2010; Rofo et al., 2023). Post-Traumatic Stress Disorder (PTSD), depression and anxiety disorder are recorded as highly prevalent after displacement and armed conflicts (Carpiniello, 2023). However, it is important to note that the definition as well of use of the diagnosis of PTSD are contested and therefore data reporting high prevalence requires a cautious interpretation (Tay, 2022). Originating from the West and the identification of traumatic symptoms amongst soldiers returning from the First World War, PTSD has since been used to diagnose forms of trauma experienced across a diverse range of contexts and countries. However, there is continuous debate in terms of its applicability cross-culturally and where and how it should be used as a diagnostic tool (Banerjee, 2015). Moreover, the screening of specific populations for such disorders is subjective due to the possible presence of other traumatic experiences such as early life trauma and the accumulation of other life events (Frissa et al., 2016) as well as the assumptions which guide initial screenings. Increasingly, studies indicate the need for a broader lens in understanding trauma and PTSD especially in terms of diverse and divergent contexts and where conflict and violence is enduring – therefore leaving no space for "post-trauma" (Miller and Rasmussen, 2010; Palmary, 2016; Ellis et al., 2019; Walker and Vearey, 2022).

In fact, exposure to armed conflict does not inevitably lead to mental illnesses and nor do mental illnesses only emerge during time of violence and conflict. Yet it is evident that the forms of exposure (either directly or indirectly), the types of exposure (e.g., human rights violations, sexual and gender-based violence, health threats, and witnessing atrocities), and the timing of exposure can all increase the risk of developing mental illness (Tay, 2022).

1.3 Understanding mental health amongst IDPs in the DRC

Within the context of the DRC, recent data about the type of mental illnesses are not available yet. One study conducted in 2010 revealed that half of the general population (50.1%) in the Eastern Congo, the most affected region by armed-conflict, reportedly met symptomatic criteria for post-traumatic stress disorder, 25.9% reported suicidal ideation, and 16% reported attempted suicide at some point during their lives (Johnson et al., 2010).

1.4 The place of mental health in the context of the transition to Universal Health Coverage in the DRC

The response to mental health challenges in the DRC is marked by a health system where mental health service delivery is very limited. In fact, the country has <60 neuropsychiatrists—one psychiatrist for more than six million inhabitants—of whom about 50 are concentrated in the capital, Kinshasa. Only three percent of primary care facilities integrate mental health services, and the country has only six hospitals specializing in mental health. There is no national budget allocated to the mental health national program (PNSM). That said, the PNSM has recently elaborated its National Strategic Plan for Mental Health; a promising step but will require

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[1] There is a growing focus area in research and clinical work in psychology and related disciplines that explores how and why trauma impacts through generations.

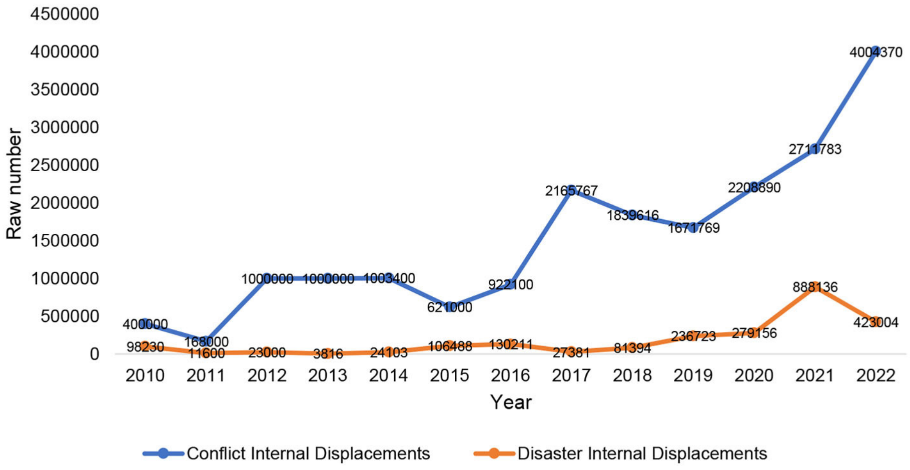

FIGURE 1
Trends of internal displacement from 2010 to 2022 in the DRC. Source: IDMC (https://www.internal-displacement.org/countries/democratic-republic-of-the-congo).

more involvement of the Government to ensure its success. In addition, some forms of psychosocial support are offered by local organizations (such as the Panzi Foundation)[2] and International Humanitarian and Development Organizations (such as OCHA and OIM), particularly in provinces affected by conflicts or in the post-conflict phase (OSAR, 2022).

Improving mental health and wellbeing is recognized as an essential component of Universal Health Coverage (UHC) (OMS, 2022) as set out as a key goal in the Sustainable Development Goals (SDGs). The DRC, like many other countries has recently committed to offer universal coverage of health care services to the entire population. The DRC aims to do this by 2030 (Ministere de la Santé Publique, 2018). This implies that all the Congolese population should receive all the quality and accessible care-including mental health care that meets their needs. However, the level of inclusion into the public health care system and universal health coverage planning is unclear. Therefore, based on the structural and systemic challenges described above, for the DRC reaching universal coverage will be impeded by the failure to improve the mental healthcare for all populations including those at heightened risks such as IDPs.

2 Method

This study draws from a review of various national laws and policies (including, decrees, orders, etc.) and international commitments of the DRC to address the mental health issues of IDPs. Publicly available documents (gray or published articles) were also reviewed. Supplementing this review, we conducted a series of interviews with various stakeholders to understand the significance of mental health in their interventions. A total of 32 semi-structured interviews, using a guideline with open questions, were conducted with one national and three provincial representatives of the National Program for Mental Health; one representative of the national and three provincial representatives of the Ministry of Humanitarian Affairs; and 24 leaders of national and international NGOs in the capital city Kinshasa and four of the most affected provinces (Tanganyika, South Kivu, Kasai Central and Ituri). Questions were related to the role or missions of the organization in relation with IDPs and/or mental health; the existing texts relating to IDPs and mental health (laws, decrees, orders, etc.), and their applications on the field; some achievements in dealing with mental health among IDPs; and barriers to accessing mental health services by the IDPs. A thematic analysis was used to examine themes and identify patterns in respondents' answers to the various questions asked.

3 Findings

This section is structured in four, interrelated parts which successively develop: the legislative framework, the organization of the mental health response, stakeholders' intervention and barriers to accessing mental healthcare.

3.1 The legislative framework

All respondents pointed to the lack of specific legislation that addresses mental health provision and rights among IDPs in the DRC. Two key international and Continental conventions addressing the rights of IDPs were identified by some respondents: the International Humanitarian Law and the African Union's Kampala Convention. Respondents noted that both conventions have yet to be ratified by the DRC National Parliament as illustrated in the quote below:

> *"There are two laws lying around without being ratified: the International Humanitarian Law and the Kampala convention. These laws show the protection of internally displaced people in*

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[2] The Panzi foundation ia a well-funded organization founded by Dr. Denis Mukwege, a Nobel Peace Prize winner.

> *their country, and for refugees, how we can supervise people who are refugees outside their country. In other signatory countries, these laws have already been ratified, here with us it is still dragging on" (Stakeholder 21, Provincial Humanitarian Affairs).*

The Kampala Convention builds upon the 1998 UN Guiding Principles on Internal Displacement, the internationally recognized framework on internal displacement, which restates the principles of international human rights, humanitarian and refugee law applicable to IDPs. This includes the right to access healthcare and therefore is critical for ensuring the wellbeing of IDPs.

Other respondents pointed to the creation of the National Refugee Commission—(Commission Nationale pour les Réfugiés—CNR) to process asylum applications and ensure the protection of refugees as well as the Ministry of Humanitarian Affairs. They saw these as positive indicators of solid political decisions for better management of migrants' issues in general but yet, still falling short of addressing mental health specifically:

> "*We already have the National Refugee Commission. There is also another major advance: the Ministry of Humanitarian Affairs which now has divisions at the provincial level, which are responsible for these issues, especially in the provinces which have been affected by several humanitarian crises with movement of populations. All this shows this involvement of the government, the responsibility of the government in the implementation of all these international and national policies and treaties*" (Stakeholder 12, International Agency).

The majority of the respondents mentioned both the ministerial decree creating the National Program for Mental Health as a positive move and also the absence of any legislation specific to mental health. As captured by one of the officials:

> "*There is a law that exists but it is more a general law on national health policy [Law No. 18/035 of December 13, 2018 establishing the fundamental principles relating to the organization of public health], specific laws on mental health need to be developed. And then two, you have to provide the resources, because in the budget law, the budgetary resources that are devoted to health are so minimal that certain components such as mental health only benefit from the salary coverage of agents*" (Stakeholder 11, National level).

3.2 Review of existing legislation

The findings from the interviews are supported by the review of DRC's legislative framework which, shows that the DRC has ratified several international conventions regarding the movement of populations (see Table 1). These include key conventions such as: the UNHCR (1951) and its 1967 Protocol; the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa; the United Nations (1990) and the one directly dealing directly with IDPs, the United Nations (1990), Integral Human Development (2019).

However, despite the DRC's commitment to IDP governance agreements, and despite the high number of displaced people in the country, specific national legislation on IDPs' rights has not yet been adopted.

Unlike other migrants or refugees, IDPs do not cross any international border and therefore remain in their own country and under the protection of their government. They should therefore, enjoy the same rights as any other citizen while benefiting from specific protection due to the vulnerabilities posed by displacement. This is reflected in Article 30 of the country's Constitution, which provides that:

> "*Any person who is on the national territory has the right to move freely there, to fix his residence there, to leave it and to return there, under the conditions fixed by law. No Congolese should be expelled from the territory of the Republic, nor be forced into exile, nor be forced to live outside his habitual residence*" (Article 30, DRC Constitution).

The Constitution also stipulates that the Congolese State is responsible for all legislation on refugees, expellees and displaced persons (Cabinet du Président de la République, 2011).

Other laws, although not specifically addressed to IDPs, have provisions protecting some of those most vulnerable including IDPs: the Family, the Children and the Penal Codes (as amended and supplemented by the law n°06/018 of July 20, 2006). The Congolese Criminal Code penalizes, for all the Congolese population, at its article 174 The Crimes of Rape, Minor Prostitution, Forced Prostitution, Sexual Slavery and Forced Marriage (Cabinet du Président de la République, 2006). The Child Protection Code (date) also contains a provision on displaced and refugee children, stipulating that they have the right to protection, support and humanitarian aid and that the State must ensure follow-up (Ministère de la Justice, 2010). However, laws addressing the specific case of IDPs' rights have yet to be promulgated.

The right to health is guaranteed in Article 47 of the Constitution and it is implied that this includes migrants who should have equal rights to health under the special provisions given for non-citizens. The Constitutional right to health is also affirmed in health legislation (such as the Public Health Law), polices and development plans although there is no specific mention of migrants or IDPs.

As for mental health for IDPs, there is no specific legislation on mental health, and legal provisions for mental health are not covered in other legislation. The DRC has ratified the international legal instruments concerning the provision of mental healthcare to those in need (United Nations, 2019), but there is yet no DRC law defining the rights and protection of people with mental illness or regulating the procedures of their admission into hospitals (On'okoko et al., 2010).

The DRC includes mental health as a component of the primary health care and its national mental health program, created in 2001 (Ministère de la Santé Publique RDC, 2001) and several national plans intend to integrate mental health provision at the operational level. However, this has not been implemented as $<5\%$ of health facilities at the operational level have integrated

TABLE 1 Key national documents on laws and right to IDPs' access to mental healthcare.

Name of policy	Year	Status	Migration aware	Migration and mental health aware
The Constitution of the Democratic Republic of the Congo	2006	Approved and implemented	Limited awareness	Migrants and mental health are not specifically mentioned. But the articles 47 and 53 underline the right of everyone to access needed care
The Family Code of the Democratic Republic of the Congo	1987	Approved and implemented	Limited to minors	The article 593 gaurantees the right to children to access needed care
The National Strategy Against Gender Based Violence 2009–2010	2009	Approved	Unclearly mentioned	This guaranteed the right to access care to all the victim. Even if not specified, this also applies to IDPs
Law No. 021/2002 of October 16, 2002, On the Status of Refugees in Democratic Republic of Congo	2002	Approved		Art 32 clearly stated the right to migrants to access healthcare (mental health implied)
National Health Development Plan 2019–2022: Toward Universal Health Coverage	2019	Approved		Access to health care (including mental health) to all is stated. IDPs, as all the Congolese living in the DRC, are also involved
National Strategic Plan for the UHC	2020			Access to health care (including mental health) to all is stated. IDPs, as all the Congolese living in the DRC, are also involved

the mental healthcare package. This is illustrated by a quote from one stakeholder:

> *"The institution that is responsible for this in the DRC is the national mental health program, set up by the government... We realized that, first of all, this program is not known, in most cases and it is not operational in certain regions... We really can't offer even 10% of the support"* (Stakeholder 12, member of inter-cluster).

The Strategy for Strengthening the System of Health (SSSH) and its implementation plan, The National Health Development Plan 2019–2022 (NHDP): Toward Universal Coverage also mention a number of activities regarding mental health. The plan also recognizes the barriers toward achieving UHC including limited financing, lack of community participation, poorly demarcated and regulated health zones and insufficient resources and it is evident that commitments on mental health have not been implemented (Ministere de la Santé Publique, 2018) and no activities for IDPs or even the general population, have been implemented yet.

Overall, it emerges from our interviews and the review that support for mental illness among IDPs does not benefit from any specific legislation. There is an evident failure to prioritize the issue of mental health problems by the Congolese national authorities and therefore the current legislative framework fails to address the challenges of mental health both generally for all in the DRC and specifically, for IDPs.

4 Stakeholders' Interventions

There is myriad of stakeholders (Governmental, Non-Governmental, UN agencies, international organizations, civil society and Faith-based Organization) helping IDPs in various areas (housing, nutrition, health, education, protection) either independently or under a coordinated cluster with other organizations sharing the same mission. While it is difficult to identify the exact focus of all the organizations and clusters very few were identified or recognized to have mental healthcare in their agenda.

The interventions from the Government take place through the Ministry of Humanitarian Affairs which is responsible for coordinating the entire humanitarian response. There is also the aforementioned Humanitarian Affairs Committee. Additionally, there are other ministries like the Ministry of Social affairs, Gender, Health and Justice that have also been mentioned to have the interventions targeting migrants in general. However, this intervention seems to be, in the opinion of the majority of respondents, very limited and does not always include mental health. There are some exceptions to this in the Eastern part of the country where some efforts, from all stakeholders including the national government, have been made to provide psychosocial care to the survivors of sexual and gender-based violence (SGBV) as detailed by the following interviewees:

> *We work with different ministries (humanitarian, Justice, social affairs, etc.), health care providers, law enforcement officers, SGBV survivors, community leaders, etc. The government is not involved enough, it does not provide enough resources to combat mental health problems* (Stakeholder 1, member of health cluster).
>
> *"In agreement with the government in its policy to combat GBV, the actors are organized in a health sub-cluster for the fight against GBV. In this sub-cluster, the actors share information on the response, we act in the management and prevention of this gender-based violence"* (Stakeholder 14).

An effort is being made to extend mental health care to the entire population through the policy of integrating mental health into the primary health care package. This care should therefore be offered at the operational level. However, as reported by respondents, <5% of health districts have the human resources capable of offering this care. No specific budget line has been allocated for these activities as the following quote demonstrates:

TABLE 2 Key stakeholders' members of the health cluster.

Provinces	Stakeholders
Ituri	Alliance for International Medical Action (ALIMA), CARE, Caritas-Développement du Diocèse de Bunia, Medical Environmental Development With Air Assistance (MEDAIR), Malteser International (MI), World Health Organization (WHO), Programme de Promotion des Soins de Santé Primaire, Réseau d'Action pour le Développement et Progrès Intégré (RADPI)
Kasai	Adventist Development and Relief Agency (ADRA)
Nord-Kivu	Actions Communautaires et Humanitaires pour le Développement (ACHUD), ALIMA, Action for the Future (AOF), Communauté Baptiste au Center de l'Afrique (CBCA), Center Hospitalier Neuropsychiatrique (CHNP)/GOMA, Santé Conseil Information Formation (CIF- Santé), Conseil sur la Santé et l'Académie de Médecine (COSAMED), Diaspora Médicale Plus-RDC (DMP-RDC), Groupe de Recherche et d'Actions sur les Migrations (GRAM), Health-Education-community Actio-Leadership (HEAL) Africa, Johanniter International Assistance (JIA), Kivu Emergency Medical Group (KEMG), MEDAIR, Médecins Sans Frontières -France (MSF-F), OIM, WHO, Save the Children International (SCI), Société Congolaise des sages-femmes Nord-Kivu (SCOSAF/NK), Transcultural Psychosocial Organization (TPO)
Sud-Kivu	Association pour le Bien-Etre Familial et Naissances Désirables (ABEF-ND), ADRA, Action pour les Femmes et Enfants Marginalisés RDC (AFEMA-RDC), Actions et Interventions pour le Développement et l'Encadrement Social (AIDES), International Medical Corps (IMC), WHO, Programme de l'Education et du Developpement Integral (PEDI), Urgence Médical internationale (UMI)

> *The simplest reason is that we do not have specialists trained in mental health, we do not have appropriate structures to offer quality mental health care, we do not also have resources available to do so such as in literature because the consequences can be such that the person even develops dementia* (Stakeholder 12).

According to our review of published documents, stakeholders' interventions are brought together in different clusters including: health, WASH (water, hygiene and sanitation), protection, shelter, camp coordination and camp management (CCCM), education, nutrition and food security. All these clusters are supposed to work in synergy and brought together in a structure called Inter-Cluster, an Inter-Agency Standing Committee coordination mechanism under the co-leadership of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the International Organization for Migration (IOM). The health cluster comprises 158 international NGOs, 58 national NGOs, 82 UN representatives, 6 with Ministry of Humanitarian affairs, 8 donors, and 5 Observers (see the Table 2 with key stakeholders members of health cluster by provinces). The stakeholders' priorities areas include the fight against excess morbidity and excess mortality linked to lack of access to basic health care, secondary health care, sexual and reproductive health care, complications of malnutrition and various outbreaks epidemics of measles, cholera and malaria in the context of an already very fragile health system (OCHA, 2021, 2023a). In their report on their response to humanitarian problems for the second trimester of 2023, this cluster recognized that mental health has not benefited from enough activities and none (0%) of the 14,000 migrants in needs were reached during that period (OCHA, 2023b).

Some respondents however reported activities that were recently conducted. These included: the integration of mental health care in 51 of the 519 health zones in mostly four provinces Nord-Kivu, Sud-Kivu, Ituri and Tanganyika; capacity building in mental health care of health providers throughout the province of Tanganyika in eight of the 11 health zones; the harmonization of mental health guidelines in 2021 among all the stakeholders providing mental healthcare; and capacity building of health care providers (clinical psychologists, physicians and nurses) from seven health zones in Ituri province (Bunia, Rwampara, Nizi, Bambu, Nyakunde, Lita and Aru).

However, most respondents acknowledged that the integration of mental health activities is recent and very limited as the following quote illustrates.

> *"The integration of mental health activities is recent; it was somewhat neglected. We currently have at least one meeting per month. We try to mobilize the actors in the field and ensure coordination. We participated in the harmonization of mental health guidelines during the workshop organized in Goma in October 2021…"* (Stakeholder 15, member of health cluster).

4.1 Barriers to accessing mental healthcare

From the interviews and documents reviews, the following barriers were identified:

4.1.1 Scarcity of specialized and skilled staff

Most respondents highlighted the fact that psychiatrists and other needed skilled staffs are lacking across the country and that this is unequal provision across the country. For example, respondents from Kasai Central, Ituri and Tanganyika reported no skilled human resources while those from South Kivu have the availability of such staff in some health facilities most notably SOSAME (Soins de Santé Mentale or mental health care facility) regional center and Panzi Foundation mostly for victims of sexual violence. This unrequal situation can be illustrated by the following quotes:

> *"Here, in the province of Ituri, there is no hospital that can take care of cases of mental illness. Only some NGOs provide some supports"* (Stakeholder 18, local NGO).
>
> *"In reality here in Tanganyika, I have never observed an actor on the ground providing mental healthcare"* (Stakeholder 21, provincial level).
>
> *"We have integrated mental health services into some district level mostly in North and South Kivu"* (Stakeholder 11, National level).

However, referring to some key stakeholders' plans (CCCM in particular), financial resources have been specifically allocated to mental health challenges among displaced populations (CCCM Cluster, 2023). The training of health workers has also been organized as some respondents reported:

> "After the workshop, we organized training for providers at DPS Bunia on Mental Health in December 2021. Six health zones (Bunia, Rwampara, Nizi, Bambu, Nyakunde and Lita) took part in this training: clinical psychologists, doctors, nurses and some NGOs invited on the management of cases of mental illnesses. We have also organized training on the management of mental illnesses in Aru" (Stakeholder 15, UN agency).

Although this may appear promising in theory, this has arguably very limited impact given the potential scale of the problem and the need for mental health care for an IDP population of over 6 million, not counting the host families of the displaced.

Apart from these NGOs, we must also highlight the role of community organizations, particularly community relays, in the promotion of mental health. This is still an experience limited to certain health zones:

> "*We have already integrated mental health care in the Walungu health zone by training care providers (doctors, nurses, community relays, etc.), we help them to refer complicated cases to specialized structures. We have integrated listening and support units into the health zone structures. We are in the process of expanding our activities in other health zones*" (Stakeholder 5).

4.1.2 Perceived lack of interest by stakeholders

Overall, mental health care has not been prioritized and considered as an urgent need by stakeholders, although respondents indicated that there has been a recent growing interest demonstrated in the section above by the training of some health providers. However, this does is not yet enough to cover the IDPs' needs. However, psychosocial support to victims of sexual violence needs to be highlighted among the effort to combat mental health issues among this population.

> *"The integration of mental health activities is recent; it was somewhat neglected... We try to mobilize the actors in the field and ensure coordination*" (Stakeholder 15, UN agency).
>
> *"The Congolese people in general are abandoned to their sad fate, because if you go to SOSAME you will see that the number that is there is really minimal compared to the mental health problem that there is in Bukavu"* (Stakeholder 06, local NGO).

4.1.3 The drain of trained health care workers

To explain the scarcity of skilled human resources in the DRC, respondents noted that some healthcare workers trained to work in mental health are recruited by NGOs during specific projects, and they then tend to leave right after the end of those projects.

> *"You train people from the health zones for mental health care, and these people develop skills but because they are underpaid, the NGOs come and recruit them and take them to them as experts and they will work for them. It is also important to improve the remuneration of service providers to help them stay*" (Stakeholder 11, National level).

The inability to sustain the achievements of the projects after they have finished and to hold onto the trained health care providers who understand the context and needs of the IDP population is therefore a major concern. This undermines any efforts to build a stronger mental health work force and in turn, limits access to mental healthcare for those in need.

4.1.4 Perception of mental illness origin and treatment

Findings from the interviews with experts also highlighted the significance of how mental illnesses are perceived by the majority of the population, even some health providers themselves, as mystical or due to curse. This is an issue that has also been identified in a number of studies (Ventevogel et al., 2013; Mutombo Tshibamba et al., 2019; Wiel and Slegh, 2022), As a result, many turn to traditional or religious healers rather than seeking help via bio-medical health facilities: "*In the DRC we have a problem of often considering mental health as witchcraft" (Stakeholder 06, Province level).* For stakeholders this perception means that those facing mental health challenges are often blamed and held responsible which also impacts on whether treatment is sought.

For example, those affected by mental illness are often accused of wrong-doing in the past and it is assumed that they deserve their curse. Therefore, effort to seek care is undermined by the assumed source of mental health. This also contributes to suspicion and doubt about the effectiveness of the "modern" (Western) medicine in treatment mental illness (Echeverri et al., 2018). For those who do not/cannot seek care this can lead to a worsening of issues, particularly for women:

> *For the mental health problem, it is often the mothers (women) who are traumatized. There are those who flee the war, even forgetting their children and they develop disorders in relation to the unfortunate events they have experienced. They are neglected, they run away from them, they take them for sorcerers because they are troubled, and these are problems we encounter in the sites* (Stakeholder 24, local NGO).

5 Actionable recommendations

As the DRC moves toward achieving UHC the findings of this review suggest that there is a need to implement measures aiming to promote and to improve mental health and wellbeing as an essential component. This should include scaling up comprehensive and integrated services for the prevention as well as treatment for people with mental disorders and other mental health conditions (United Nations, 2019). Drawing from suggestions from respondents in what follows we set out some recommend key steps to address which could pave a way toward ensuring the UHC is achieved with support for mental health at the center of its commitments.

5.1 Strengthen focus and leadership of the government on mental health responses

One of the main recommendations by respondents to ensure a holistic solution to mental health issues among IDPs is that the Government should invest more, in terms of increasing budget allocation and providing necessary resources to the Humanitarian Affairs and the National Program for Mental Health. Government leadership should also reinforce collaboration between the aforementioned institutions through the elaboration of a joint plan to engage other stakeholders. This much needed plan is of great importance as all the stakeholders should align to guarantee the rationalization of their interventions.

5.2 Scale-up the integration of mental healthcare at the operational level

The aforementioned effort to integrate mental health at the operational level- which has begun with 51 health zones- is a guarantee on early screening of mental health problems at the district level. This could also help IDPs, as well as the host population, to receive the needed care in facilities close to their habitation. If district level plans are effectively rolled out, these can include IDPs into planning so that parallel *ad hoc* programs by NGOs are not ineffectively duplicating services. This implies that stakeholders should invest more training for district health workers in screening, treating or referring mental health problems. They should also elaborate a supply plan for all the medications and needed materials.

5.3 Train the communities in screening for mental health issues

The involvement of community health workers in the promotion of mental health within the community is a positive experience that needs to be expanded. In fact, the DRC already benefits from a vast network of community health workers that are involved in the promotion, prevention and even curative health provision. Training such workforce could be particularly useful in the screening of IDPs that require mental healthcare. There are guidelines that have shown their effectiveness for such purpose (WHO, 2005; Echeverri et al., 2018).

5.4 Sensitize IDPs and their host population

Interventions aiming at raising the awareness to reduce mental health stigma have been reportedly shown to be effective in countries like South Africa (Kakuma et al., 2010). In the DRC, stakeholders should invest in the sensitization of the IDPs and host populations to help provide more education on mental health issues and prevent stigmatization of those affected. A joint behavior change communication plan that also use the network of community health workers can help for that purpose.

6 Conclusions

This policy brief raises the alarm on the mental health problem among IDPs that is often neglected but has harmful effects on their wellbeing. It has highlighted the major challenges that currently limit an effective mental health response to IDPs in DRC. Insufficient resources, a failure to prioritize mental health issues among stakeholders, and the stigmatization of mental health challenges require more attention in order to improve responses that are also critical to the DRC achieving the goal of UHC. Effective solutions, as suggested by respondents are dependent on the involvement and investment of all stakeholders and especially the Government to take mental health seriously and center mental healthcare in a "health for all" approach.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The study protocol was approved by the Ethic Committee of the Kinshasa School of Public Health, Kinshasa, DR Congo (Approval number: ESP/CE/20B/2021). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

PM: Writing—original draft, Formal analysis, Methodology, Conceptualization, Data curation, Project administration, Supervision, Validation, Writing—review & editing, Resources, Funding acquisition, Software, Visualization. GL: Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Writing—original draft, Writing—review & editing, Software, Supervision, Visualization. RW: Conceptualization, Methodology, Supervision, Validation, Visualization, Writing—review & editing.

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The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

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Rethinking (local) integration: domains of integration and their durability in Kismayo and Garowe, Somalia

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Amidst the ever-expanding debates in various academic and policy fields around migrant and refugee integration and local integration, we bring these two concepts in conversation with one another. Until very recently, theories of integration have had a state-centric focus in the Global North. This article expands and complicates this literature to focus on displaced Somalis within Somalia and its borderlands living in the cities of Kismayo and Garowe using mixed qualitative and quantitative methods in five displacement settlements. Toward this end, we use the often- engaged term "domains of integration" to frame integration. In our conceptualization, however, we incorporate the concept of "local integration" as a durable solution. In brief, we see the domains of integration as a productive concept in the Somali context. However, in Somalia, where clans are interwoven into the state, which lacks resources and power, clan affiliation represents social connections domains, yet also influences the state's role in the foundational domain of rights and citizenship and makers and means (employment, housing, education, health). International donors and NGOs, as well as international capitalist urban expansion also have a large role in these processes. As such, we argue that the ten domains of integration (discussed in detail below) intersect and blur to an even greater extent than in European and North American contexts, particularly around crucial issues such as housing, land, and property; a key factor in people's decisions to remain or leave.

KEYWORDS

Somalia, IDPs, integration, local integration, displacement, refugee returnees, durable solutions

Introduction

The trope of "transnational nomads" is often used to describe the Somali diaspora, dispersed across the world through displacement, resettlement, and other migrations. In exile or transit, Somalis often maintain transnational networks of social and economic support through familial and clan structures, which enables them to integrate (Horst, 2006). This study, however, examines the conditions and processes of durable integration for Somalis displaced *within* Somalia and its borderlands, including those returning as refugees from Kenya in five settlements in Kismayo and Garowe. The highly contested idea of integration requires additional unpacking to fit the Somali context, which has been shaped by conflict, natural disasters, and the resultant migrations, urbanization, and transformations of the state over the last three decades. To contribute to the integration debates, we recognize that the Global South cannot be approached with the state-centric focus we encounter in North America and Europe (Landau and Bakewell, 2018; Abdelhady and Norocel, 2023). At the same time, we caution against lurching in the other direction, portraying African states generally, and the Somali state specifically, as mere exceptions, oddities, or failures that cannot reflect on processes of integration in the Global North and beyond (Vigneswaran and Quirk, 2015; Boeyink and Turner, 2023). Toward this end, we use Ager and Strang's (2008) oft-engaged work on the interlocking "domains of integration" to frame integration. In our conceptualization, however, we incorporate the concept of "local integration" as a durable solution, which is a scholarly and policy discussion that often happens in parallel or in isolation for protracted displacement contexts in the Global South. In brief, we see the domains of integration as a productive concept in the Somali context. However, in Somalia, where clans are interwoven into the state, which lacks resources and power, clan affiliation represents social connections domains, yet also influences the state's role in the foundational domain of rights and citizenship and makers and means (employment, housing, education, health). International donors and NGOs, as well as international capitalist urban expansion also have a large role in these processes. As such, we argue that the ten domains of integration (discussed in detail below) intersect and blur to an even greater extent than in European and North American contexts, particularly around crucial issues such as housing, land, and property; a key factor in people's decisions to remain or leave.

The article is divided into five parts. First, we provide background of the displacement context, giving brief characteristics of the five field sites in Kismayo and Garowe. This is followed by situating our study in the debates around processes of integration and local integration. The third section outlines our mixed quantitative and qualitative methods and analysis. The fourth, and main results section, is organized around the four domains of integration (foundation, facilitators, social connection, and markers and means) and their sub-domains. Within each domain we use our data to present the significance and importance and how it relates to displaced people's decision to stay or go. Finally, we return to (local) integration theory and the policy implications for displaced populations in Somalia.

Background

Somalia has experienced over 40 years of conflict and state erosion dating back to 1977/78 Ethio-Somali war (Bradbury, 1994; Elmi and Barise, 2006). The military regime of General Mohamed Siad Barre, which ruled the country since 1969, was ousted in 1991 leading to the subsequent collapse of the state and protracted humanitarian crises (Bradbury, 1994). After the civil war, power was divided and contested between the Transitional Federal Government and the Islamic Court Union (ICU), which was eventually toppled through involvement of Ethiopian forces from 2006 to 2008. The more radical Al-Shabaab militant group emerged. Today, Al-Shabaab is predominant in rural areas in southern and central Somalia and is a major driver of forced migrations, particularly through its at times excessive taxation of local populations (Mubarak and Jackson, 2023).[1] The compounding effects of conflict, the prolonged absence of a functioning state, and environmental disasters, particularly droughts, have resulted in multiple phases of widespread displacement. See Figure 1 for locations of fieldsites and areas they moved from.

Protracted displacement and historical migration have resulted in a globally dispersed Somali diaspora. UNHCR currently estimates that there are more than 700,000 Somali refugees and asylum seekers, most living in neighboring Kenya and Ethiopia, and nearly 4 million people have been internally displaced (UNHCR, 2023). Moreover, at the end of 2022 there were an estimated 140,000 "returnees" or refugees repatriating from nearby countries. Most returned from Kenya and were resettled in Jubaland where Kismayo is located (UNHCR, 2022). We take caution with these figures, knowing displacement figures are difficult to accurately capture (Crisp, 2022). More importantly, however, we are tentative in labeling those on the move because displaced people elude simple categorizations (Zetter, 2007; Bakewell, 2008). We agree with researchers who problematize the IDP categorization in Somalia where wealthier or well-connected people displaced by drought settle in cities and never register as IDPs, blurring the distinction between IDPs and so-called "economic migrants" [Research and Evidence Facility (REF), 2018, p. 40]. An example of this comes from Garowe, where many members of Rahanweyn clan never register as IDPs. Through clan connections, they successfully establish small businesses, despite their clan not being prominent in Puntland.

Fundamental to understanding displacement in Somalia are the linguistic underpinnings, which help explain differentiated access to rights and privileges displaced Somalis experience, despite having Somali citizenship. Somali words "*barakac*" or "*barakacayaal*" characterize people who were forced to leave their place of origin and live in settlements recognized as IDP camps. Key to the definition is that people leave their "place of origin," an area where they draw from support of their clan. Alternatively, "*qaxooti*" denotes refugees who cross borders. "*Qax*" means to flee a place because of war, insecurity, and fear of persecution. The word *barakac* means to leave place of residence due to war, insecurity, and natural disasters. Although the two words have similar meaning, a clear semantic distinction has developed in recent years. Furthermore, the use of the word *barakacayaal* for IDPs has gained traction because of its formal use by UN and international organizations providing assistance. The distinction between *barakac* and *qaxooti* becomes blurred when discussing citizenship and refugee status among ethnic Somalis displaced from other Somali inhabited borderlands such as Ethiopia into Somalia. These displaced people consider themselves and are treated as IDPs rather than refugees. Indeed, due to their ethnicity as per 1962 Somali Citizenship law, they are legally and in practice considered Somalis and treated locally as IDPs. Similarly, many returnees from Kenya or Yemen are resettled in the camps and settlements as IDPs.

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[1] Al-Shabaab also receives local and clan-based support in its strongholds and the Somalia government forces also displaces people in the other direction deeper into Al-Shabaab-controlled territories (Mubarak and Jackson, 2023).

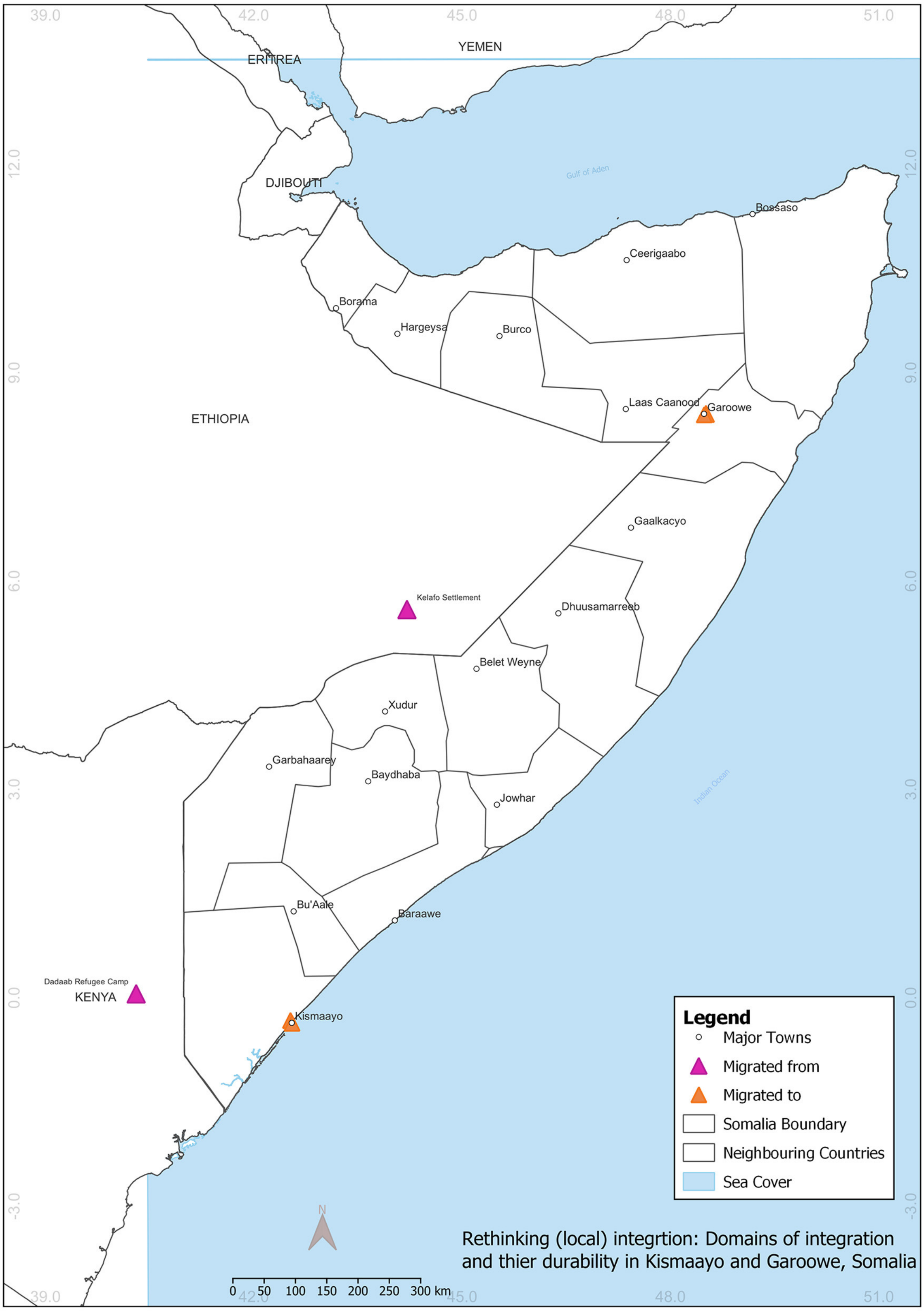

FIGURE 1
Map of Somalia.

While comparing across sites in Kismayo and Garowe, the massive scale of displacement makes it impossible to generalize for all camps as there are reportedly more than 2,700 IDP sites across every state in Somalia/Somaliland (CCCM Cluster Somalia, 2023a). One generalizable aspect is the urbanization of most displacement locations. War and drought, which devastate agricultural and livestock assets, are clear displacement factors leading rural-urban migrations. People are drawn to cities by the prospects of safety from war, availability of jobs, and access to educational and healthcare services. However, as we discuss, urbanization and rising land prices leaves displacement sites vulnerable to eviction, which explains the importance our participants place on housing, property, and land, which are key themes in important recent monograph, *Precarious Urbanism* by Bakonyi and Chonka (2023), who conduct similar research in Baidoa, Bosaso, Mogadishu, and Hargeisa. This precarity is most pronounced in Mogadishu where self-established camps are run by brokers or "gatekeepers" (HRW, 2013) who have a clientelist relationship with camp residents, allowing access to housing and connection to aid in exchange for up to 50% of aid IDPs receive (Bakonyi, 2021, p. 14). Alternatively, Kismayo and Garowe do not have camp brokers, but rather "camp leaders" of prominent camp residents are appointed by governmental authorities. The following subsections give further background to these regions, cities, and displacement sites.

Kismayo

The port city of Kismayo is the largest city of the Federal Member State Jubaland, which gained federal recognition in 2013. The city hosts 170 verified IDP sites of 145,000 individuals (CCCM Cluster Somalia, 2023b) (see Figure 2). Severe drought and Al-Shabaab strongholds surrounding Kismayo are the primary displacement drivers [although Al-Shabaab strongholds in Lower and Middle Juba have also seen growth in population (Mubarak and Jackson, 2023)]. The city also accommodates Somali refugee returnees, mostly from Dadaab camps in Kenya. By 2023, following the repatriation program beginning in 2014, an estimated 55,000 returnees (including those assisted financially and logistically by UNHCR and unassisted or "spontaneous") initially returned to Kismayo (UNHCR, 2022). Many felt pushed out by the Kenyan government's threats to forcibly close refugee camps and were drawn to the perceived improved security and job opportunities in the city (Ahmed et al., 2023). These migrations have profoundly affected the city as they have nearly doubled the estimated urban population since 2014 (JMOPW and UN-Habitat, 2020, p. 11). The Jubaland government, one of the most recent federal member states, has a centralized structure and established the Jubaland Commission for Refugees and IDPs (JUCRI) to oversee the settlement of displaced people. JUCRI appoints influential residents of displacement sites to be camp leaders or liaisons between government and humanitarian provisions. However, many of the services are funded or provided by international NGOs.

Displacement sites in Kismayo and Garowe can be divided into two typologies, "informal and formal," based on home and land ownership and physical structures, though these categories blur over time as we demonstrate. The informal sites are built on public or private land and the houses are temporary shelters made of corrugated iron and plastic sheets. Informal settlements are at the highest risk of eviction due to their lack of legal protection. In contrast, the homes in the formal settlements are permanent structures made of bricks that were built for displaced people by international organizations on land that has been provided by the government. These formal settlements also include health and education facilities and other amenities (NRC, 2021, p. 21). Displacement sites differ in other ways such as location (inner city, outskirts), size, duration of existence, and composition of residents.

The field site, Fanole, consists of more than 20 unplanned displacement settlements south of the city (see Figure 3). It is occupied by people from surrounding areas around Kismayo. Private individuals from powerful clans took public spaces, through "land grabbing" during the civil war. These private individuals allowed IDPs to settle and build temporary shelters on the land to protect their ownership. Newly migrated settlers build their own shelter with plastic and iron sheets, with some materials donated by NGOs. These households are considered "occupiers" and while they do not pay rent, they are at high risk of eviction.

Midnimo (meaning unity in Somali, to denote the unification of refugees long displaced in Kenya), also known as New Kismayo, is a large, planned structure, which was negotiated between UN organizations and Jubaland government and local communities in 2017 to house displaced populations, returnees, and so-called "host community members" (see Figure 4). This resettlement scheme had detailed planning for spatial organization and social services, transport and commercial integrations into the wider city, making the area "some of the most attractive locations in the city" (Mohn et al., 2023, p. 12). There is a large, functional health center, primary school, community and women's center, and sports grounds. As such, Midnimo has been hailed as a success by researchers and international policymakers for its property rights protecting against eviction and integration to services and infrastructures as the sixth neighborhood of Kismayo (Ahmed et al., 2023, p. 27; Mohn et al., 2023, p. 13). However, IDPs in Midnimo and other areas complain of the inequality and preferential treatment of returnees from Kenya who receives greater and more consistent amounts of aid than others (Ahmed et al., 2023, p. 15). Though not a field site of this project, following the success of Midnimo, Luglow was constructed in a similar top-down fashion, though it was built 20 km outside the city. This distance has caused security concerns and made integration to services and employment difficult (Ahmed et al., 2023, p. 7; Mohn et al., 2023, p. 15). Bakonyi and Chonka (2023, p. 148–154) discuss similar dynamics in resettlement schemes in Bosaso and Hargeisa, which provided housing security but also isolates communities apart from jobs and services in the city, and further entrench the otherness of IDPs. This indicates the importance of spatial integration for displacement sites.

Garowe

The first Federal Member State of Somalia, Puntland has benefited from being insulated from the worst effects of drought and war in comparison to central and southern Somalia (see Figure 5). This has been a primary pull for displaced people to travel large distances to reside in Garowe and the port city of Bosaso. This peace dividend has made a more vibrant economy and job availability in Garowe as compared with Kismayo. By 2023, around 55,000 individuals reside in 25 verified displacement settlements (CCCM Cluster Somalia, 2023b). The reasons for displacement are varied from violence and drought to tsunamis. Compared to

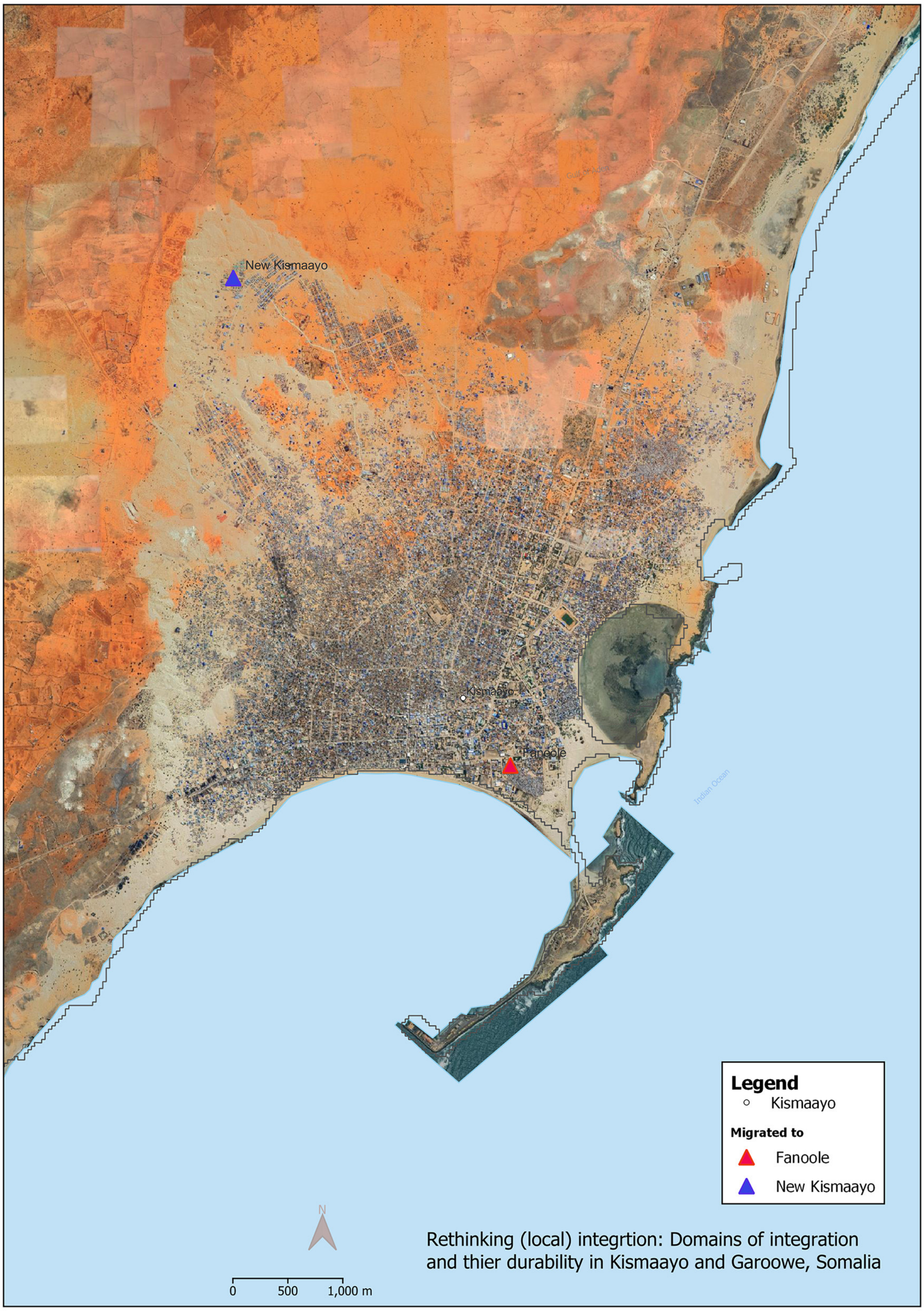

FIGURE 2
Satellite photo of Kismayo.

Jubaland, the administration of displaced people is handled more at the municipal level, where camp leaders are appointed by the municipality. Unlike Jubaland, large-scale interventions such as Midnimo and Luglow have not been implemented in the city, leaving a more informal character similar to Fanole in Kismayo. Indeed, a reported 60% of displacement settlements are facing

FIGURE 3
Photo of Fanole.

FIGURE 4
Photo of Midnimo (New Kismayo).

an extreme or high risk of eviction, which is largely due to the rental agreements in place at the camp level (CCCM Cluster Somalia, 2023b). However, there are contrasting sites such as Bilan, presented below, which demonstrate differing outcomes of durable solutions.

Established in 2009, Shabelle camp is one of the largest displacement settlements in the north of Garowe (see Figure 6). Most Shabelle residents are Bantu Somalis (known in Somali as *Jareer*, meaning "hard hair") that lived along the Shabelle river in the Ethiopia-Somalia borderlands facing a series of

FIGURE 5
Satellite photo of Garowe.

FIGURE 6
Photo of Shabelle.

displacements from the Ogaden War in the 1970s, spillover from the 1990s civil war, and localized violence in the Somali region of Ethiopia in the 2000s. Despite many coming from Ethiopia, they are considered *barakac* rather than *qaxooti*, or refugees. However, due to their Bantu ethnicity, *Jareer* have been historically racializd and marginalized in Somalia, though they still claim membership of clan lineages based on histories of slavery or clientelist protection (Besteman, 2016). Like Fanole, Shabelle consists of informal, self-built shelters. This arrangement of informal communal ownership was made as an agreement between the district authorities and the landlords to house IDPs for 10–20 years. However, with more than 10 years passing since this agreement, in conjunction with lucrative rise of land prices, the landowners are becoming impatient with this arrangement. This raises fears among Shabelle residents of imminent evictions. Local authorities are discussing relocating these and other informal sites outside of the city, although this risks disconnections to valuable services and livelihoods as in the Luglow settlement of Kismayo.

Jilab, established in 2010, is a cluster of settlements in the southern outskirts of Garowe. Long term residents of informal IDP camps and people displaced by droughts in Nugal region were offered permanent settlement in Jilab, resulting in a population of mixed clan lineages (see Figure 7). Earlier residents living in the initial Jilab camps were able to acquire land and own the houses they stay in. However, recent Jilab residents in the newer camps rely on rented houses and are classified as having high and extreme risks of eviction due to the inability to pay rent. In earlier established sites Jilab 1 and 2, there is a mixture of housing tenures. The original displaced people were given land and ownership as mentioned. However, many informants described camp leaders and authorities allocated housing to non-displaced Garowe residents. As such, both original displaced inhabitants and “hosts” from Garowe have rented their homes to more recently displaced families. This has resulted in a mixture of secure and highly precarious housing arrangements across Jilab.

Finally, Bilan offers a contrast to Shabelle and Jilab because it was established nearly 20 years ago after the 2005 tsunami displaced many people from the coast. Many initially lived with relatives until UN-HABITAT and the Puntland Ministry of Interior and Garowe municipality selected a proportion to have land and home ownership in Bilan. Eventually the settlement was integrated into the city (see Figure 8). Importantly, these displaced individuals come from the same dominant clan, Ciise Maxamuud sub-clan of Darood, which is prominent in Garowe. This group was able to leverage kinship ties into legal protection. Because of these clan affinities and longevity of residence, most living in this site do not consider themselves to be displaced. In fact, many even rent out their properties to newly displaced people and have gained the assets to move into Garowe city. We see similar displacement and connections to locally influential clans, offering greater resources, protections, and sense of belonging (Bakonyi and Chonka, 2023, p. 165).

Across the five sites there are relatively similar levels of access to services such as healthcare and education. Each location has health centers; however, locations such as Fanole and Bilan, which are located more centrally in Kismayo and Garowe cities respectively, have closer access to larger, more specialized hospitals. Similarly, each settlement has primary education, although Fanole’s facilities are significantly lacking with only one classroom, compared to a more functional school in Midnimo. As mentioned, there are generally more jobs available in Garowe than Kismayo, though this is changing due to the

FIGURE 7
Photo of Jilab.

FIGURE 8
Photo of Bilan.

arrival of foreign labor. As a response to recurring drought, various donors and NGOs distribute cash to households, which is a valuable resource to many, though many participants complained that this money does not last and not all people receive it.

Integration and/or local integration?

The boundaries of integration, as theory, practice, and discourse, have eluded consensus among academics and policymakers. Moreover, there are parallel, mostly siloed debates within forced migration studies and policy around "local integration" as a "durable solution" to protracted displacement. This section aims to unpack and reconcile these related, yet often separate discussions to understand plans for migration and integration of displaced Somalis in Kismayo and Garowe.

Integration

Integration in scholarship and policy is often assumed to be a process that betters the treatment and outcomes of migrants and refugees. One paradigmatic definition points to the aspirational nature of integration as:

> The processes that increase the opportunities of immigrants and their descendants to obtain the valued "stuff" of a society, as well as social acceptance, through participation in major institutions such as the educational and political system and the labor and housing markets. Full integration implies parity of life chances with members of the native majority group and being recognized as a legitimate part of the national community (Alba and Foner, 2015, p. 5).

In line with this approach, the influential work of Ager and Strang (2008) formulates ten interlocking normative understandings of integration, which they call the "core domains of integration." Shown in Figure 9, they created four categories: "foundation," "facilitators," "social connection," and "markers and means." Within these domains the valued "stuff" of society include employment; housing; education; health; social bridges, bonds, and links; language and cultural knowledge; safety and stability; and rights and citizenship. Phillimore and Goodson (2008, p. 322) critique this approach on operational grounds arguing the functional indicators (markers and means) lack sufficient data to capture the realities for displaced people and need supplemented with a qualitative element, "to better understand the interactions between indicators and to understand more about the experiential side of integration". Moreover, Grzymala-Kazlowska and Phillimore's (2018) edited collection argue against the assumed homogeneity of "host communities" in integration research and policy, pointing to changing dynamics of "super-diversity" around the world and call for reciprocal understandings of the term.

On the other hand, many scholars offer more wholesale critiques of integration, arguing the term is conceptually "fuzzy." Many points out the normativity present in scholarship by Ager and Strang and others saying that, "the aim should be to study what is happening, the actual processes, not to prescribe or judge what ought to happen, the desired end goal" (Spencer and Charsley, 2021, p. 5). Some even call for an abandonment of the concept, saying discourses and policies of integration further entrench immigrant minorities as "others" (Rytter, 2019), and is otherwise an extension of neocolonial domination (Schinkel, 2018). In other post-conflict cases in Africa, such as Burundi and Rwanda where there was ethnic genocidal violence, integration is conceptualized in different ways without engaging in the same integration literature at all (Purdeková, 2017). Building on this critique, recent scholarship notes that these debates have mostly taken place in the Global North. Abdelhady and Norocel (2023, p. 123) contend that, "instead of the state-centered approach to integration that dominates analyses in the Global North, interrogating immigrant integration in the Global South decenters the state and underscores informal and local experiences of joining communities and forging attachments". Landau and Bakewell (2018, p. 5) make similar points and add to the longstanding critique that integration "is infused with normative assumptions about the nature of host communities and their responsibilities to outsiders" and claim that "making sense of mobility's socio-political consequences in Africa means moving past discussions of the formal policy regimes that often frame Euro-American analyses. Beyond the general weakness of many African legal systems, few countries have overt integration policies and the term is rarely used".

Local integration

We agree with many of the critiques above, especially the call to decenter the focus on the state and critically analyze the nature of citizenship. However, we disagree with the claim that "few countries have overt integration policies and the term is rarely used." Many African states have negotiated and contested policies of local integration as a durable solution for displaced populations within and without their borders. Indeed, the Federal Government of Somalia has created the National Durable Solutions Strategy and is signatory to a wide range of legislature and international instruments relating to refugees and IDPs (Federal Government of Somali, 2020). Like integration, local integration needs to be unpacked because it has changed in meaning over time and lacks a shared understanding. Furthermore, local integration policies naturally apply differently between refugees and IDPs.

The 1951 Refugee Convention set out three durable solutions: voluntary repatriation, resettlement (to a third country) and local integration.[2] Local integration in this original formulation explicitly meant naturalization or granting citizenship. However, because this option of citizenship has rarely been offered to refugees, it became known as the "forgotten" solution to displacement (Jacobsen, 2001). Hovil and Maple (2022) claim that it is the "evaded" solution because governments deliberately avoid naturalization. Instead as a substitute "de facto integration" through self-settlement of refugees from below and livelihood and "self-reliance" projects implemented from above has been the focus of governments, policymakers, and academics when discussing local integration. This allows Global North states to continue containing undesirable populations and funding the majority of protracted refugee situations in the Global South, without finding durable solutions. In turn Global South states avoid

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[2] See Fiddian-Qasmiyeh et al. (2014) for primers on each of these aspects of durable solutions.

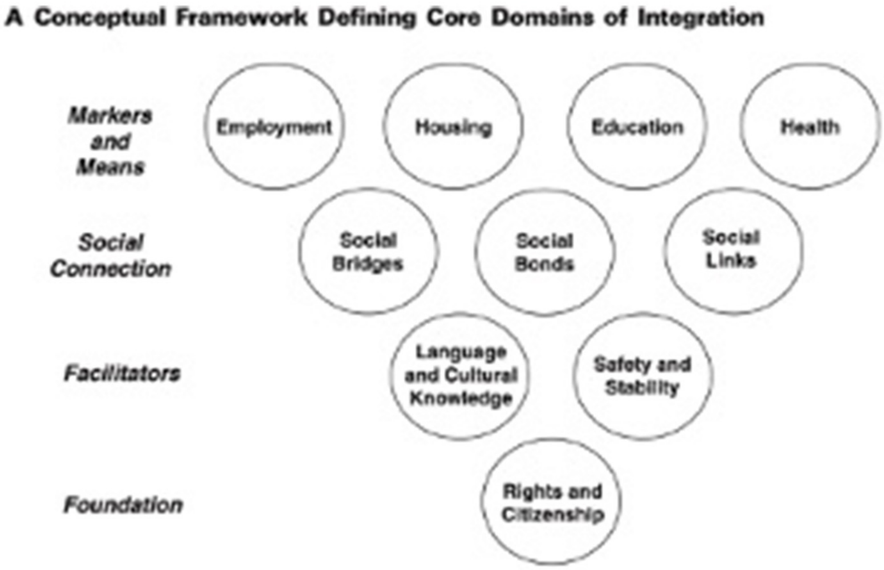

FIGURE 9
Domains of integration (Ager and Strang, 2008, p. 170).

the domestically unpalatable political act of granting citizenship. Local integration's original intent as a solution to displacement through citizenship has been neutered. Without discrediting the things refugees do to integrate themselves into societies from below, with or without the consent of the host states, Hovil and Maple (2022, p. 264) call for a return to naturalization as a viable solution to refugeehood: "instability breeds instability: when national refugee policy is highly susceptible to change and shifts based on political pressures and forces, it does not matter how 'de facto integrated' into the community a refugee is, their status remains vulnerable." They emphasize "the urgent need for these self-driven approaches, which are often quite fragile, to be matched by formal, legal integration, in order to offer the solidity and stability that is otherwise lacking". What does "local integration" means for internally displaced people, where citizenship seemingly is not a relevant factor?

Local integration and IDPs

Largescale IDP situations also use the language of durable solutions. The Framework on Durable Solutions for Internally Displaced Persons, established in 2009 by highest-level humanitarian coordination platform, the Inter-Agency Standing Committee, consider the three durable solutions as: "Sustainable reintegration at the place of origin (hereinafter referred to as "return"); Sustainable local integration in areas where internally displaced persons take refuge (local integration); Sustainable integration in another part of the country (settlement elsewhere in the country)" (The Brookings Institutions and University of Bern Project on Internal Displacement, 2010, p. 5). For IDPs, naturalization is a moot point because they already have citizenship. As such, local integration for IDPs takes a similar tone to discussions on integration, which is more about indicators of integration such as livelihoods and access to services such as education and healthcare, rather than a permanent solution to displacement—a crucially missing point according to Hovil and Maple (2022). This article asks the question, is there an anchoring component for IDPs and returnees to locally integrate in a way that naturalization fortifies local integration for refugees?

To answer this question, we use Ager and Strang's (2008) domains of integration framing in Kismayo and Garowe, which has been applied in other IDP contexts such as DRC and Ukraine (Chuiko and Fedorenko, 2021; Jacobs et al., 2021). Although Ager and Strang focus of refugee integration in the UK, they recognize adjustments are needed to suit contexts different from London and Glasgow:

> This mechanism not only provides a basis for using the same framework in contexts with widely differing conceptions of citizenship, normative expectations of social integration within communities, educational attainment etc. [...] Its wider utility and explanatory value now needs to be tested in diverse contexts to gauge whether the proposed structure captures key elements of stakeholder perceptions of what constitutes integration in an appropriately broad range of settings and timeframes (Ager and Strang, 2008, p. 185).

Although Ager and Strang's framework is self-described as presenting "normative understandings of integration"—a key source of critique by many scholars—we use this approach to present what displaced Somalis describe as barriers to integrating on their own terms. We make no prescriptions for what they *should* do or where they *ought* to migrate; we asked them through surveys and life history interviews about their life throughout displacement and if they plan to leave where they currently live, which we expand in the section below. We agree with Hovil and Maple's argument that without citizenship, "instability breeds instability." However, based on our findings, we see the relationship between citizenship and state in Somalia complicated by area-based clan structures, whereby those displaced from outside locally dominant clans or sub-clans have differentiated access to rights and resources, particularly around land and property, which is a bedrock that other domains of integration must be built on.

Methodology

This study is a part of multi-sited, mixed methods research project exploring access to healthcare at the intersection of gender and protracted displacement amongst Somali and Congolese refugees and IDPs in the Democratic Republic of Congo (DRC), Somalia, Kenya and South Africa. The data collection was conducted in Garowe and Kismayo between 2020 and 2021. The study adapted the Social Connections Mapping Tool methodology to the displacement context Somalia (Strang and Quinn, 2021; Boeyink et al., 2022). The mapping tool combined participatory workshops (of 178 participants) which asked what people or institutions (social connections) people in their community turned to for health, mental health, and sexual and gender-based violence support. Their responses formed a list or social connections. This was followed by a quantitative survey of 800 IDPs and returnees asking inquiring about wealth, health status, and amount of contact and trust with the list of social connections. We also conducted 60 face-to-face semi-structured interviews with displaced people across the five sites. The survey documented the main demographic characteristics of the participants, reasons for displacement, social connections, employment, education, health, and other support resources as key elements for access to services. The semi-structured interviews were used to gain deeper understanding of the participant's displacement history and how factors such as gender, residency, livelihood, and socio-economic status affected their displacement and influenced their access to healthcare. Ethical approval was granted by the (University 1) and in-country by Somalia Federal Ministry of Health, and all participants provided written consent to participate. Further authorizations of access were received from the Ministry of Interior of Puntland State and Garowe District Local government for IDP camps in Garowe and Jubaland Commission for Refugees and IDPs (JUCRI) for IDP camps in Kismayo.

The positionality is important as the researchers collecting data were all further educated than most participants, many of whom were experiencing significant poverty. Moreover, in Garowe, all researchers were from Puntland unlike most of the participants so had different clan affiliations. In Kismayo, there was a mix of Puntland and Jubaland researchers, which had some clan connections with the participants, which aided in building trust. Despite the discrepancies in clan and class, the research team spent time building connections to "camp leaders" who acted as spokespersons for the settlements to the government and NGOs and who were trusted among the IDP camps. The camp leaders vouched for the researchers and encouraged participation, which helped build initial trust. Moreover, all interviewees had already participated in the survey and were familiar with the research project. All interviews and surveys took part in Af Maxaa Tiri Somali language (apart from two interviews conducted in Af Maay Somali language in Kismayo), which allowed researchers and participants to speak in their first languages. The interviews were transcribed and translated to English. Undoubtedly some nuances may have been lost in this process, particularly when people spoke in local idioms or proverbs that do not directly translate to English.

Analysis

The quantitative survey data was collected in Kobo Toolbox and was analyzed in SPSS v24. The participants demographic data such as age, family size, and duration of displacement were transformed into categorical variables, by using median and interquartile range and were used to generate summary statistics to examine the distribution of the socio-demographic characteristics of the IDP population. See Table 1 for results. This was done to gain a better understanding of the sample and to identify any potential confounding variables that could impact the outcome variables.

The main focus of the study was to identify social connections and explore their relative importance to IDP access to health care services. However, it examined a number of elements within the domains of integration, including a question about intention to leave or stay as proxy variables for integration. The survey question was framed as follows:

Are you planning on leaving this place during the next year?

a. Yes, and I have already made arrangements
b. Yes, but I haven't made any concrete plans
c. Yes, but I don't have anywhere to go or a way to leave
d. No, but I think I will leave in a few years
e. No

We recognize this singular question is inadequate to determine whether the displaced informants were integrated into society. However, we used this question as a starting point because inherently no person can integrate if they will imminently leave. This quantitative data was the bedrock of our analysis in that in pointed toward important factors for why people wanting to leave, such as the camp they live in or what type of housing they are living in (see Tables 2, 3). Our qualitative data was used to supplement this quantitative data to gain more insights into people's reasons for fleeing, plans for staying, and levels of integration within Ager and Strang's framework.

Univariate logistic regression analyses were used to determine whether each independent variable was associated with the participant's response of their plan to leave the IDP camp during the next year. Variables with a p-value of 0.1 or less were included in the final model of the multivariate logistic regression. Multicollinearity problem was detected in the final model, to overcome those challenges we ran the chi-square test to find the association between the independent variables, and later we eliminated IDP camps/independents variable which is associated with city (Garowe and Kismayo) where IDPs were living. A multivariate logistic regression was conducted to examine the impact of all significant independent variables on the outcome variables. This allowed for the identification of the independent variables that were the most

TABLE 1 Socio-demographic characteristics of IDPs/returnees in Somalia.

Demographic characteristics				
Variable			Frequency	Percentage
Planning to leave		No	586	73.3
		Yes	214	26.8
Resettled cities		Garowe	400	50
		Kismayo	400	50
IDP camps		Shabelle	176	22.0
		Jilab	208	26.0
		Bilan	19	2.4
		Fanoole	233	29.1
		New Kismayo	164	20.5
Gender		Female	498	62.3
		Male	302	37.8
Family size		<3	75	9.4
		4–7	305	38.1
		8–11	288	36
		More than 11	132	16.5
Level of education		No education	613	76.6
		Primary	147	18.4
		Secondary	32	4
		Higher education	8	1
Born in the IDP camp		No	612	76.5
		Yes	188	23.5
Gender of head of the household		Female	281	35.1
		Male	519	64.9
Duration of displacement (Years)		≤ 2	72	11.8
		3–5	198	32.4
		6–8	121	19.8
		9–11	73	11.9
		≥ 12	148	24.2
Age group		≤ 25	211	26.4
		26–35	224	28
		36–45	173	21.6
		≥ 46	192	24
Type of displacement		IDPs	657	82.1
		Neither	18	2.3
		Returnee	125	15.6
Reason for displacement	Poverty	No	595	74.4
		Yes	205	25.6
	Infrastructure	No	795	99.4
		Yes	5	0.6
	Catastrophe	No	281	65.7
		Yes	147	34.3

(Continued)

TABLE 1 (Continued)

Demographic characteristics				
Variable			Frequency	Percentage
	War	No	595	74.4
		Yes	205	25.6
Type of work	Tax	No	773	98.0
		Yes	16	2.0
	Farmer/fisher/header	No	783	99.2
		Yes	6	0.8
	Skilled	No	681	86.3
		Yes	108	13.7
	Casual labor	No	540	68.4
		Yes	249	31.6
	Housewife	No	539	68.3
		Yes	250	31.7

strongly associated with the participant's response of their plan to leave the IDP camp while controlling for the effects of other variables in the model.

Four of the coauthors participated in the qualitative analysis using web-based collaborative qualitative analysis program, Taguette. The team agreed to code the interviews by some variations of Ager and Strang (2008) domains of integration and then the writing team discussed and analyzed the codes, agreeing which quotes to include in the article.

Results

Foundations

Ager and Strang (2008, p. 176–177) emphasize that indicators for "foundations" should draw attention to the ability of displaced people to access rights that provide "the basis for full and equal engagement within society". Citizenship and rights are crucial to such engagement; however, they also note that, "there is probably no theme that creates more confusion and disagreement regarding understandings of integration than that of citizenship, and the rights and responsibilities associated with it. This partly reflects the widely different understandings of citizenship but, more fundamentally, of nationhood across societies" (Ager and Strang, 2008). This is particularly relevant in this research in Somalia, where the focus is on "internally," rather than "externally" displaced populations, a country with a prolonged recent history without a central government, and even longer histories of contested and porous borders.

There was a widely shared understanding among participants that being "internally displaced" or *barakac,* was a matter of identifying as Somali, rather than being displaced from locations within the country's borders. One participant, originally from Kelafo, a predominantly Somali town located within Ethiopia, was asked if he considered himself to be foreign in Somalia. He replied, "No. I saw myself as Somali living at the border of Ethiopia and Somalia, and who then came to his country." Like many others in similar circumstances, he considered himself internally displaced even though he had crossed an international border, and he was treated as such by receiving communities and governmental and non-governmental organizations. The significance of citizenship was clearly articulated by returnees who had resided in refugee camps in Kenya. As one returnee woman explained,

> I am still in Somalia, not in a foreign country. Although I do not stay in my own home and I live in a displaced people camp, in my mind I feel that I am in Bu'ale (southern Somalia). Despite the difficult conditions in our lives, I consider myself as someone who is in his settlement... I am still in Somalia, I use Somali language and the officials in the government are all Somalis. The people around me are all Somalis. When I go to the town, no one asks me for a permit or status document. I don't face any discrimination. I was in Dadaab refugee camp sometime back. People could not even go outside of the camp or move freely. If some small incident took place, people were being detained. But now I am in my country with no problem at all.

However, there is a clear point of tension between ideas about national belonging, which are widely held by all participants, and notions of local belonging, which were more contentious and have significant ramifications for integration. Clan affiliation is the strongest thread that runs through notions of local citizenship, access to rights, and all the domains of integration. As one man in Garowe stated, "the host community does not consider me one of their own, although I have been here for a long time. So I assumed my natural role as an IDP." When asked the reason for this, he replied "tribalism." Similarly, a female IDP in one of the Garowe camps told us that she had not received any form of aid, "The aid recipients are registered on nepotism. When we asked him (the camp manager) why he didn't register us, he suggested that we were business people. When we confronted him about other people who have businesses whom

TABLE 2 **Person's plan to leave the IDPs and the associated factors.**

			%	*P*-value	cOR	95% CI
Where IDPs located		Garowe	50%	0.000	0.380	0.274–0.527
		Kismayo	50%	Reference		
IDP camps		Shabeelle	22.0%	0.063	1.623	0.974–2.704
		Jilab	26.0%	0.011	0.463	0.256–0.839
		Bilan	2.4%	0.159	0.229	0.029–1.781
		Fanoole	29.1%	0.000	3.753	2.360–5.969
		New Kismayo	20.5%	Reference		
Gender		Male	62.3%	0.003	1.624	1.182–2.232
		Female	37.8%	Reference		
Age group		≤ 25	26.4%	0.000	0.398	0.248–0.637
		26–35	28.0%	0.516	0.872	0.576–1.319
		36–45	21.6%	0.202	0.746	0.476–1.17
		≥46	24.0%	Reference		
Born in the IDP camp		No	76.5%	0.000	2.264	1.477–3.47
		Yes	23.5%	Reference		
Gender of head of the household		Female	35.1%	0.717	1.063	0.765–1.477
		Male	64.9%	Reference		
Level of education		No Education	76.6%	0.426	2.349	0.287–19.241
		Primary	18.4%	0.259	3.394	0.406–28.373
		Secondary	4%	0.251	3.667	0.399–33.715
		Higher education	1%			
Family size		≤ 3	9.4%	0.086	0.567	0.296–1.085
		4–7	38.1%	0.019	0.587	0.375–0.917
		8–11	36%	0.216	0.757	0.486–1.177
		≥12	16.5%	Reference		
Duration of displacement		≤ 2	9%	Reference		
		3–5	24.8%	0.027	2.174	1.09–4.334
		6–8	15.1%	0.008	2.658	1.289–5.483
		9–11	9.1%	0.321	1.518	0.666–3.46
		≥ 12	18.5%	0.004	2.789	1.378–5.646
Displacement type		IDPs	82.1%	0.209	1.337	0.85–2.105
		Neither	2.3%	0.583	0.693	0.187–2.565
		Returnee	15.6%	Reference		
Reason of displacement	Poverty	No	78.8%	0.377	1.184	0.814–1.722
		Yes	21.3%	Reference		
	Infrastructure	No	99.4%	Reference		
		Yes	0.6%	0.732	1.464	0.163–13.171
	Catastrophe	No	81.6%	0.169	0.761	0.515–1.124
		Yes	18.4%	Reference		
	War	No	74.4%	Reference		
		Yes	25.6%	0.000	2.338	1.665–3.285

(Continued)

TABLE 2 (Continued)

			%	*P*-value	cOR	95% CI
Work/Employment	Tax	No	98.0%	0.469	1.595	0.45–5.655
		Yes	2.0%			
	Farmer/fisher/header	No	99.2%	0.581	1.832	0.213–15.776
		Yes	0.8%			
	Skilled	No	86.3%	0.34	0.804	0.516–1.253
		Yes	13.7%			
	Casual Labor	No	68.4%	0.27	0.828	0.592–1.156
		Yes	31.6%			
	Housewife	No	68.3%	0.88	1.026	0.731–1.441
		Yes	31.7%			
Do you know the place you are currently living?		Charity	15.9%	0.365	1.248	0.773–2.014
		Occupy	25%	0.000	2.469	1.679–3.632
		Rent	17.4%	0.801	1.063	0.659–1.714
		Own	41.8%	Reference		

he has registered for aid benefits, he did nothing. So we were overlooked that way." Another woman in Garowe said, "The camp manager is a bad man he treats people unfairly and with discrimination. When there is assistance, he gives everything to his close relatives."

In short, those displaced to areas where their clans were already present are more likely to find social and economic support, which facilitates integration. Those with few or weak clan affiliations are more likely to struggle. The relationship between clan and citizenship emerges in formal and informal ways. One woman in Garowe told us that as someone from a minority clan in the region, it was more difficult to seek justice and protection: "While we were in Mogadishu we were treated as equals, now we are treated as inferior. If you have an altercation with some girl, all the others from the area would gang up on you and say that you are not from here, so in that instance, Garowe is worse. So if we have problem with someone here, we just let it go, we can't go into conflict because people would gang up on us." Even those in areas where their clan is present do not share uniform experiences. One participant shared the abuse and discrimination he and his children had experienced in their home village. The interviewer asked, "Didn't you have any family or relatives who could defend or help you? Are you not from this area?" The participant confirmed that he was from the area, but no one from his clan offered any assistance, and instead he was accused of being a terrorist and a member of Al Shabaab. Therefore, while recognizing the importance of clan affiliation, we urge caution in oversimplifying what are complex and intersectional relationships that interact with race, class, age, and other factors.

Race is also a salient marker of exclusion from full foundational rights in Somalia, particularly for *Jareer* or Bantu Somalis. While this group is not subject to the same degree of violence and outright hostility, they still face discrimination, and intermarriage is still extremely rare between *Jareer* and those within the Somali clan lineage structure. This racialization gets further entrenched through IDP labels and exclusions (Bakonyi and Chonka, 2023).

Facilitators

Ager and Strang identify "facilitators" as sites of intervention to facilitate or constrain integration. They establish language/cultural knowledge and safety/security as the two facilitators in their research. These facilitators are closely aligned with notions of rights and citizenship for internally displaced people. A woman in one of the Kismayo camps explained that familiarity with the land and culture, and the fact that she had relatives and friends living there, made it an attractive location. When we asked a male interviewee, originally from Kelafo, Ethiopia if he considers himself to be displaced, he told us, "At first, yes; now, no, because I'm in one of Somalia's regions. I am Somali. These people who reside here are Somalis. They don't speak a foreign language; we speak Somali. Today, I believe I am in Somalia and that I am a Somali boy. I came from my region and arrived in my other region." As mentioned, in the methodology section, most of the interviews were spoken in Af Maxaa Tiri Somali rather than Af Maay Somali. While this language difference did not factor significantly in our study, Bakonyi and Chonka (2023, p. 154–156) found significant exclusion and discrimination in Mogadishu and Bosaso toward Maay Somali speakers.

Many interviewees in Garowe highlighted the relative peace and stability of the region as a key factor that attracted them. One man commented "we chose Garowe because it was very peaceful, also many government and international agencies are based here. We also chose it for education and health services. Also, we chose it because we can work and earn a living in peace. We got most of those things." Security, safety, and peace were frequently referred to as an absence of conflict or crime, but also in reference to security of land or housing, as discussed in more detail below.

TABLE 3 Association of person plan to leave and the socio-demographic characteristics.

		P-value	aOR	95% CI
Residence	Garowe	0.002	0.479	0.304–0.755
	Kismayo	Reference		
Gender	Female	0.008	0.59	0.400–0.871
	Male	Reference		
Age group	≤ 25	0.129	0.637	0.355–1.141
	26–35	0.614	1.143	0.68–1.919
	36–45	0.771	0.924	0.543–1.573
	46	Reference		
Family size	≤ 3	Reference		
	4–7	0.817	1.092	0.516–2.313
	8–11	0.854	1.075	0.499–2.316
	≥12	0.799	1.114	0.485–2.562
Duration of displacement	≤ 2	0.053	0.461	0.211–1.009
	3–5	0.303	0.756	0.444–1.287
	6–8	0.637	1.144	0.654–2.003
	9–11	0.659	0.857	0.431–1.703
	≥ 12			
War	Yes	0.049	1.494	1.001–2.231
	No			
Do you know the place you are currently living?	Charity	0.990	0.996	0.566–1.756
	Occupy	0.000	2.384	1.515–3.752
	Rent	0.081	1.736	0.934–3.228
	Own	Reference		

Social connections

In Somalia, the notion of a shared religion, language, and set of cultural values are often cited to illustrate relative homogeneity (Elmi and Barise, 2006), however, this perception risks overlooking the challenges faced by IDPs. Ager and Strang (2008, p. 177) describe social connections as the "connective tissue" that mediates between foundational principles and public outcomes such as health, employment, housing, etc. This biological metaphor is apt in this context, where the "connective tissue" was most frequently understood in relation to ideas of family, blood, and clans. Ager and Strang (2008) distinguish forms of social connections as relationships with (i) family and/or those with shared values, such as religious or ethnic groups (social bonds), (ii) "other communities" (social bridges), and (iii) structures of the state (social links). However, in this research we found that clan belonging, or "social bonds" was thread throughout all aspects of the conceptual framework.

As noted above, Somali ethnicity, citizenship, and clan belonging are tightly interwoven. This profoundly impacts how people access services, seek livelihoods, and understand themselves as integrated (or not). Many participants told us that they had received food, money for bus fares, or offers of free transport or temporary accommodation from strangers during displacement journeys. These acts of charity are commonly seen as a cultural and religious requirement among our participants, all of whom are Muslims. Close family or wider clan ties would enhance the expectation that people should provide support. As such, the notions of "social bonds" and "social bridges" are hard to disentangle, as the notions of "family" and those with shared values are expansive categories that blur into "other communities" in terms of religion and geographic location. Many interviewees expressed a reliance on family to pay for healthcare. One female participant told us that she and her husband are both physically disabled and live with and rely on their adult daughter for care and support, highlighting the role of such relationships in physical and emotional, as well as material support. Interviewees suffering from ongoing illness or injuries frequently mentioned the absence of kin or community who might provide or pay for care. In such cases they either expressed a lack of connections, or only had family facing similar levels of destitution. Ager and Strang's concepts therefore may not appear readily applicable in this context, however they illuminate the extent to which contextual notions of kinship and belonging are interwoven in diverse sets of relationships. Furthermore, they allow us to interrogate how gender, clan, and socioeconomic status can shape the extent to which bonds, bridges, and links bleed into one another.

Our interlocutors suggest that social bonds within a community are also shaped by gender; noting it was often women who organized financial collections for medical care, or that women more actively maintained social networks and communication. One female IDP in Garowe said, “Women are closely connected and have constant communication. You should have seen us yesterday, all of us have been in one house. People do talk to each other, they check on each other, they visit each other but they can’t offer much help to each other, because they are in the same situation.”

Relationships with the state (social links) are similarly shaped by clan affiliation. The “4.5” power sharing of the Somali government (parliamentary and cabinet) means that the representation is distributed to the four large clans: Darood, Hawiye, Dir, and Rahanweyne, while 0.5 is assigned to the minority clans. In Puntland and Jubaland there is no such formula, however, political seats allocated for each sub-clan. Members of Parliament act as gatekeepers to opportunities such as employment. During social connections workshops, residents in Bilan expressed that they have local parliamentary representatives because they are from major clans in Puntland. Conversely, IDPs in Shabelle and Jilab are largely from southern Somalia and have not had political representatives in Puntland historically.

Levels of integration are not entirely determined by clan membership, however. For example, connections to the state for IDPs outside of the dominant local clan structures are evolving through democratization. IDPs were allowed to vote in Puntland’s first “one-person, one-vote” local elections. This brought politicians to displacement settlements seeking votes and promising development projects and services and greater recognition for IDPs. The election even saw IDPs elected to Puntland’s regional parliament (Mohamoud, 2023). The election means that the concerns of *barakac* from outside Puntland and non-members of powerful regional subclans have some degree of representation of their interests locally. While there were some controversies, fighting, and postponed votes at this election (Al, Al), this event demonstrates that social connections to the state (social links) may be possible for IDPs beyond traditional clan connections. Although it is too early in this process to see what tangible effects there are beyond electioneering promises made by politicians, the distinctions between social connections and foundational rights and citizenship may become more fluid over time. Displaced people outside of dominant clans may feel empowered to make stronger rights claims as voting citizens. Any social connections, whether bonds, bridges, or links, are crucial in acquiring the “stuff” of markers and means: employment, housing, education, and health.

Markers and means (employment, housing, education, health)

Employment

Access to livelihoods plays a crucial role in causes of displacement, motivations for relocation, and capacity to settle in new locations. As such, employment has been the most extensively researched domain in the field of integration (Castles, 2002). In essence, access to money can buy the other markers and means of housing, education, and health. Indeed, as other researchers, those in Somalia with the financial means and strong social connections never live in camps but rather integrate into cities and do not make it into a study such as ours [Research and Evidence Facility (REF), 2018, p. 40]. However, for most of our informants living in camps, lack of access to livelihoods was the principal cause of their displacement and daily struggle. Many participants commented on how drought and conflict had impacted their crops, livestock, and capacity to meet their basic needs. One man stated, “I was a pastoralist, I farmed and I herded livestock. I fled recurrent droughts, civil conflict and lack of basic social services.”

Many say that Garowe and Kismayo offer far more employment opportunities in comparison to their former rural villages and towns, which have been devastated by war and drought. However, many lament that recent years have seen struggling economies, particularly for those living in displacement settlements. Our study revealed that the majority of IDPs are engaged in casual and domestic labor, accounting for 31.6 and 31.7% respectively. In contrast, only 13.7% of IDPs are involved in “skilled” work (such as nurses, musicians, and artists), and only 0.08% are working in Somalia’s production sector, which includes fishing, farming, and animal rearing. Our qualitative data shows that IDP communities lack qualifications and skills to enhance their employment.

Labor in the cities is highly gendered as well. In the Garowe and Kismayo, men largely found employment on construction sites while women were more likely to perform domestic labor, including laundry services, garbage collection and working as housemaids. In Kismayo, a small number of women also worked in construction. A female IDP elaborated on these gender differences: “Women mostly depend on their children who go to work in the cities, there are many girls who want to work but don’t have places to go to work.”

The growing cities, which have been infused with global capital and labor, have made the work situation for men and women worse in recent years. The relative stability of Garowe has resulted in a growing construction industry, attracting companies and workers from abroad, resulting in far greater competition for employment, significantly reducing job opportunities for IDP men in particular. One male participant in Shabelle explained these challenges: “I was a young man and there were droughts (. . .) The people there were farmers, and there is drought, there is no work at the farms, and you become worried once you have no job and you leave.” He continued, “Normally you stay where you can get work and live it. I did not get that vibe in Beledweyne. Now that I am in Garowe, it is better in terms of my livelihood.” Despite these positive comments on the possibility of earning a living in Garowe, he later reflected: “Here in Garowe, I work as a mason in construction, and it is not reliable, we have no job security, we get work 1 day and the other day we can’t (. . .) recently there are foreigners who work in the construction business, such as Bangladeshis and others from African countries. Before there was no such competition, and the work was 90% reliable. So, nowadays livelihood is not reliable as before.” Another man in Shabelle similarly commented,

> In Garowe, the livelihood has changed in the last few years. In the past we had ample work opportunities, and we used to earn a good daily wage up to 100,000 Somali Shillings. But now the living cost has increased, and the work opportunities have decreased. This is caused by many foreign workers who came to the town. The construction business is dominated by companies and such companies hire foreign workers. If you go through the camp, you will see hundreds of skilled youths who can't find work.

As noted for housing, the clans and nepotism played similar roles in determining livelihoods and wider economic support, but only when it comes to higher paying levels in government, NGOs, or businesses. An example of this includes the Rahanweyne in Garowe as mentioned earlier. Clan connections allow displaced Rahanweyne to mobilize resources to travel large distances to Puntland, bypass camps, and find well-paying jobs from their kinship ties. Alternatively, most IDP sites act as labor reserves full of low-paid casual laborers, which are exploitable and competition for jobs is fierce. However, unlike in other cities in Somalia (Al, Al), clan connections were less important in obtaining these precarious jobs. Access to employment was a particularly important factor in people's desire to leave the camp for those renting (rather than owning or occupying) their accommodation, as the inability to pay rent put them at high risk of eviction.

Housing

A crucial area of chronic instability and a key obstacle to integration is the insecurity of housing and the persistent fear of eviction. One woman in Garowe stated, "We are not the owners of the land; it belongs to the local people. It's a challenge when they tell us to leave; we have nowhere to go." Similarly, a woman in Fanole camp, when asked if she considered herself an IDP she replied, "Yes, because this is not my land. If you are told to move, we will. This land belongs to other people who allowed us to build. They can evict us anytime of their choosing." Although they did not explicitly say so, these comments relate to the power that comes from connections to clans in power at the area of displacement. This is evidenced by the privileged displacement site of Bilan. Due to clan affinity in government, these people displaced by the tsunami were quickly granted permanent land and housing, which they have leveraged to full integration into Garowe.

Housing has a direct impact on IDPs' physical, emotional, and mental wellbeing, as well as their capacity to feel "at home." Physical size, durability of materials, and ownership are all markers of appropriate housing, but people frequently talk about the social and cultural importance of housing (Ager and Strang, 2008, p. 171–172). Ownership emerged as an acute concern and many participants expressed a desire to acquire property on which to build modest houses. Our surveys reveal that those who live in rental houses are 2.093 times more likely to be planning to leave due to their inability to pay monthly rent. Similarly, people who occupy their homes but do not pay any rent are 1.770 times more likely to say they are planning to leave compared to the people who own their houses. In the qualitative data, participants emphasized the significant role of housing in their lives, identifying it as one of the reasons for self-identifying as "displaced." One participant explained, "I have no shelter. I live in another man's land, where I built a tent. My condition may have improved, but still, I am an IDP because I don't have permanent shelter. I have no land or a house to my name."

Even those who had lived in cities for a long time continue to feel displaced, owing mostly to inability to own a house and land. This article does not have the space to analyze the complex idea of "home." A quote in the "Foundations" Section shows that some feel at home simply by being in Somalia, while other displaced people often spoke of the feeling of displacement being tied to the quality of physical structure they live in. One participant in Shabelle told us "I live in a makeshift shelter. I can't live in the town. I can't afford to live there. If Puntland government—since I lived here for 25 years—gives me land where I can build a home, then I would not consider myself as an IDP." Participants drew attention to the relationship between their status as IDPs, their persistent lack of secure accommodation, and their grievances regarding the resettlement process as demonstrated by this elderly man in Jilab:

> This housing project was built by the Faroole administration. It was given to someone, and now it is owned by someone else. I asked some man I know to allow me to live in this house because I can't pay rent. He gave me the house. I pay him when I could. He calls me sometimes and asks for his rent. I tell him sometimes that I don't have anything. So, in general, we are IDPs. We have nothing. We live in tough conditions. But still, thank God for everything.

The daily experience of persistent eviction threats was a primary cause for IDPs to contemplate leaving. Specifically, in IDP camps in Garowe such as Shabelle, where an informal agreement has been in place between private landowners and the municipality, the value of the land has grown exponentially. This further contributes to the eviction demand of the landlords as explained by a woman there: "We have settled down here after all of the challenges we faced. We now have challenges in the land where we reside. We are urged to leave because the owner of the land died and now it belongs to the orphans and they want to share their inherence."

Such accounts clearly differ from those IDPs who have been provided with housing. Many of these demonstrate a heightened sense of belonging to the community and no longer see themselves solely as IDPs. One woman in Jilab told us, "After a house was built for us, now I feel like I'm at home. We are Somali people living in our land. I see no problem." Similarly, another woman in New Kismayo stated "Before I was an IDP, but, since I got this room, I believe I am no longer a displaced person. And I feel blessed."

Education/health

Education and health are important markers and means of integration for our informants, however, we group these categories together because we did not find these services as primary drivers for people's decision to stay or remain in the displacement sites, apart from returnees from Kenya who experienced quality education in refugee camps. This resonates with Phillimore and Goodson's (2008, p. 318–319) findings, which notes, "the issue of health was only really a concern to those individuals who had some kind of health problem and, in that respect, it is a latent need that is not considered until respondents experience a problem". Moreover, unlike the other markers and means, clan dynamics did not contribute directly to accessing education or health resources, but rather individual households mobilized their own kinship and clan-based networks for money contributions for education and health purposes.

Our research shows that a significant proportion (76.6%) of IDPs lack access to formal education due to their origins in rural and nomadic areas where the education system is poorly functioning or non-existent. As such the informants generally had positive things to say about education amidst displacement. All five study areas possessed schools, although there were notable differences in terms of capacity and educational quality. For instance, in Garowe, Shabelle and Jilab have primary schools that reaching grade 7 in the Somalia education system. However, to complete grade eight, students had to transfer to schools elsewhere outside the camp. In Kismayo, the educational landscape varied significantly. The New Kismayo area boasted a fully functional primary school, while Fanole informal camp had a smaller makeshift single hall primary school. As with housing, interviewee pointed to the importance of money in having a quality education beyond basic primary school:

> While in Kelafo, we lived in the countryside, the education was poor, but if children were taken to the town they got better education, even better than here. Here in Garowe, education is very expensive, the textbooks are very expensive. So, you can't afford to get educated. If a single child goes to education, he is charged $40 for tuition, and she is in 8th grade, if you don't pay the child is thrown out of school. So, education has become unaffordable.

Health concerns were also prominent in our qualitative data, and like in the quote above, participants actively associated their ill-health with the stresses of displacement, including inadequate housing, lack of employment, and the limited access to nutrition and affordable healthcare. One participant in Garowe commented that, "diseases are caused by social problems, stress, poverty and lack of stable life."

The health system in Somalia has been characterized as, fragile, underfunded, insufficient and inefficient, although there have been gradual improvements in health systems strengthening and expanding access to health care in recent years (WHO, 2010). In line with the Somalia government's official health-service priorities under the Essential Package of Health Service 2020 (EPHS)—which was designed to address healthcare needs of vulnerable populations including IDPs—there are health centers in every settlement, which provide primary health service including maternal and child health, nutrition, and outpatient services. Similar to the responses on education, many participants stated that they had very little access to health services prior to displacement (apart from those fleeing from Kelafo town in Ethiopia where the government provided more education and health services) and healthcare and camps were seen as an improvement. A man in Shabelle told us, "Here is a good place for children's education and health. MCH [maternal and child health] is also found here. And if you take the patients to a general hospital, they are accepted. Education and health care are better than where we were displaced." Some IDPs identified previous healthcare barrier as the reason for their displacement, including a woman in New Kismayo who stated, "I got so sick in Umbareer [southern Somalia] and then I was brought here [Kismayo]." However, healthcare, like education, comes at a cost as this quote from a woman in Jilab indicates: "Here you must pay for everything, and you don't have money every time. Even if you need a match you must buy, debt is not allowed nowadays, the situation is very tough." Another woman commented "Garowe is the best in terms of health care availability, because here medications are available, although it is paid for by the patient. However, in terms of doctors, availability of medications, and quality of health facilities, Garowe is the best."

Social connections again emerged as highly important, as family or wider clan members frequently contribute to payments for healthcare and offer guidance on where to seek help. Notably, women were more likely than men to comment on the importance of education in interviews, indicating the gendered aspects of displacement and integration. The impact of a lack of local social connections was apparent when people tried to seek assistance through formal camp structures, as demonstrated by one female participant in Garowe. When asked about seeking healthcare, responded, "It is required for the camp manager to connect you with those organizations; I doubt he would do so for me."

In contrast to this discussion above, those who repatriated to Kismayo from Kenya uniformly spoke of better education and health in the refugee camps in Kenya. As one woman in Midnimo noted, "This country is my country first and there is nothing better than a person's country, but life and education were good for us where we were (refugee camp in Kenya)." Even though the returnees have better housing than most IDPs in New Kismayo, some of them still prefer to go back to refugee camps largely due to better access to education. As one woman declared: "Yes, if there was a chance to go back, I would have gone back because there were very good education opportunities for the children there. I even wish to go back because of that." Others reported that they had left their children in the refugee camps to complete their education. Returnees reported similar experiences about healthcare in Kenya as one woman shared: "Kenya was better in terms of health and education (…) I am in my country, and we have to pay money for the schools and health services." Although education and health clearly impact the experiences and future opportunities of displaced people, apart from some returnees, these were not the most motivating factors people cite as reasons for wanting to leave.

Conclusion

Focusing on five formal and informal sites of displacement across Garowe and Somalia, this article joins the growing chorus calling for an expansion of understandings of migrant and refugee integration beyond the Global North. We engage with the influential domains of integration framework categorized by foundation, facilitators, social connection, and markers and means introduced by Ager and Strang (2008). Our contribution builds on yet nuances these debates by including internally displaced migrants (including Somalis crossing the Ethiopian-Somalia borderland) and refugee returnees—groups that have not been part of integration discussions. Furthermore, we conjoin integration literature, which often runs parallel to, rather than in conversation with durable solutions and local integration debates from the academic and policy field of forced migration. Similar analysis could be done in other Global South contexts to comparatively reflect on the efficacy domains of integration have in other situations.

From these analytical efforts, we argue that domains of integration is a useful framework to understanding processes of integration for displaced people in Somalia, yet we agree with recent critical research that integration in the Global South blurs and collapses across Ager and Strang's (2008) integration categories. This requires a renewed understanding of the relationship between citizen and state (Landau and Bakewell, 2018; Abdelhady and Norocel, 2023). While Somalia is often epitomized for state failure or collapse, Kismayo and Garowe have experienced relative stability and state building progress. Moreover, despite Somalis sharing common language, culture, and religion, control over the decentralized municipalities and federal states of Jubaland and Puntland remains largely influenced by clan politics. Thus, Ager and Strang's framework is useful in mapping how clan networks, which cut across bridges, bonds, and links in the social connection domain also holds significant power and salience over the foundation (rights and citizenship) and markers and means (employment, housing, education, and health) of society. Hovil and Maple (2022) argue for the centrality of citizenship in ensuring the durability of local integration. However, durability for internal displacement requires an understanding of citizenship in relation to clans and area-based belonging, which differentiates access to foundational rights and key markers such as employment and housing—the primary drivers influencing people's decisions to stay or leave IDP settlements.

This case study offers key policy insights for the protracted nature of displacement in Somalia and beyond. Across all sites, access to health and education are limited to the basic level, where higher incomes are required for specialized care and further education, which are an improvement for most displaced from rural areas. As such, healthcare and education does not significantly factor in their decision stay or go. For returnees from Kenya, however, these services are vastly degraded compared to the Kenyan refugee camps, which makes some long for a return to these opportunities. One of the most durable markers to stay was based around housing and land.

The sites of Fanole in Kismayo and Shabelle in Garowe suffer from informality and precarity, which diminishes their prospects of integration. As "outsiders" to the local clan structures, Fanole and Shabelle IDPs were allowed to be occupiers of privately owned land and are now facing eviction due to the rising value of land through rapid urbanization. Due to lack of stable housing or strong clan connections, many informants expressed still feeling displaced, despite residing there for many years. Alternatively, residents of Bilan, in Garowe displaced by tsunami, tapped into clan networks in the government acquiring permanent housing and land rights. Residents of the first Jilab camps were also given housing and land like Bilan, but many complain that camp leaders ensured non-displaced local clan members were given some of the homes. Moreover, many residents of Jilab and Bilan have since integrated into the city and now rent to newly arrived IDPs who are at risk of eviction due to lack of employment and ability to pay rents. Midnimo, or New Kismayo, with heavy financial and logistical investment from international donors, shows that durable solutions can transcend clan salience by ensuring land and housing rights in a well-connected part of the city. This approach must be cautioned, however, as a similar scheme in Kismayo, Luglow, due to its lack of spatial integration to the city, has been far less successful thus far. This shows that international donors have a role to play beyond recurrent humanitarian subsistence, although it is costly and requires buy-in from the local government.

Looking forward, prospects for integration will remain fluid. Land values are likely to increase across the country if stability endures, which will likely lead to further evictions displacing new settlements further to the outskirts of the city, especially for those from outside the clans in power. Urbanization is also globalizing cities such as Garowe, which makes finding employment among IDP camp "labor reserves" increasingly difficult due to the arrival of foreign companies and workers accepting lower wages (Bakonyi, 2021). On the other hand, democratization in Puntland has seen IDPs elected to local parliament and makes IDPs without local clan affiliations a potentially power constituency worth courting. In this sense, we find it important to remember that integration is a process and not a measurable endpoint, and that the durability of protection will be dependent on stability across the integration domains.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by the University of Edinburgh Research Ethics Committee. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

MA-S: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Software, Supervision, Validation, Writing—original draft, Writing—review & editing. CB: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing—original draft, Writing—review & editing. AB: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing—original draft, Writing—review & editing. LL: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Supervision, Writing—original draft, Writing—review & editing. SM: Conceptualization, Investigation, Methodology, Project administration, Supervision, Writing—review & editing. AJ: Conceptualization, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing—review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Perceptions of health: (dis)integration and (mis)integration of refugees in Nairobi, Kenya

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This article utilizes 40 in-depth interviews of healthcare workers (HCWs) including Kenyan nurses, medical doctors, psychologists, pharmacists, refugee NGO officers, and others based in Nairobi who come in professional contact with Congolese and Somali refugees on a regular basis. They were asked to describe barriers to healthcare, care seeking behaviors, and pathways to care that refugees experience. These responses are juxtaposed with 60 life-history interviews, exploring the same topics with Congolese and Somali refugees living in Kawangware and Eastleigh estates. In short, this article argues that refugees and HCWs have a shared understanding of the barriers to healthcare for displaced people, such as poverty, refugee documentation issues, and inadequacy of Nairobi's healthcare system for marginalized populations. However, there is a significant disconnect in perspectives for how healthcare integration should take place regarding major causes of ill health, such as malnutrition and poor hygiene. Refugees understand oppression as a primary structural determinant of health, whereas many HCWs take an individualized view, advocating for modifications of knowledge and behaviors of refugees rather than adjusting structural issues. This is reflective of larger processes, whereby refugees are actively "(dis)integrated" by state and society and are observed by many Kenyans as "(mis)integrating," or integrating "wrongly" or "badly," which has major implications for how to shape possible policy interventions.

KEYWORDS

Nairobi, refugees, Congolese, Somalis, barriers to healthcare, perceptions of health, structural determinants of health, integration

Introduction

Kenya is currently hosting nearly 600,000 refugees and asylum seekers[1], though these numbers are indefinite estimates. Most refugees reside in two camp complexes—Kakuma and Kalobeyei in the Northwest and Dadaab in the West, while an estimated 100,000 refugees reside in urban areas.[2] Despite the long-running encampment policy of the country forcing

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[1] For shorthand, we will use the term refugees, despite many displaced many individuals in Nairobi having asylum-seeker status or being undocumented altogether.

[2] https://data.unhcr.org/en/country/ken

refugees to live in camps since the 1990s, thousands have left the camps, or bypassed them entirely, due to the lack of economic and educational opportunities or escape the violent containment of encampment (Brankamp, 2019) to make their way to Nairobi, where there are more options for livelihoods and healthcare. Focusing on Congolese and Somali refugees residing in Nairobi, in a context where refugees have been actively excluded through securitized and punitive refugee policies, this article explores multifaceted processes of integration through the prism of healthcare.

The question animating this inquiry is how integrated into the healthcare system are refugees? Because integration is simultaneously done *by* and *to* refugees, we examine this process by analyzing the care-seeking behaviors and perceptions of causes of ill health among Nairobi refugees as perceived by refugees and frontline Kenyan healthcare workers (HCWs) as one key interlocking component of integration. In short, this article argues that refugees and HCWs have a shared understanding of the barriers to healthcare for displaced people, such as poverty, refugee documentation issues, and inadequacy of Nairobi's healthcare system for marginalized populations. However, there is a significant disconnect in perspectives for how healthcare integration should take place regarding major causes of ill health, such as malnutrition and poor hygiene. Refugees understand oppression as a primary structural determinant of health, whereas many HCWs take an individualized view, advocating for modifications of knowledge and behaviors of refugees rather than adjusting structural issues. Speaking with the literature of migration and integration, we argue that refugees see themselves as systematically "(dis)integrated" from healthcare (Collyer et al., 2020), whereas HCWs see refugees by what we term as "(mis) integrated" or "wrongly" integrated due to their behaviors or lack of understandings. These perspectives of (dis)integration and (mis)integration mirror longer histories of migration and exclusion of migrants and refugees in Nairobi and xenophobic perceptions of the Kenyan host society.

Through surveys, in-depth interviews, and life histories, we ask refugees and HCWs what they perceive to be the primary causes of ill health, the rationales for care-seeking strategies, and the largest barriers to finding adequate care. This article is divided into five main sections. First, we outline the methodology of the project. The second section has two subsections, which provides context of the refugee situation in Kenya and Nairobi, including refugee policies and backgrounds on Somali and Congolese refugee populations, in particular. It introduces the myriad barriers refugees face to access the healthcare system in Nairobi. Third, we briefly analyze theories of integration. We argue against an individualized, outcome-based usage of integration; instead of using novel terms (dis)integration and (mis)integration, we make the case that integration is best understood as a structural process, where refugees negotiate and contest normative notions of how one "should" integrate. The fourth section expands on the integration arguments by empirically comparing refugee and HCW perceptions on health. We contend that refugees understand structural marginalization, or (dis)integration is a primary driver of health, whereas many HCWs see refugees (mis) integrating or integrating wrongly through individual actions or lack of knowledge on hygiene and malnutrition. The concluding section synthesizes the data through the prism of integration and possible policy considerations.

Methodology

This study is a part of a wider project exploring displacement and health at the intersection of gender for displaced Congolese and Somalis in DRC, Somalia, Nairobi, and Johannesburg, South Africa. While many nationalities reside in Nairobi and Johannesburg, Congolese and Somalis were the two largest populations in both locations, which offered the opportunity for comparative analysis across all sites. Moreover, Congolese and Somalis differ socially and culturally in that Congolese are majority Christian and Somalis are majority Muslim, with both speaking different first languages. In Nairobi, Kawangware and Eastleigh were chosen for the high number of Congolese and Somali refugee residents, respectively. Data collected for this research included quantitative and qualitative methods—although this article primarily engages with qualitative interviews. Participatory "social connection"[3] workshops were used to explore what people, organizations, or institutions displaced people turn to when experiencing disruptive mental health problems, physical pain, or sexual and gender-based violence (SGBV). The workshops created and distilled lists of the 30 most relevant social connections, which was followed with a survey of 886 individuals older than 18 years (roughly half participants having Kenyan citizenship) using Kobo Toolbox on mobile devices. The survey collected basic demographic information and asked the participant their level of trust, amount of contact, and frequency of reciprocal help they have given to each of the 30 social connections.

At each survey, the participants were subjectively evaluated by research assistants (RAs) on a subjective five-item scale determining their cooperation and eagerness for engagement in future in-depth interviews. In total, 60 participants (30 Somali and 30 Congolese) scoring 4 (high) or 5 (very high) were selected and consented to give in-depth life history interviews. The informants were asked to describe their displacement and health histories, what they thought caused ill health, care-seeking behaviors, and barriers to care. After difficulty accessing informants, interviews were conducted in health clinics with the support of community health volunteers (CHVs). This gatekeeping likely biased the sample as the participants were at least in some contact with these volunteers and/or clinics and would likely be of lower income than those who access private clinics and do not necessarily represent the experiences of all refugees.

Additionally, 40 key informant interviews were conducted from the list of social connections created from the workshops. These individuals included Kenyan HCWs such as nurses, medical doctors, psychologists, pharmacists, from private and public facilities, and refugee NGO officers who come in regular contact with refugees. To aid in building trust and facilitating communication, the interviews were conducted in the preferred languages of participants such as Somali, French, and/or Swahili by research assistants (RAs) who were Congolese nationals, ethnically Somali (some had refugee status and others had Kenyan citizenship), and one non-Somali Kenyan who spoke Swahili and Arabic. All interviews lasted between 30 min all the way to an hour and a half. Interview data were audio recorded with consent and translated and transcribed in English. The data were

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[3] See Strang and Quinn (2021) and Boeyink et al. (2022) for more details on these methods.

coded and analyzed using TAGUETTE software. The codebook was agreed upon by the research team, and two RAs coded using various themes, such as certain health conditions, types of barriers to healthcare, types of healthcare providers, causes of illness, livelihoods, documentation, and many other relevant themes. Review of the coding by the authors informed the arguments of this article.

Ethics was approved by [University 1], [University 2], and Kenya's National Commission for Sciences, Technology, and Innovation (NACOSTI). Each researcher participated in training on ethics and safeguarding. All participants were read, provided, and consented to information sheets and promised confidentiality. Finally, in consultation with a psychiatrist, the research teams were trained how to sensitively approach potentially distressing research and set up processes of support, or mental health first aid, to cope with difficult research. Although the interview guide did not contain questions dwelling on potentially distressing personal experiences, some participants shared painful stories. As such, a referral pathway was set up for intense distress. Counselors of NGOs were made available for participants who felt the need for counseling or psychological support. Many of these painful stories recounted by the informants stem from the marginalization they face by the Kenyan state and society, which is outlined in the following section.

Displacement and health in Nairobi

Since the 1990s, the Democratic Republic of Congo (DRC) and Somalia have been plagued by major wars and long-simmering conflicts exacerbated by poverty and natural disasters, leading to the displacement of millions to Kenya and surrounding countries. Kenya, like other East African countries such as Tanzania, received such large numbers of displaced people, which resulted in instituting a highly securitized encampment policy, where refugees do not have the right to free mobility or formal employment outside the camps. While previously administered by the government and Kenyan organizations, camps came to be governed and managed by the UN High Commissioner for Refugees (UNHCR) and other international organizations and NGOs (Kagwanja, 2002; Milner, 2009). This segregation is a key example of "(dis)integration" of refugees in Kenya, which will be further examined below.

Despite this prohibition of refugee movement, thousands of refugees have moved to Nairobi, pushed out by poor camp conditions, and drawn by possible livelihoods and freedoms of the city. Refugees have historically been required to live in camps; however, because such large numbers of refugee have migrated to Nairobi, this population is locally tolerated to a degree, which causes legal ambiguity and barriers to integration. This is a prime example of "(mis)integration"—the processes in which refugees integrate in ways contrary to what is desired by the Kenyan state and much of its population. Currently, refugees must register with UNHCR and the Department of Refugee Services (DRS), although this is a highly bureaucratic process that is time-consuming and costly. Many do not register or renew documentation, or their attempts are delayed or given up on altogether (Pavanello et al., 2010; Graham and Miller, 2021). There is some optimism for a change in direction for Kenya's refugee policy after the passage of the Refugee Act 2021, which is being described as the "Marshall plan of Africa" (Malik, 2023), though the implementation is still ongoing and it is unclear how progressive this policy will be in the end (Leghtas and Kitenge, 2023). These changes are not yet reflected in the Nairobi County Integrated Development Plan 2023–2028 (Nairobi City County, 2023).

Even with proper documentation, it is nearly impossible to acquire a work permit, which leaves the only possibility for livelihoods in the informal economy or through those with access to remittances abroad, resulting in highly precarious income. Most Kenyans also work in the informal economy, although there are at least pathways to acquire permits if they have the resources. This legal ambiguity has led to refugees in Nairobi, with or without documentation, to fall prey to predatory police services who solicit bribes. This is true for many Kenyans, although refugees and migrants face the elevated threat of detention and/or deportation.

Somalis have had contentious relationship with the Kenyan state and society since colonialism, which has resulted in suspicion, xenophobia, and periods of collective punishment (Boeyink, 2017). In essence, Somalis have a history of being both (dis)integrated by the state and (mis)integrating themselves into society in enclaved ways. One way this is manifested by Somali refugees, facing insecurity from Kenyan security forces, as mentioned above. In a sense, Somali refugees are an easy target for discrimination. First, many Somalis live in the Eastleigh estate, known as "Little Mogadishu" because it is an area of Nairobi where Somalis have resided for a long time (Campbell, 2006; Carrier, 2016). Second, we say this cautiously to not reify ethnic and racial stereotypes; Somalis in Nairobi are often believed to look identifiably different to most Kenyans due to particular phenotypical physical characteristics. Moreover, Muslim dress, especially the common headscarves of women, present aesthetic markers that stand out differently than Congolese and other non-Muslims. On the other hand, Congolese "blend in" as they are more dispersed across the city, primarily in informal settlements such as Kawangware. This population is more spread out because eastern DRC is more ethnically and linguistically heterogenous and fractured, and there is not a densely populated area such as Eastleigh from which people can settle in and find co-ethnic support.

Somalis and Congolese also differ significantly in their socioeconomic integration into Nairobi. One significant study found that while fare of Somali refugees similar to Kenyan citizens in terms of incomes and other metrics of wellbeing, Congolese outcomes are far lower than Somalis and Kenyans. However, incomes of Somali women are nearly half of that of Somali men in the refugee community, which shows how highly gendered vulnerability is in this context (Betts et al., 2018, pp. 16–20). Many people make their way to Nairobi without resources or the social connections they have severed upon arrival and for various reasons struggle to integrate economically (Boeyink, 2017). For example, a Congolese woman fled in 2014 due to a massacre occurring near her village. In the chaos, she was separated from her husband and boarded a lorry hauling lumber to Kenya with her 2-month-old baby. She did not know anybody when she arrived in Nairobi.[4] Similarly, a Somali woman described leaving Somalia with her grandmother to live in Nairobi. Shortly after arriving, her grandmother died and she bounced around living conditions until she was forced to marry a man at 19 years old. She is now economically dependent on this man but has no other reliable

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[4] Female Congolese refugee, Nairobi.

connections in the city.[5] The economic precarity demonstrated by these women and many other refugees is a key factor, excluding them from the healthcare system in Nairobi.

Refugees and healthcare

In the academic literature on refugee healthcare in Nairobi—from general overviews of refugee healthcare (Pavanello et al., 2010; Arnold et al., 2014; Jemutai et al., 2021; Mohamed et al., 2021); studies about access to mental health (Tippens, 2017; Mutiso et al., 2019); sexual, reproductive, maternal, and new-born health (Lowe, 2019; Lusambili et al., 2020); as well as following female genital cutting (Kimani et al., 2020)—there is nearly universal agreement about the main barriers to healthcare for refugees in Nairobi, which we build in the empirical section below. These obstacles include poverty, gaps in affordable healthcare services and supplies, refugee documentation, and discrimination. Issues of healthcare costs and poverty stand as the biggest impediments to care. One study shows that 95% of refugee participants citing costs as a barrier to accessing healthcare (Muindi et al., 2019). Arnold et al. (2014) importantly note that, apart from documentation and migrant discrimination, these barriers are also faced by Kenyans who do not have the means to pay for adequate care, which offers clear evidence of the structural inequality of the healthcare system. Despite the barriers to care, as Nairobi is one of the economic powerhouse cities in Africa, quality healthcare does exist. Moreover, there are free services offered by government clinics and hospitals as well as NGOs. However, this is a patchwork of care, which does not come close to reaching the myriad needs of such a large and marginalized population. One large study found that 43.7% of the study participants received help from an NGO, and only 12% of these had received medical support (Muindi et al., 2019).

As mentioned, there is an established base of literature clearly agreeing the gap in experience of healthcare refugees. With few exceptions shown below, however, most of this research do not ethnographically and qualitatively explore the everyday lived realities, perceptions of care, or healthcare pathways that refugees experience in trying to access care or choosing to abstain from certain services. Moreover, there is little discussion in this literature of the structural oppression as a determinant of ill health for refugees in Nairobi. Recent study in this special issue by McAteer et al. (2023) follows the medical pathway of a displaced individual as he navigates private and public clinics and his own personal networks to bring the inadequacy of services to life. This research shows that only well-resourced and connected individuals and families can navigate this complex terrain. Research by Lowe (2019) on maternal health of Somalis in helps illuminate the cultural disconnect between Somalis and HCWs in Nairobi. She explores the frustration and bafflement of policymakers and doctors when Somalis defy expectations such as leaving free healthcare in refugee camps to seek more quality care of private facilities in Nairobi or when Somali women refused cesarean births against medical advice.

Julie Tippens, building on conceptualizations of structural violence and vulnerability, is the most explicit in her critical stance:

> In the sociopolitical context of Kenya, in which urban refugees have become abruptly illegalized and peripheral, psychosocial wellbeing is contingent on navigating and negotiating health-promoting resources in a limited and ever-changing landscape. The exertion of violence against urban refugees in Kenya is indeed patterned; however, violence is enacted within a fluid environment: everything, from the enforcement of laws to the stability and composition of the household unit, is subjected to change. The only certainty is uncertainty, and this precariousness is the crux of structural vulnerability (2017, p. 1091).

We share the view with Tippens, adding that this structural marginalization is reflected also in poor nutrition and hygiene among refugees, which leads to poor health outcomes. We make the case below that perceptions of HCWs in Nairobi observe lack of information or awareness as determinants of ill health—mirroring the public health literature in this section—which minimizes structural oppression as drivers of illness. Furthermore, similar to the study by McAteer et al. (2023) and Lowe (2019), we take a ground-level view of refugee and Kenyan HCW perceptions to highlight disconnects in structural understandings experienced between these two groups. It is against this backdrop that we critically examine integration, where refugees are actively excluded spatially, economically, and socially. These exclusions profoundly affect access to healthcare, yet refugees find ways to make homes in ways contrary to the way the Kenyan state and society normatively deem acceptable.

Integration and care-seeking

Integration, (dis)integration, and (mis)integration

Integration is a complex, multidirectional process involving all aspects of society where migrants and refugees act to integrate themselves into a society (or not) and are simultaneously acted upon by actors and institutions within a society to be integrated (or not). The influential study by Ager and Strang (2008) notes that there are important "domains of integration," of which health is one of the many factors. This view, when operationalized into measurements of scales of integration, narrows the concept of integration as an individualized outcome. We hold the view with others that integration is a societal process rather than an end state (Collyer et al., 2020; Spencer and Charsley, 2021). In this section, we examine the attempt of one study to quantify integration and challenge its aggregation of domains of integration. We use this as a justification to focus on the processual exclusion of refugees from healthcare in Nairobi, which points us toward the concepts of (dis)integration and (mis)integration.

Beversluis et al. (2016) build on the framework by Ager and Strang (2008) on integration to create a 25-point "refugee integration scale" (RIS) using Nairobi as a pilot to test its validity and reliability. In their efforts, the scale asks 25 questions in the following domains of integration: (1) language and cultural knowledge (three questions); (2) safety and stability (four questions); (3) social bonds (one question); (4) social bridges (three questions); (5) social links (three questions); (6) employment (four questions); (7) housing (two questions); (8) housing; (9) health (one question); and (10) rights and citizenship (three questions). Each indicator is weighed four points for a total of 100:

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[5] Female Somali refugee, Nairobi.

> Through attempting to quantify integration on a scale ranging from 0 to 100, we do not intend to imply that there are absolute end points to either—that a person who scores 100 has achieved a clearly defined status of "fully integrated", an end point at which the process of integration stops. Similarly, a score of zero does not imply the lowest possible level of integration. Rather, we assign a number to an individual's level of integration, acknowledging that the absolute numerical value is arbitrary and has limited inherent meaning, but can allow comparisons between individuals and groups over time and place […] we have chosen to target this scale at an *individual's* level of integration. We do not target household or general community for responses, although an aggregate measure of individual responses may be useful in analysis (p. 118).

While this quote acknowledges the limitations of quantifying individualized integration, we argue that this framing obscures interlocking structural oppressions that refugees in Nairobi (and elsewhere) face in general. More specifically, its methodology inherently minimizes the importance of healthcare in processes of integration. For instance, the one question about accessing health states: "I am permitted to access health care services for me and my family just as easily as our Kenyan neighbors." First, the wording around "permitted" obscures *de jure* and *de facto* exclusion. As we demonstrate, refugees are "permitted" to access a range of health services that Kenyans are, but in practice are excluded based on costs and discriminatory practices. Second, having only one question on health minimizes the importance of wellbeing as an indicator of integration. For example, if someone suffers from ill health of a certain magnitude, this affects all other aspects of integration such as seeking livelihoods. From a policy standpoint, healthcare has also been deemed a priority for UNHCR and the Kenyan government, as evidenced by its inclusion in the CRRF as a key priority area and should be considered as a crucial component when conceptualizing integration (O'Callaghan et al., 2019). Moreover, as many questions ask refugee participants to compare themselves with their Kenyan neighbors, this also obscures the sociospatial aspect of poverty in Nairobi. Most refugees in Nairobi live in poor informal urban settlements, which exclude analysis of the spatial exclusions of estates and neighborhoods from other areas with greater access to wealth and power. While the RIS may be useful in diagnosing degrees of inclusion and exclusion, particularly when aggregated and compared across ethnicities and nationalities, this points to the causes of integration or analyses of power, which intentionally disintegrate certain groups.

To explore these dynamics of politics and power, we draw from the collection, *Politics of (Dis)integration* (Hinger and Schweitzer, 2020). They define integration as a "set of normative assumptions, practices, policies, and discourses that are always embedded in specific contexts and directed at particular groups or categories of people […]. The context and perceived desirability of integration of migrants and minorities ultimately depends on how they are categorized by the state in which they live" (Collyer et al., 2020, p. 2). Contrasting this, they use disintegration as a "coming apart of society," with the purpose of exclusion for certain groups: "disintegration policies and practices do not only overlook settlement but also actively set out to do harm and discourage it, although they are sometimes justified within a broader integration framework" (Collyer et al., 2020, p. 2). It is important to note that integration and disintegration are not merely opposites but co-constitutive of one other: "integration and disintegration are not a simple binary categorization but are intertwined in that the logic of one is always present in the other. This connection is sometimes explicit, often implicit but ever-present in migrant lives. We use the notation (dis)integration to describe this intertwining" (Collyer et al., 2020, p. 3). The (dis)integration of refugees in Kenya is clear through the policies of spatial segregation through encampment, the *de facto* enclaving of refugees in poor informal settlements in Nairobi, and the exclusion through documentation obstacles to accessing employment and healthcare.

Continuing this prefix wordplay, we introduce the term, "(mis) integration." Scholars exploring integration are often criticized for the normative connotations that integration brings. Policies and discourses of integration are often accused to normatively suggest what migrants and refugees *ought* to do or that they *should* assimilate to achieve a desired integration outcome (Spencer and Charsley, 2021). We take this conceptual fuzziness head on by adding the prefix, "mis-", which is a prefix meaning "badly" or "wrongly." Integration is fundamentally relational and "in the eye of the beholder." By using (mis)integration, we can empirically identify where actors are normatively setting out how they perceive integration should take place. For this article, the ideal integration from the perspective of the state or HCWs may differ significantly from a refugee from DRC or Somalia. (Mis)integration represents this relational framing. Thus, when a refugee in Nairobi integrates into society in ways the state or HCW perceives as "badly" or "wrongly," this constitutes refugee (mis) integration. Research by Lowe (2019) on maternal health of Somalis in Eastleigh mentioned in the previous section is a prime example of (mis)integration and healthcare, where Somalis interact with the healthcare system in ways contrary to what is expected of them. We analyze this concept further below in our discussion of poor nutrition and hygiene among refugee populations. Many HCWs observe these as behaviors in need of correction through awareness raising. In other words, they are perceived by many HCWs to be (mis) integrating into Nairobi through their (in)actions, whereas refugees observe their structural (dis)integration into accessing adequate food and clean environment.

Results

Barriers to refugee healthcare

On the ground, the interviews with refugees and HCWs confirm and deepen the consensus that refugees face many obstacles refugees face in accessing care. One Somali refugee succinctly summarizes the issue: "Poverty is the main underlying factor contributing to the poor health conditions in the community." If you are poor, it means that you cannot settle your medical bills.[6] Another Somali refugee reflects on the difficulties and stresses the lack of documentation brings: "In the country, you are given nothing, documentation, and other life aspects, you are disturbed so much. If you move you will be detained, the security officers will arrest you and you will not be excused for saying am a refugee, that will not work. Am someone who has been

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[6] Female Somali refugee, Nairobi.

suffering and burdened more."[7] Innumerable others describe a situation where they went to a hospital or clinic and needed a specific treatment, scan, or surgery but could not receive it because they could not afford the specialized care, thus exacerbating their issues. HCWs concur with this assessment. A psychologist states,

> Lack of finances is another issue, we find that if it's too far to reach, since you don't have that money for transportation, you would rather go to whatever chemist is next to you and get medication because if you have to go to Huduma [government service center], it will cost you going all the way to Huduma. So there's finances issues—actually finances is number one.[8]

This HCW notes the geography of (dis)integration in Nairobi. Refugees reside away from many of the key services and cannot even afford transportation—and the risks of police bribes along the way. Even if they make it to the Huduma government service center, they must navigate the broken asylum documentation bureaucracy. Another Congolese woman bluntly assesses the inequity in the health system for refugees:

> We have diseases out here. Someone who can become sick, then they remember the stress they get at hospitals, they just stay with it and don't go to hospital. They should help us, take care of us and give us good people, so that we feel loved, even when we get to hospitals, we don't see a difference. A refugee that loves Kenya is one with money and has capability, they are the ones who know Kenya's importance, but refugees like us, you just hear, better to stay home.[9]

This woman agrees with the psychologist about the difficulty of paying for transport, but there are even more barriers involved. Asking to be given "good people," the informant here is joining many others in describing discrimination from administrators and practitioners at the point of service. She recognizes that for those refugees with the resources, Nairobi is a great place to access to care. For the rest, they are dejected to the point of abstaining from care-seeking altogether.

In a wide-ranging interview with a HCW at a free health clinic in Eastleigh, this participant aptly summarizes how challenges for refugees described above lead to poor uptake in services and health outcomes, which suggests widespread and systematic (dis)integration:

> You realize that most of the migrants that we have, or the refugees that are there are undocumented, and if they're undocumented, they don't easily come out of their homes, especially even when they're sick. They fear when they go to the facilities that they will be asked for ID or some registration document, which they may not be having, and somebody will bring the police or cause an alarm, such that they will be displaced or deported back to their homes. They have poor health seeking-behavior especially because of the legal status, where they live. Number two, some of them they have a language barrier […] Also, they also have a challenge in access to continuity of care. For example, if somebody started on anti-[tuberculosis medicine] today, and for one reason has to go back to their home countries in Ethiopia, then that TB care stops there the next day, or in somewhere in north-eastern the next day, or somewhere else hiding from the authorities. The continuity of care, and also the outcomes of these patients is usually not very good, especially for diseases which have long term care […] Lastly, I would say, financing, if you cannot access work, you cannot be able to pay for a service. Most of the health services are quite costly, so the fact that they don't have access to insurance is a problem you see.[10]

This HCW worker covers a lot of ground. He discusses the issues of documentation, policing, language barriers, the precarity of forced mobility to their country of origin and elsewhere, which disrupts continuity of care, the high costs of care, and inaccessibility of NHIF health insurance for most refugees. There are myriad inhibiting factors leading to poor health outcomes and suggesting that larger systemic issues are impeding healthcare integration. This is agreed between refugees and HCWs.

As mentioned, these barriers are well known by policymakers. In principle, there are healthcare services and programs that refugees are entitled to designed to mitigate these barriers, including the National Hospital Insurance Fund and free public and NGO-funded clinics and hospitals. Unfortunately, there are major gaps in their functionality and availability to refugees. As part of the Comprehensive Refugee Response Framework (CRRF), a global push for piloting enhanced refugee protection, UNHCR worked with the already established National Hospital Insurance Fund (NHIF) to integrate refugees into the social protection system. This program, available to Kenyan citizens, offers health insurance targeting "vulnerable" households to access many healthcare facilities. UNHCR pays KES 500 (USD $5) each month per household and, by 2019, sponsored approximately 8,000 households (Maara, 2022). An "alien ID card" or UNHCR document known as the "mandate" is required for eligibility, which is difficult to obtain as demonstrated. For well-connected and knowledgeable refugees who are up to date with their documentation, this insurance is very helpful, as described by a Congolese woman:

> We as refugees get many opportunities to be treated for free, sometimes getting free medicine when you are sick and organizations writing a letter for you. There's this card you get called NHIF. As a parent, you can go and give birth, even when you are sick and the bill becomes high like when you are admitted, you share the bill with UN, you pay half, and they pay the other half.[11]

A different Congolese woman is even more direct about the NHIF: "We have good access [to healthcare] especially if you have money, they'll treat you well like anybody else or if you have the NHIF card that they gave us. Like I can say, I used my card when giving birth to my last child. I did not pay anything. I just paid 300 for subscription and everything else was free."[12] Conversely, a Somali woman in Eastleigh states the difficulties without the NHIF card, which refers to

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[7] Male Somali refugee, Nairobi.

[8] Psychologist, Nairobi.

[9] Female Congolese refugee, Nairobi.

[10] Medical doctor, Nairobi.

[11] Female Congolese refugee, Nairobi.

[12] Female Congolese refugee, Nairobi.

as "the UN card": "If you had the UN card it was not hectic, you could go to any hospital that you want. If you do not have the card from UN, you can be prescribed for an expensive medication and you cannot afford to buy."[13] Moreover, many participants who were able to obtain an NHIF card, describe the sponsorship ending without having payments being made by UNHCR or other NGOs: "UN used to pay [for NHIF] on our behalf, but they later told us to use our own money. I sometimes could not get the 20 shillings to deposit in the card and I did not go for the re-registration."[14] This is confirmed by a HCW based in Kawangware:

> We deliver healthcare to NHIF card holders but not to everyone. It depends on how many the donor has recommended. After we offer them, once the year is over, we are not able to pay for the NHIF again. The card become useless because you have to pay for it again. For most refugees they lack finances, they have no money to seek medical healthcare. They have no insurance and the ones who have are very few who will not be able access if their cards are not paid for.[15]

Finally, we heard accounts that many healthcare providers turning away NHIF cards in favor of cash (Muindi et al., 2019), which was confirmed by HCW informant at a maternity dispensary.

There are also free clinics offered by public, religious, or NGOs across the city, some of which refugees are entitled to (depending on available documentation). The main issue is that providers readily admit that their services and availability of medicine are severely limited, which pushes care-seekers to the expensive private health sector. One HCW at a free clinic in Eastleigh describe how the demands for care far outstrip the supply:

> Here, we give free services. That means the lab is free, consultation is free. Even meds you get them free […] So, what normally happens is that when the refugees know that the medical stock has come, they come to the hospital collect medication to keep with them at home to use when one falls sick. As a result, they get out of stock very fast. The IOM [International Migration Organisation] did a budget for like one year, but let me surprise you: The stock they bring won't even last for one week. […] We can even go like for even three to four months without the supply. Around here, I think we are the only ones offering free services.[16]

This quote is notable not only because the supply of medications did not last but also there are very few free alternatives in the area. Both refugees and HCWs alike recognize that they have succeeded in providing free or affordable initial consultation or diagnostic services, yet the next steps of medication or treatment are unaffordable as described by a HCW of a free clinic in Eastleigh: "If you prescribe a drug-like Augmentin [antibiotic], it goes for almost six hundred, so they will not buy, they will only buy a painkilling and they keep on coming back with the same issues."[17] As demonstrated in the research by McAteer et al. (2023), in the absence of free and affordable care, refugees must deal with the economic shock of paying for private care, deal with the immense complexity of the healthcare system, or remain untreated, which significantly impairs other aspects of integration such as employment and housing. When HCWs, often community health workers, observe refugees lacking financial means, they will refer them to NGOs which offer livelihood, legal, documentation, health, and education supports.

Perceptions of health

Broadly speaking, when we asked refugees what causes poor health for them in Nairobi, they cited the environmental conditions of forced precarity due to legal limbo and poverty. Many (though not all) HCWs instead individualized illness, blaming refugees' lack of knowledge or specific behaviors leading to poor health. We observe stark parallels to the economic development maxim, "give a man a fish, and you feed him for a day. Teach a man to fish, and you feed him for a lifetime," which was provocatively challenged by anthropologist James Ferguson:

> Those more oriented to political economy have noticed instead the suggestion that poverty derives from a primordial ignorance on the part of the poor and have observed that poor people are in fact far more likely to lack the material means to enter an occupation like fishing (boats, motors, nets, and access and rights to waterways) than they are to be held back by a lack of knowledge (Ferguson, 2015, p. 35).

He goes on to attribute poverty to a problem of distribution due to the decline in the efficacy of labor as a poverty salve. We contend, however, that healthcare experts and practitioners in Nairobi take up the development and public health trope that hygiene and nutrition are an issue of knowledge and expertise, whereas refugees share the view of the political economists that these issues are more caused by lacking material means.

Structural determinants of health

Beyond blocking access to adequate health facilities and treatments, refugees are keenly aware that structural urban poverty is intersectionally compounded by gender and displacement. (Dis) integration of refugees from the formal economy by government and Kenyan society is the cause of poor health in the first place, particularly around the issues of mental health, malnutrition, and hygiene; however, it begins with a lack of income, which is a point made by a Congolese woman: "Money can help us a lot. Tell those people that we want them to assist us financially. It is difficult to pay rent, to get food so if you help us well, we shall be happy […] The problem is totally lack of money."[18] A Congolese man also made the connection between the environment and poverty: "The cause I can say is first adapting to the weather. Then dealing with, let us say for example, this June is cold, so, a refugee cannot afford to buy a sweater because they do not have money. The cold hits them on the chest then maybe they get pneumonia. They do not have ways to deal with what can give

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[13] Female Somali refugee, Nairobi.

[14] Female Congolese refugee, Nairobi.

[15] Counseling psychologist, Nairobi.

[16] Healthcare administrator, Nairobi.

[17] Health administrator, Nairobi.

[18] Female Congolese refugee, Nairobi.

them infection."[19] The colder months of Nairobi were commonly referenced by others as significant causes of illness. With lack of incomes, they could not have adequate shelter and clothing to deal with this perceived determinant.

A Somali woman joined others in pointing to the profound stressors caused by the effects of poverty: "Other factors include lack of clean water, insomnia and anxiety which also come as result of poverty."[20] People constantly worry where their job and meal will come or how they will afford education and health fees for their family. This could compound already existing trauma of war and displacement present that refugees might experience. A Somali man expresses the depression that results from joblessness:

> What causes the depression is lack of jobs. When a person is jobless, they will talk to themselves, they will say to themselves, my peers are working, there's no one to hold your hand, you have been educated, you hide it from your family. If you sit in front of your mother and father, you have been educated, you are not working, so, you tell yourself you are the one who is depressed, so, don't bring that to your parents. There are some people who even kill themselves or hang themselves because of the severity of unemployment-induced anxiety and stress.[21]

This quote importantly points to the disruptions in career paths and the social and familial pressures of economic success. Despite education, meaningful work is severely impeded by displacement. This leads to how another Somali man evocatively describes life coming to a standstill due to poverty and (dis)integration of refugees in Nairobi:

> The problem refugees face here is employment, not being able to reach where the person needs to visit because he cannot go. You cannot even marry. There is nothing you can do for yourself. You cannot go to a region outside Nairobi for whatever reason. There is a lot, we are in jail that seems no one knows about. You have no opportunity to work because it is only through informal means but there is no official work you can do. There is no place you can work; you can do nothing. You are someone overtaken by the status since you don't live in your own residence, everywhere you rent which is expensive. It is like a hectic, hell of life.

This "hell of life" described above resulting from poverty and displacement prevents key rites of passage and sources of joy and belonging such as marriage, travel, fulfilling work, and home ownership led to a feeling of life incomplete. However, even those who are able to establish a family and have children, poverty and marginalization cause significant stress due to unfulfilled gender and care expectations for both men and women as described by a Congolese man:

> Even the men are not exceptional because they provide for the children in terms of accommodation, health, etc. If he cannot afford, he gets stressed. But when the mother is a single parent, she bears both responsibilities which results in stress and being poor. When someone does not have enough medication, worry and stress multiply. You will fall sick because you cannot help. You cannot help your relatives and family and there is no fundraising, rent and other ending aspects of livelihood. It is a very difficult matter and whoever can comprehend, it is not easy. So, it has a lot of impact on us.[22]

Although we lack the space to expand analysis here, this informant's analysis of the gendered experiences of displacement fit what scholars in many other displacement contexts engage with. There are different pressures to provide income and care with men often expected to be the breadwinners and the stress and existential disappointment when they cannot. The informant is also attuned to the intersectional experience of poverty that single mothers face when they must provide and care and struggle to do both due to disruption of networks and (dis)integration brought by displacement (Fiddian-Qasmiyeh, 2017; Buckley-Zistel and Krause, 2022).

Beyond just identifying the prevalence of stress or "pressure" as many informants describe, there is also an acute awareness of the somatic manifestations this stress brings. Many recognize that high stress, depression, and anxiety can cause headaches, hypertension, ulcers, and other bodily pains. In addition to describing instances of suicide, a Congolese man discusses severe harm he believes comes from the daily financial stressors: "My friend died of a heart attack because of lacking what the children will eat, something like that. All this is brought about by lack of money. I think those are the things that bother people the most."[23]

Beyond poverty causing severe stress and psychosomatic fallout, many refugees recognize that poverty leads to nutrient deficiencies and difficulties in sustaining hygiene, which contributes to poor health. For instance, a Somali refugee in Eastleigh explains directly, "Poor health is caused by poor sanitation, polluted water. Most people complain about consumption of polluted water. Moreover, people throw garbage anywhere, this affects people's health."[24] A Congolese man echoes this as an issue in Kawangware when asked about hygiene of fellow refugees: "It depends on your surroundings and the living spaces. For instance, the slums. Even in Kawangware, the sewer waters and remnants were all over and people were just eating there in those shacks like restaurants."[25] This individual recognized the spatial segregation of informal settlements, which most refugees and other marginalized poor Kenyans are relegated to is a central environmental determinant of health, which is a key aspect of the (dis)integration of health.

Regarding nutrition, when asked for the reasons of the most common illnesses among refugees in Nairobi, a Congolese man attributes sees poor diets caused by poverty to be a primary driver: "I think it depends on their diet and nutrition. People eat whatever is affordable. They eat the same food all the time."[26] Finally, another

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[19] Male Congolese refugee, Nairobi.

[20] Female Somali refugee, Nairobi.

[21] Male Somali refugee, Nairobi.

[22] Male Congolese refugee, Nairobi.

[23] Male Congolese refugee, Nairobi.

[24] Male Somali refugee, Nairobi.

[25] Male Congolese refugee, Nairobi.

[26] Male Congolese refugee, Nairobi.

Congolese man summarizes the structural constraints of nutrition and hygiene:

> First of all, the community needs to get food. Getting food helps prevent a lot of illnesses. If they get good food and a place to live where they do not have mosquitoes, it will help. Illnesses will reduce. If they have good food, a good dwelling, and clean water, it will prevent illnesses. However, if they get medicine but they do not have food, they will still get sick. If they do not have money, they will drink water from wherever, they have no choice. We need to take preventive measures instead of treatment. We should protect these people from diseases.[27]

The quote of the interlocutor elucidates the interlocking deficiencies that stem from poverty and displacement. He recognizes that even if somebody gets access to care and/or medicine—which we have demonstrated is difficult to obtain without resources—the structural and spatial environment, where adequate shelter, clean water, food availability, and protection from mosquitoes are difficult to come by, will lead to continual recurrence of illness. When these questions about the determinants of health were asked of HCWs, we received significantly different answers, focusing on individual responsibility and knowledge as causes of illness rather than structural oppression.

Individual determinants of health

Recalling Ferguson's discussion of philosophies of development, HCWs take more of a "teach a man to fish" approach to public health for refugees in Nairobi compared with the political economy philosophy of refugees. Many HCWs take the view that refugees are (mis)integrating, or not integrating correctly, by their choices and lack of knowledge about nutrition and hygiene practices. While most HCWs were sensitive to the barriers of care, other HCWs, including this administrator of a free clinic, are dismissive of these concerns:

> I don't see any obstacles because we don't charge our services, they are free. But the only problem, supplies, that would be the problem we have on our side. For the community, they just have to avail themselves, I don't think there is an obstacle for them […] But when the supplies are there, our services are free. So, I don't see why it could be an obstacle.[28]

In the same statement as saying the clinic has supply issues, this HCW is, in essence, placing the blame of not accessing health services on refugees themselves, which is especially striking given the small number of free clinics available. Quotes like these follow a pattern. HCWs frame poor health being caused by a lack of information and need of awareness among refugee care-seekers. However, at worst, they are blaming refugees for not caring for themselves. We argue that this perspective glosses over the structural constraints refugees face. The following quotes from a medical doctor, a dispensary nurse, and a dispensary clinical officer are instructive of this sentiment:

> Doctor: We normally get hygiene related medical conditions. Mostly they do get infections, UTI [urinary track infection], but we try to advise them on how to wipe themselves where they go to toilets, also to take water in plenty, such things. Another condition is diarrhea. We try to educate them on how to handle food, food hygiene, also how to help anemia— low blood levels. When you tell them to take fruits, they don't like fruits. They don't like green vegetables, liver, they don't like it. Tell them to take liver, they say "yuck"!
>
> Interviewer: Do you think they don't take it seriously because they don't understand the conditions they are in and the extent of the infections?
>
> Doctor: No, actually, they don't understand. Because even if I give you medicine to treat infection, and yet continue with the same practice, the hygiene, you're not changing, you will still get infection. So many cases we get appears to be neglected. They are a lot. The diseases that people have problems with include metabolic diseases and mental illnesses. Both are neglected, and the doctors are not that much interested in talking to the patient about diet. There are not many good doctors who do that. Obesity—which is caused by the diet, diabetes, blood pressure, heart pains—all those can be corrected easily if the people are given good awareness regarding foods.[29]

Here, the doctor states explicitly there is a lack of understanding in practices of nutrition and hygiene by refugees. The informant insists that these major causes of infections and illness "can be corrected easily" through awareness and behavior change, but it does not occur to them the resources that it would require to have adequate living conditions, clean water, and sanitation, or the available income to pay for a diverse diet. Moreover, it is known that UTIs occur at higher rates in pharonically circumcised women (Amin et al., 2013), which suggests a lack of cultural understanding from this HCW. A nurse at a dispensary echoes these sentiments:

> One, because we don't offer services at a cost, we normally support our refugees by giving them free services, as stipulated by the government. This is a dispensary; we don't have any charges. Second, we normally offer them free health talks and health education. We normally also engage with CHVs to sensitize them on good hygiene and nutrition guidance. By the way, there is challenge with refugee communities in terms of nutrition. If you go to a nutrition clinic, most of severe malnourished children, comes from refugees. We normally give them a health talk and health education on how to balance the diet, so that the children can be able to grow. Malnutrition in children is a common problem and we really realize this when we actually ask the combination of foods, they normally offer their children.[30]

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[27] Male Congolese refugee, Nairobi.

[28] Health center administrator, Nairobi.

[29] Medical doctor, Nairobi.

[30] Nurse, Nairobi.

This nurse identifies anecdotally that a high proportion of malnourished children come from the refugee population in Nairobi. Instead of commenting on the marginalized position, they occupy vis-à-vis Kenyan citizens as a possibility for high prevalence of malnutrition, or difficulties in obtaining food they used to consume in their country of origin, the nurse implies by the education work they do that refugees need to be "sensitized" to good hygiene and nutrition. Putting bluntly, this conveys that refugees should "know better" to avoid malnutrition:

> Refugee children get a lot of pneumonia and a lot of malnutrition; that is a concern. Because it's higher compared to the locals under five, the malnutrition is very high. The other conditions are just respiratory, the GIT [gastrointestinal tract disorders] issues and we also have quite a number of young diabetic refugees, quite a number which is not the same, you notice, it's a bit higher. I also think it's the lack of understanding of how they should treat the children but it's quite high and alarming too from the refugees. For example, on nutrition—which I have said malnutrition is too much. If you find a mother has been educated and put on what to give, but that patient will come as a patient another day because now you are trying to evaluate because you can see the child is malnourished. But when you try to go through the information that was given previously, you can also see what they discussed in the case notes. But what the patient is doing and what she was told, is completely two different things. You find either the concentration, is not mentally stable to handle […] you find that now she will go and do her own things, the child does not improve. Now they will be given something for supplement, for a sick malnourished child, but when they come back the child is not improving. If you try to ask, you will find there is another neighbor, who also had a child like that, and they decided to share. Now you see we are just rotating the same: this one doesn't improve, the other one doesn't come. So, I think the women have a challenge.[31]

The clinical officer makes many of the same individualized points as the doctor and nurse. However, they go even further by pathologizing the lack of malnutrition improvement by suggesting that they are "mentally unstable" rather than unable to materially affect changes due to poverty and marginalization, which is a common outcome of the individualization of public health (Yates-Doerr, 2020). The officer observes it as a problem that two neighbors are sharing supplements for malnourished children, rather than being a larger societal problem of "shared destitution," resulting from widespread poverty and lack of social protection (Omata, 2017).

We cannot make a blank statement that all HCWs blame the lack of knowledge to malnutrition or unhygienic behavior. Indeed, a pharmacist in Kawangware states the contrary opinion plainly: "In my opinion most of the health problems refugees face arise from their environment. In Kenya we all know the refugees live in clustered areas where they cannot get enough provisions and it's hard for them to find clean water. All these bring health issues and ease the spread of communicable diseases like Tuberculosis."[32] On the other hand, there very well may be health education needs in these communities. However, enough healthcare providers expressed these views without any consideration of structural determinants of health to suggest that it is a widely held position among those working closely with refugees in Nairobi, which has implications for how refugees receive care and integration in the city. Moreover, there are enough reports in our data and other research that a non-trivial number of HCWs in Nairobi actively discriminate services to refugees. This suggests that there needs to be an overhaul in the understandings of refugees and health of HCWs more than there needs to be awareness-raising within refugee communities.

Conclusion

We find the terms (dis)integration and (mis)integration to be productive concepts in the highly contested theoretical terrain of refugee and migrant integration. These two concepts display the relational and processual elements of integration at many scales, rather than the individualized and outcome-based views advanced by others. As the definition of (dis)integration sets out, these practices, policies, and discourses attempt to actively discourage inclusion or make them "come apart from society" (Collyer et al., 2020). We observed this at the country and municipal levels in Kenya with spatial segregation through encampment in the peripheries of the country and the enclaving of refugees in poor and informal communities in Nairobi. Moreover, (dis)integration occurs through the exclusionary refugee documentation regime in Nairobi, which severely impedes access to employment and healthcare. (Dis) integration is also apparent at the individual level with constant arrests and harassments of refugees by security forces or discrimination or unsanctioned price inflation at the point of service by healthcare providers. There is a parenthesis in (dis)integration because integration and disintegration are not mere opposites. There are efforts to bridge gaps in care. NGOs and healthcare organizations have interventions for refugees across the country, although these are piecemeal and not sufficient to overcome the interlocking structural oppression of refugees. This holistic view of (dis)integration is held by most refugees we spoke to when they evaluated the primary causes of illness among their population.

Our introduction of the term (mis)integration also aptly analyzes the situation of refugees in Nairobi generally but also zoomed in to the domain of healthcare as well. Like (dis)integration, (mis)integration has the conceptual elasticity to incorporate multiple scales. Refugees in Kenya, and Somalis in particular, have a long history of (mis) integrating. Refugees have defied (dis)integration through encampment for the last 30 years by moving to Nairobi and across the country, integrating in their own ways. The existence in Eastleigh or "Little Mogadishu" densely populated by Somalis is constantly derided by the Kenyan state through security crackdowns, or you will hear ordinary Kenyans talk about the "otherness" of Somalis and Eastleigh with the clear assumption that they are not integrated correctly. When focusing through the lens of healthcare, HCWs are often confounded by practice decisions of Somalis such as the refusal of cesarean births (Lowe, 2019). Our analysis concludes that many Kenyan HCWs have normative understandings for how healthcare integration should take place. They diminish the structural causes of hygiene and malnutrition by perceiving the causes of these issues being poor choices and

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[31] Clinical officer, Nairobi.

[32] Pharmacist, Nairobi.

behaviors—the (mis)integration of individuals. This individualized focus on integration is precisely what this article is critiquing. By focusing on the individual and minimizing systemic oppression, this has key implications in the lives of refugees. These perceptions actively impede progress in reforming the healthcare system in a way to be more inclusive of refugees. Moreover, with HCWs sharing their perceptions of the failings of refugees, this affects the point of service care that refugees receive. Although no HCWs reported doing so, we heard many reports of poor interpersonal treatment or outright denial of service to refugees.

This research has some limitations. This includes interviewing at health clinics, rather than in peoples' homes, which likely biased the sample. Moreover, while we conducted quantitative surveys, this article only used the qualitative data as this is primarily research on experiences and perceptions of displacement and health. Nonetheless, this article brings up numerous important policy implications for refugee healthcare in Nairobi and Kenya. We agree with refugees in the structural nature of refugee (dis)integration, and therefore, change is extremely difficult. As such, most recommendations are "easier said than done." For example, it would be easy to say, yet difficult to make a reality for Kenya to provide more free healthcare services for refugees as it struggles with economic growth and poverty like many other countries in the Global South. With this in mind, we focus on five possible and actionable recommendations based on our analysis, which are by no means "silver bullet" solutions in a society with a long-entrenched history of xenophobia. First, we observe the passage of the Refugee Act 2021 and its accompanying "Marshall plan" as a possible conjunctural moment of change. There is vagueness in the language that should be pressed into to create an inclusive environment in Nairobi, particularly around documentation and right to work. Second, while global aid is highly constrained from the fallout of COVID-19 and the invasion and humanitarian needs of Ukraine, the NHIF should offer subsidies for more than a year, perhaps phasing out support over 5 years. This must be made available to those without proper refugee documentation, as they can often be most vulnerable. Third, we recommend setting up and communicating to refugees reliable complaint systems in clinics and hospitals where refugees can report discrimination in pricing and service in ways that protects whistleblowing. Fourth, while we acknowledge the care available to refugees and asylum-seekers in Nairobi is *ad hoc* and lacking, we recommend a comprehensive mapping (in the appropriate languages) of the health, legal, education, and livelihood resources that these communities are eligible for, and this is widely distributed to refugees and institutions and organizations frequently in contact with these populations. Finally, we observe it as crucial to train and hire refugee HCWs to provide linguistically and culturally appropriate services but also to ensure that the perspectives of health as structural (dis)integration, as elaborated in this article, are shared in healthcare spaces.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by the University of Edinburgh Research Ethics Committee; Kenya National Commission for Sciences, Technology and Innovation (NACOSTI). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

CB: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. BM: Conceptualization, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. MW: Data curation, Formal analysis, Investigation, Methodology, Writing – review & editing. PM: Formal analysis, Investigation, Methodology, Writing – review & editing. LA: Investigation, Methodology, Project administration, Supervision, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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State care services as devices of acceptance to the social body: the case of Afro-descendant migrant mothers in Chile, beneficiaries of the National Child Health Program

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Introduction: In the field of medical anthropology, particularly from the practices of medical care in a situated context, the text discusses how state care services under the "National Child Health Programme" implemented by nursing professionals in Chile transmit values and expectations that could be transformed into devices of acceptance to the social body for migrant mothers of African descent who come with their children to health centres.

Methods: The Methodology employed in this study was devised through a case study in the commune of Talca, within the Maule region, utilizing semi-structured interviews with nurses who work within the Programme, as well as open interviews and thematic workshops with migrant women users of the Programme.

Results: The results point to the valuation of the programme by the women, who identify it as an instance of providing and receiving care for their children; they also recognise that they are judged by their caregivers for not "correctly" following the instructions given to them with their children living in Chile or for exercising transnational maternity. On the other hand, nursing professionals revealed racial and class prejudices about women of African descent, especially Haitian women.

Discussion: It is suggested that this programme, recognized regionally as an effective assistance and care policy in the fight against infant mortality and morbidity, becomes an acculturation device for migrant mothers and their children born in Chile. It is expected that both mothers and children adhere to the program's guidelines, resulting in similar behaviours and attitudes as those of Chilean mothers. This generates few instances of learning and appreciation of the native cultures of the new Chilean infants and reveals that categories of differences such as ethno-racial, gender, and migratory status are articulated in the nurses' health practices, emphasising the mandate to follow the instructions of migrant mothers and their children.

KEYWORDS

migrant women, state care benefits, nurses, black motherhood, children's health

1 Introduction

In Chile, the conceptualization of health within modern state development projects involved the transition from an activity carried out by religious entities and philanthropists to a public institutional framework aiming for uniformity and mass provision of healthcare services (Álvarez Díaz and Aguirre Munizaga, 2021). The significance of health and its access as a public policy materialized with the establishment of the National Health Service in 1952. In its early stages, the service operated through a national structure comprising Regional Health Zones, each overseen by a medical director, and an interconnected network of hospitals of varying complexity levels. Additionally, this structure included peripheral health centers (called consultorios) and rural health post[1].

> In the field of obstetrics, this meant shifting childbirth from home settings to hospitals and applying concepts and practices oriented toward the care of sick individuals, now directed toward birthing mothers and newborns (Castro, 2003). The social process of childbirth and postpartum, previously shared by family and close friends, came under the purview of medicine and its practitioners. Between 1962 and 1964, the National Fertility Regulation Policy was established, the Chilean Association for Family Protection (APROFA) was created, and the first Family Planning Policy focusing on women's sexuality was enacted. (Álvarez Díaz and Aguirre Munizaga, 2021, p. 369) [Translate by authors].

In this context, various programs directed from the central level and implemented at the territorial level by the healthcare assistance network aimed to provide planned and coordinated health programs, specifically for population groups, such as: "healthy child check-ups, prenatal care, professional childbirth assistance, milk distribution and supplementary feeding programs for children, child and adult vaccination, rehabilitation, environmental sanitation" (Goic, 2015, p. 778) [Translate by authors].

Following the military dictatorship (1973–1989) and the return to democracy in 1990, the discourse of the state and public health professionals regarding health indicators emphasized the need to restore the image of a progressing state concerned about the well-being of children and committed to reducing the inequality exacerbated during the dictatorship. In this context, the "National Childhood Health Program" was established in 1991, which currently has the following general objectives:

> Reduce mortality and morbidity among children younger than 10 years of age. Strengthen timely, efficient, continuous, decisive, and quality healthcare for boys and girls in the public health network. Contribute to improving the quality of life for the child population, regardless of their health and socioeconomic status. Promote healthy habits and reduce health risk factors in children younger than 10 years old, considering a life course approach. (Gobierno de Chile, 2013, p. 1) [Translate by authors].

After two decades of implementation, Chile exhibited unequivocal indicators of access to healthcare for the national population and its effectiveness, with the lowest rates of infant mortality (7.2 per 1,000 live births) and maternal mortality (18.5 per 100,000 live births) in Latin America. The public and private healthcare system achieves a 100% professional attendance rate for childbirth and high coverage of immunizations, outcomes attributed to the National Childhood Health Program, among other measures. "These indices reflect the strength of the public health sector, which serves 80% of the population, and the social significance of its healthcare concepts" (Goic, 2015, p. 771) [Translate by authors]. In other words, there is widespread recognition of the value of the program and the monitoring guidelines it incorporates for the care of children by the local population.

However, with the increase in international and cross-border migration in Chile over the last decade, new users have been incorporated into the public healthcare system, including migrant mothers and their Chilean-born children. The discourse of healthcare professionals has emphasized equality in the provision of healthcare services, including access and coverage of the Childhood Health Program, under the National Policy for the Health of International MINSAL, FONASA, and Superintendencia de Salud (2017).

Two important questions arise in this context. First, whether the State Childhood Health Program enjoys the same recognition among the migrant population. Second, whether the care practices toward children in Chile (regulated by the aforementioned state program) can unequivocally continue to be presented as the only valid way to manage the health of migrant mothers' children, and, of course, the mothers themselves, particularly in terms of maternal processes, breastfeeding, and attachment practices.

In this regard, the text presents a critical approach from the perspectives of medical anthropology and acculturation, examining the normativity and homogenization of institutionalized care practices in maternal and child healthcare. It questions the imposition of a singular valid form of care (the Chilean way), which is not only controlled by healthcare personnel but must also be strictly adhered to "instructions" by migrant mothers. This adherence is observed as necessary for them to be considered valid and legitimate members of the destination society, i.e., to be recognized as valid and legitimate individuals within the context of the Chilean state and citizenship.

Text is structured into a section titled Background, where some reflections on medical anthropology, the objectives, and scope of the National Childhood Health Program are presented. Subsequently, it provides background information on Afro-Latin immigration in Chile, the violence experienced by pregnant migrant women, and the acculturation mechanisms. The Methodology section outlines the objectives of the research, the approach used, and certain characteristics of the participants. The Findings section describes the background information gathered through interviews with nurses and migrant women, organized according to the specific objectives of the research. In the Discussion section, the research findings are analyzed in light of the different specialized literature that underpins the theoretical framework of this investigation, namely, medical anthropology and acculturation. Finally, Conclusions propose some

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[1] These ambulatory care facilities are situated in rural geographical areas, catering to populations of fewer than 20,000 residents. They are overseen by a health professional with technical expertise, supported by a team of professionals typically comprising individuals from the fields of medicine, nursing, dentistry, and obstetrics and childcare.

actions toward eradicating violence against migrant women in Chile, particularly in primary healthcare centers.

2 Background

2.1 Medical anthropology and critical reflexivity

The entry of social sciences into the realm of health and modern medicine is relatively recent. In its early stages in the mid-20th century, it primarily aimed to investigate how the social and environmental conditions in which a specific population lived influenced the emergence (or absence) of certain diseases. In other words, it sought explanations beyond the biological, taking into account the limitations of medical treatments offered at that time. Thus, "the recognition of social elements in the health-disease-care process has allowed understanding it as a historically, socially, and culturally determined process" (Díaz Bernal et al., 2015, p. 658) [Translation by authors], going beyond biological phenomena. It attempts to comprehend how beliefs, values, practices, and social structures influence the health and well-being of individuals and communities (Lock, 2000).

Therefore, medical anthropology complements perspectives from local cultures with studies in public health and epidemiology, aiming to comprehensively and diversely understand the health-disease process, as well as care and prevention. In this context, one of the main issues addressed by medical anthropology in the applied field is the existence of sociocultural differences or distances between those managing health-related activities and the health-disease-care process and those benefiting from them (Díaz Bernal et al., 2015). This includes actions that alter practices and cultural behaviors specific to certain communities, as well as differences and asymmetries in the interaction between healthcare personnel and the user population of various health centers. Therefore, applied medical anthropology critically focuses on challenging the universality and ahistoricity inherent in the biomedical model. This model homogenizes subjects (always referred to as "patients"), prioritizes biological determinism over social and structural factors, and offers unilinear explanations of disease and healing processes.

Medical anthropology places particular emphasis on the social determinants of health, recognizing that factors such as class, gender, ethnicity, and access to resources influence health and healthcare. Within this framework, the maternity of migrant women involves complexities related to access to reproductive healthcare (Inhorn, 2007), cultural and social pressures, and childbirth, motherhood, and breastfeeding practices in both the countries of origin and destination. Therefore, a critical approach from medical anthropology entails not forgetting women's agency in the process (Van Hollen, 2003), recognizing the constraints they face in a medicalized and non-native context (Sadler Spencer, 2004, 2016), where dehumanizing, acculturating, and hegemonic power dynamics are formed.

In this context, a critical examination of the National Childhood Health Program is necessary based on two arguments. First, the program promotes a societal mandate of exclusive motherhood in women, viewing them as the sole responsible caregivers, lacking knowledge on the matter. As Caro (2009, p. 34) notes: "The type of woman produced by institutional discourse is the woman-mother, compelled to learn how to 'properly' raise her children (which hides the assumption that her prior knowledge is inadequate or non-existent) [Translation by authors]." Second, for migrant Afro-descendant women, this mandate and its underlying notions of inadequacy and responsibility become palpable in relation to the "instructions" for caregiving and judgments on their transnational motherhood. In other words, it also posits a standardization of the idea of a singular appropriate form of care: the national one, to which migrant mothers must adhere.

2.2 National Children's Health Program: between protection and control

Since 1991, following the restoration of the democratic political system, Chile has progressed in global indicators across social, cultural, political, economic, and health domains. Changes in the population's epidemiological profile over the past decades have necessitated adjustments in central-level public policies and their territorial deployment throughout the country. Health programs have incorporated modifications into how childhood is perceived and embraced within healthcare centers, yet they continue to operate under a unitary state logic that assumes population uniformity in demands and needs. Discursively, it is noted that:

> Promoting optimal early childhood development has become a priority at both international and national levels, recognized as one of the most influential social determinants of health. Concurrently with advances in scientific knowledge, in 1990, Chile ratified the Convention on the Rights of the Child, adopted by the United Nations General Assembly in 1989. This convention promotes four fundamental principles: non-discrimination, the safeguarding of the child's best interests, their survival and development, protection, and their participation in decisions that affect them. Since then, there has been progressive work to ensure these rights in the various spaces that children occupy in the community. However, despite the achievements, significant inequality persists, significantly impacting health indicators and the quality of life for children. [Translation by authors].

Moreover, it is acknowledged that there is a phenomenon of child poverty in the country, meaning that the child and adolescent population experiences higher levels of poverty compared with the general population. This is directly related to the family composition of these households, often led by a mother who serves as the head of the household and sole financial provider. This phenomenon is even more pronounced in the population younger than 4 years (EnfermeríaAPS, 2013).

In response to this, in 2008, the Comprehensive Early Childhood Protection System was implemented nationwide, better known as *Chile Crece Contigo*, which acquired the status of law in 2009 (Law 20.379). This system is a management model composed of various state agencies with the objective of providing differentiated conditions to socioeconomically deprived families, thereby reducing more complex inequalities during the critical period of development, specifically from gestation to 4 years of age. However, several authors have been critical in highlighting how the program was conceived and the implications of this for its development:

> Chile Crece Contigo program originated from measures proposed by the Advisory Council for the Reform of Childhood Policies, which operated in 2006. This council was composed of representatives from the Catholic Church, the Ministry of Education, and the medical field. The council's final report suggested establishing a system that contributes to ensuring all girls and boys undergo a full and balanced development process during their early years of life (Moreno, 2006). A consultation process took place involving representatives from more than twenty public institutions, civil society, and children and adolescents (Final Report Council, 2006). There was no requirement or indication of the involvement of women's organizations in the consultation process, highlighting an initial separation in the treatment of policies directed toward children and gender and family policies. It is thus configured that addressing the needs of children is dissociated from the challenges faced by those responsible for their care: mothers and, to a lesser extent, fathers. (Caro, 2009, p. 27) [Translation by authors].

This is due to a technocratic, centralized, and normative idea of what would be the most appropriate ways to protect children and, at the same time, control the exercise of motherhood and, consequently, the sexuality of women. In this sense, Caro (2009) argues for the existence of a paradoxical logic in state protection discourses, as they go hand in hand with control in social interventions:

> Protection, in most cases, implies control either of the person being intervened or of their environment. Being labeled as a subject "to be protected" places them in a position of vulnerability compared to others because they are assumed not to possess those standards considered normal at an individual or social level for the "normalized" development of that person. They are presumed to be a "not yet." (Caro, 2009, p. 28) [Translation by authors].

It is worth noting that some actions have been adapted in pursuit of recognizing the autonomy of women and children. For example, the launch of the Biopsychosocial Development Support Program, which aims to "reinforce promotional and preventive actions with a view to protecting early childhood and achieving optimal development conditions, both at the primary care level and in motherhood" [Translate by authors]. Additionally, aspects that were previously not visualized or prioritized, such as the ethno-racial origin of children, the geographical areas where they live, and the socio-health conditions in which they develop, have been considered. These conditions manifest in unequal health outcomes in the child population aged 0 to 9 years.

While there is recognition of openness to other social categories and an intention to move toward a less centralized idea of the national territory, these advances still follow logics that position women from a material deprivation perspective. Equality is perceived primarily as an economic issue, "linked more to class than to other differences since the program is presented as a means to break the cycle of reproduction of inequality and poverty in families" (Caro, 2009, p.32) [Translate by authors]. In other words, there is a lack of an intersectional perspective (Fernández Labbé et al., 2020; Pinto Baleisan and Cisternas Collao, 2020; Reyes Muñoz and Reyes Muñoz, 2021) that considers other categories of difference that accentuate inequality in the national territory, such as migratory differences.

Similarly, the National Childhood Health Program includes various strategies for implementing, monitoring, and to a lesser extent, evaluating the general and specific objectives derived from its implementation. These strategies include targeting and annual supervision of the activities outlined in the program, which includes "skills leveling for professionals through a relevant and continuous training system for healthcare teams" [Translate by authors]. These strategies are administratively monitored in the Regional Ministerial Health Secretariats, Health Services, and Health Centers in the territory. The purpose is to:

> Contribute to the health and integral development of children under 10 years of age, in their family and community context, through activities that promote, protect, prevent, recover health, and rehabilitate, encouraging the full expression of their biopsychosocial potential and a better quality of life[2]. [Translate by authors].

The National Childhood Health Program is presented as a public policy for the promotion of rights and protection of childhood, including the gestation and motherhood period. At the same time, it proposes strict control and monitoring in the execution of the activities it encompasses. This policy has as its basis and principle the same conditions for all participants of the program, however this assumption acts overlooking the differences of the population. What is expected is an acculturation of the other, a need to redirect the cultural forms, thoughts, and actions of diversity under the idea of equality policies that are absolutely exclusive of those who need to be addressed in diverse and intersectional ways.

2.3 Afro-Latino immigration in Chile, violence against pregnant women and acculturation

Migration in Chile has a long history and intersects, as in all Latin American countries, with a history of conquest, colonization, and slavery. In the country's history, migrations of people from Peru, China, and Bolivia to the northern region during the saltpeter and mining boom in the late 19th and early 20th centuries are relevant. These migrations marked a social, demographic, and phenotypic identity in those territories. The migration of Yugoslav, German, and Polish people in the south and southern region of the country is also

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[2] The overall objectives of the National Child Health Program with a Comprehensive Approach are four: (1) Reduce infant mortality and morbidity in the population under 10years of age; (2) Strengthen timely, expeditious, continuous, decisive and quality health care for boys and girls in the public health network; (3) Contribute to the improvement in the quality of life in the child population, regardless of their health and socioeconomic condition; (4) Promote healthy habits and reduce health risk factors in children younger than 10years of age, considering the life course approach.

noteworthy, following the process of colonization and whitening of the Mapuche territory. This migration is characterized by a desired type of migrant compared with those who arrived in the northern region, primarily due to the European and white origin of the former (Cano and Soffia, 2009, Cátedra de Racismos y Migraciones Contemporáneas de la Vicerrectoría de Extensión y Comunicaciones de la Universidad de Chile, and Movimiento Acción Migrante, 2019).

However, despite a migratory history in Chile, the act of migrating is often put to the test, "both in a pragmatic sense, involving problem-solving practices in daily life, and in a societal, structural sense, linked to social mobility (…). At both levels, explicit and implicit forms of rejection and discrimination occur" (Sibrian, 2021, p. 2) [Translate by authors]. In this context, the challenges of any migration, according to Siberian, include obstacles in the new territory, such as job placement and access to health, as well as expectations of recognition and acceptance by the citizens of the destination country. It is at the intersection of obstacles and expectations that several complexities arise in the migratory experience of those who participated in this study.

Afro-Latin American immigration, particularly from the Afro-Caribbean regions of the Dominican Republic and Haiti, has received the least recognition and social acceptance in Chile, especially between 2010 and 2019, just before the arrival of people from Venezuela, who today also face such social stigma. Perceptions of the local Chilean population regarding foreign communities currently residing in the country have revealed a societal culture that is racist, classist, and increasingly xenophobic (Castillo et al., 2023). These ideologies, rooted in the modernization project of the state since the early 20th century, have constructed the imagery of a country that observes itself as white and Europeanized, despite its Amerindian, Afro-descendant, and mestizo origins (Reyes Muñoz et al., 2021).

Social stigmatization directed toward black populations, particularly Dominicans and Haitians, is based on their ethno-racial, class, and gender condition. In the case of Haitian women, this stigmatization is further compounded by their linguistic difference and their country of origin, classified as the poorest in Latin America and the Caribbean. Stigmatization is observed in the numerous biases expressed by health professionals and officials who, for instance, judge women for their attachment practices, parenting, breastfeeding, and motherhood, and for not conforming to presumed "national" and international standards of motherhood (Reyes Muñoz et al., 2021; Reyes Muñoz and Chatelier, 2023). They are also judged for supposedly "not planning their motherhood" due to their "high pregnancy rates compared with Chilean women" and for not controlling their gestation process from the 7th or 8th week, as is the trend among local citizens.

Regarding the State, the record from the year 2021 on an institutional page of the Health Service indicates:

> Of the total foreign mothers, Haitian women contribute the highest percentage of births, accounting for 21.1%, followed by Peruvian women at 14.7%. Regarding regions, those with the highest percentage of births to foreign women are Tarapacá with 33.7%, Antofagasta with 28.5%, Arica and Parinacota with 22.8% (all in the northern zone of Chile), and the Metropolitan Region with 21.0%. However, according to the Ministry of Health (MINSAL), pregnancy check-ups have decreased, as the number of entries into the prenatal care program for pregnant women fell by 7%, reaching 162,542, the lowest figure in the last 5 years. (Migración en Chile, 2021, p. 1) [Translate by authors].

The data reveal that Chile has lowered its indicators regarding pregnancy, monitoring due to the arrival of foreign women. In this context, at the local level, Haitian women are often at the focus of the discussion. This is because in Haiti, women do not usually monitor their pregnancies as closely as in Chile, including cases where women are not monitored in their gestation until the day of delivery itself. This could be due to the existence of support networks among women in the family and friends of the expectant mother, who monitor the pregnancy and provide assistance to pregnant women during the process. Additionally, economic precarity, the costs of care, and the distance to some health centers may contribute to this situation (Reyes Muñoz et al., 2021). On the other hand, it is also essential to highlight that in Chile, pregnancy and childbirth are continuously monitored but also highly medicalized and pathologized (Sadler Spencer, 2004, 2016).

Research on the violence faced by racialized women who are mothers has been developed and expanded in recent years in Latin America. Examples include the studies by Lube Guizardi et al. (2019), León Gin (2014), Posso Quiceno (2010), Betancourt Burón and Gross Gutiérrez (2018), and Arias Hurtado and Carrillo Pineda (2019), among others. Social inequalities in child health have been predominantly studied in relation to the family's socioeconomic status, class analysis, and the educational level of parents (González-Rábago and Martín, 2019). However, there has been less focus on inequalities associated with racism and the migratory status of these children and their parents. This has become an important category to analyze in the field of health inequalities and their social determinants in recent decades. González-Rábago and Martín (2019) point out that evidence of health inequalities among migrant and local adult populations is strong, but studies on the generations descended from immigrants are still scarce in Europe and Latin America.

In Chile, there have been some recent studies addressing the ethnic-racial category as a constitutive element of structural inequalities experienced by migrant women who are mothers in the health system (Reyes Muñoz et al., 2021). These studies also explore the conditions of access and use of the health system (Antilef Ojeda et al., 2020), discrimination and exclusion toward migrants in the health system (Liberona Concha and Mansilla, 2017; Zepeda Vega and González Campos, 2019), and maternity among Haitian women in Chile (Abarca Brown, 2018; Reyes Muñoz, 2023; Reyes Muñoz and Chatelier, 2023). These studies demonstrate that state and societal logics bring acculturation policies toward the Afro-descendant and migrant population.

In this regard, several studies in Chile have addressed how migrants, who assimilate into Chilean societal logics, are perceived as less threatening by locals compared with those who opt for biculturalism (maintaining their cultural identity while simultaneously adopting aspects of the dominant culture), as proposed by Berry (2003) in his theoretical model on acculturation. This theory establishes four types of acculturation, understanding that migrant individuals must make complex individual adjustments, as well as emotional and sociocognitive adjustments, to respond to the double dilemma of maintaining the cultural identity of origin or incorporating cultural characteristics of the host societies and thereby losing significant elements of their own culture.

These acculturation types are integration or biculturalism (maintaining one's cultural identity while simultaneously adopting aspects of the dominant culture), assimilation (orientation toward the receiving culture and abandonment of one's own cultural identity), separation (maintaining one's cultural identity while simultaneously developing a negative attitude toward the culture of the receiving society), and marginalization or anomie (a negative attitude toward both cultural frameworks).

For example, in the research conducted by Mera et al. (2017) in the city of Concepción (in southern Chile), significant elements were found between perceived discrimination by migrants and their overall psychological well-being, which decreases when migrants choose the assimilation strategy. However, this has consequences for how they relate to their own communities in the destination countries. The study by Arenas and Urzúa (2016) on South–South migrants in northern Chile illustrates this. It indicates that migrants who chose loyalty to the in-group, i.e., a strategy of integration and separation from the host population, have a more positive orientation toward their ethnic group, unlike those who use an assimilation strategy.

3 Methodology

This research is part of a broader study framed within the doctoral research process of one of the authors, aiming to analyze the phenomenon of structural racism toward Haitian women—mothers and expectant mothers—living in Chile, from an intersectional approach. The study received approval from the Ethics Committee of her educational institution, the University Católica de Murcia, Spain, under the number CE0171925.

The presented text discusses how state care services under the National Childhood Health Program, implemented by nursing staff in Chile, can become a mechanism for the social acceptance of Afro-descendant migrant mothers who seek healthcare for their children in health centers across the country. To achieve this, five specific objectives were developed: two to understand the experiences of Afro-descendant women residing in Chile regarding access to healthcare for their children: (i) Describe the experiences of Afro-descendant migrant women in Chile regarding access to health; and (ii) Describe the experiences of migrant women bringing their children born in Chile to the check-ups of the National Childhood Health Program. Additionally, three objectives were designed to understand the implementation experiences of the program by nurses working directly with migrant mothers and children in primary healthcare. These were: (iii) Describe the experiences of nurses working with migrant mothers and their children in the National Childhood Health Program; (iv) Describe nurses' perceptions of the motherhood of migrant women in general, particularly Afro-descendant women; and finally, (v) Describe the cultural adaptations made by nurses to the National Childhood Health Program when working with migrant children or mothers.

All participants in this research: migrant women and primary health care nurses, (see Tables 1, 2) were informed about the research objectives and provided informed consent by signing consent forms (Tables 1, 2).

Narrative Productions were also conducted in six thematic workshops with migrant women to discuss their experiences in health centers in the Maule Region, city of Talca, Chile. Narrative Productions (Luxán Serrano and Azpiazu Carballo, 2017) stem from and build upon the work carried out in a conversation group or an individual interview, where people discuss a topic or a phenomenon, bringing forth relevant reflections about migrant motherhood.

TABLE 1 Characterization of Afro-descendant migrant women participants.

Women migrants	Nationality	Time of residence in Chile
Woman Migrant 1	Haitian	5 years
Woman Migrant 2	Colombian	6 years
Woman Migrant 3	Haitian	6 years
Woman Migrant 4	Venezuelan	8 years
Woman Migrant 5	Haitian	5 years
Woman Migrant 6	Venezuelan	7 years
Woman Migrant 7	Venezuelan	5 years
Woman Migrant 8	Ecuadorian	5 years

Self-elaborated based on fieldwork conducted during the years 2019–2020 in the Maule Region, Chile.

4 Findings

4.1 Experiences in the access to healthcare for Afro-descendant migrant women in Chile

The experiences of migrant women when attending different healthcare centers are diverse. When broken down by nationality, the narratives are primarily shaped by the experiences of childbirth among Haitian women and their transnational motherhood, where it is highlighted:

> *One of the most notable differences is that in Haiti, there are more natural childbirths. There, what we do is natural childbirth because that's how we want it. A cesarean section is only performed when the delivery is difficult… if there are complications. If there is a possibility of natural childbirth, a cesarean section is never done. Doctors do not perform a cesarean section just because a woman wants it; it is done only if the baby is in distress. Another very different thing is that in Haiti, the baby is not bathed when born, only cleaned. Because that will harm the baby later on. But here, the doctors do not understand and scold the women because they only want to clean with a cloth and be with the baby. And they take them away, they snatch them away, not letting the mother spend more time with the baby…" (Narrative Production) [Traslate by authors].*

Haitian women also describe the misunderstanding they feel when healthcare professionals find out they have a son or daughter living in Haiti and therefore they prefer not to mention it. This reveals a 'different' way of thinking and understanding the exercise of motherhood by migrant women but also the fear of being judged as bad mothers, despite being aware of the difficulties of their experiences and that, many times, transnational motherhood is not the option they would have chosen. This makes them feel guilty in front of

TABLE 2 Characterization of nurses participating in the study.

Research subjects	Years working with migrant population	Training in intercultural health	Training in gender and diversities	Training in migration policies
Nurse 1	3	No	No	No
Nurse 2	1	No	No	No
Nurse 3	3	No	No	No
Nurse 4	7	No	No	No
Nurse 5	5	No	No	No
Nurse 6	7	No	No	No
Nurse 7	6	No	No	No
Nurse 8	7	No	No	No
Nurse 9	10	No	No	No

Self-made based on fieldwork; years 2021–2022, in the Maule Region, Chile.

healthcare professionals, who, as Martínez Pereira (2021) points out, assign exclusive responsibility to women for their circumstances. As reflected in the narratives:

> *I think, I do not know… It's better not to say that one has a child there (In Haiti). They look at you badly. (Migrant Woman 1).*
>
> *I have a problem because my son lives in Haiti. They (healthcare professionals) thought, like, I'm crazy. They did not understand. I cried and cried, and they did not understand. (Migrant Woman 3).*
>
> *I have my son in Haiti. I think that's why they treat me poorly here. I believe they (healthcare professionals) think I'm bad because I'm not with my son. (Migrant Woman 5).*
>
> *[Translate by authors].*

The fear of rejection demonstrates an intention to do well, comply with what is requested, the effect of the normative mandate that must be fulfilled to participate in a healthcare system that does not feel like their own but in which they want and need to participate.

In the case of Venezuelan women, from another perspective, their stories reveal disparities between the healthcare received in their home country, where they paid for medical care, and Chile, where they are treated in the public service through the National Health Fund, which may involve co-payment or may be free depending on the income of the users. The interviewees point out that their experiences with healthcare in Chile are not as positive as in their home country, attributing this difference to the payment for private services in Venezuela versus the public healthcare they receive in Chile:

> *Healthcare in Venezuela is a bit more affordable than here, and generally, I used to go to private clinics. Also, the company I worked for covered health insurance; so, I preferred to attend private consultations, and I had no problem doing so. Because the public healthcare, like the CESFAM (Family Care Center) here, has a lot of people, and it would collapse, so I preferred to have a bit more money with insurance and have private consultations. (Migrant Woman 4).*
>
> *I consider that the attention in my country is much better than here. Here they have 10 or 15 min to see the patient and that's it. And sometimes they do not examine you as it should be. On the other hand, in my country (if I paid for a consultation, I did not go to the CESFAM like here where it is free) the attention can last an hour, they even do tests, and everything to say, to find out what you really have. But here (in Chile) I have taken my baby, who is 10 months old, to the hospital and I tell the doctor that he has a fever or vomiting and this and this, and they only give him medicine for the fever and I spent four or five hours there in observation and they do not do any tests, nothing… So that part is a little negative here, although as I said in my country I paid. So there they really try to see what the patient has, and in that case I say that I prefer the medical attention in my country as such. (Migrant Woman 6).*
>
> *[Translate by authors].*

In the narratives of Venezuelan women, there is criticism and objection to the normalized practices in Chilean healthcare, such as "sometimes they do not examine you as it should be," while acknowledging that the condition of gratuity implies a tacit acceptance of the mistreatment being criticized, "although, as I tell you, in my country, I paid."

The participants recognize the gratuity of public healthcare, regardless of nationality. However, as mentioned in the preceding paragraph, this condition seems to imply accepting all actions and behaviors, including mistreatment, as part of receiving a free service, which is often difficult for migrant women to challenge or criticize in the moment.

4.2 Experiences of migrant women with their children in the controls of the National Child Health Program

Regarding the specific experiences of migrant women in the check-ups for their children who attend the National Child Health Program, a very positive evaluation is noted. Mandatory check-ups and follow-up are appreciated as a genuine concern on the part of healthcare personnel. The centrality of gratuity persists, compared with the home country, seemingly also interpreted as a reward for completing the process:

> *In general, my experience here in Chile has been very good. Because back in my country, in Ecuador, they do not force you to go to the health center. For example, if you are pregnant, if you want to, you go to the health center, and if you do not want to, you just do not go to the health center and go when you are going to give birth. And when the baby is small, if you want to, you take it to the vaccinations and if you do not want to, you do not get any vaccinations and there is no problem, they do not say anything… they do not persecute you. On the other hand, here they force you to go to the check-ups, and if you do not go, they call you; they worry. And I feel that this is important because over there, for example, babies sometimes die, and mothers die too, especially in childbirth. In the hospitals the attention is very bad… so not here, here they care, they call you, the social worker asks you why you did not go to appointments, to check-ups. And that is important. Also, here they give the "Purita" milk to the mother and when the baby needs more milk they give another milk for free… so in my country they do not even give a diaper, here they gave me a crib, a complete set of baby things, clothes, diapers, games… In my country there is nothing like that, that's why I never checked myself or anything, because they do not care if you go or not. (Migrant Woman 8) [Translate by authors].*

Here, we observe how adapting to the requirements and practices of healthcare personnel is a way of demonstrating appreciation for the program. Therefore, while recognizing the shortcomings of the program, there is simultaneous gratitude for its existence and the care it provides during the gestation process for pregnant women and children. Gratuity remains a crucial element that motivates continued participation.

> *Everything is very good; the work, the health care… for example, now that I had my baby in the hospital, everything was very nice. Because in my country, for example, they do not take care of you with so much importance. For example, my baby was hospitalized for eleven days and every day the doctor came by and they explained to you what was wrong with your baby; the social worker was also looking after you, the nurses were looking after the baby… there was never something like saying it was bad… everything was excellent. And I was very happy because in reality the attention here is nothing compared to my country, in my country, first of all there is not even a pediatrician there, like here, specialties… if my baby had been sick maybe I would have spent a lot of money there, but instead here it was very free, it did not cost me a penny. Very nice attention, the doctors were excellent and I was very happy because my baby, thank God, is well and was able to come out well and it did not cost me anything, because the attention was free and very good. And then at the "Poli" (Family Health Center) at all the check-ups they have been very kind; I go with my baby to the appointments that are scheduled in advance and the nurse, the social worker, the whole team is there to attend us well; it is really a blessing. (Migrant Woman 2) [Translate by authors].*

As it is evident, the interviewed women feel satisfied, especially regarding the check-up for their children. The follow-up is not considered an unnecessary or mechanical practice; on the contrary, it is a way in which they feel their presence, as well as the presence of their children is valued, and where they perceive a genuine concern for their well-being.

4.3 Experiences of nurses working with foreign mothers and their children in the care of the National Child Health Program

In this section, we will discuss the perspective that nurses have regarding the National Childhood Health Program and the care provided to migrant women and their motherhood practices.

The general knowledge that nurses have about this program would indicate that, with a greater number of years working in it, their knowledge becomes more specific, providing a theoretical background for the implementation of the policy. In contrast, the knowledge of nurses who have recently joined the program is more general and focuses on the practical aspects of care. For instance, a nurse with less than a year of experience in this area states:

> *Well, Chile Grows with You, which is more commonly known as the program, oversees the health care of children, specifically focusing on complementary feeding and also addressing children with food allergies. It also includes vaccinations, stimulation rooms with preschool educators, speech therapists, etc. However, sometimes parents do not take their children to these programs. Sets of games are also provided to encourage the cognitive development of children. (Nurse 2) [Translate by authors].*

A nurse from a busier center, with 3 years of experience in the program, states:

> *The program looks for risk factors and potentialities, in addition to assessing tools for these children. Moreover, there is constant evaluation throughout the life cycle; from two months up to 9 years… well, 9 years, 11 months, and 30 days… because then children move on to another program. Also, it is a multidisciplinary program, with many professionals attending to them and providing what is necessary for their integral development. (Nurse 1) [Translate by authors].*

Now, unlike the general view regarding the program and its ability to describe it, it seems that the time spent working on it does not imply mastery of other topics of interest for migrant women. However, unlike the general view about the program and their ability to describe it, the time working in this program does not imply knowledge of other topics of interest to migrant women, such as intercultural health, health and migration policies, or gender and sexual diversity, where the interviewees also demonstrate and recognize an important deficit in their training:

> *Regarding human rights, more than the program itself, there is the part of professional ethics that implies that we have to treat everyone equally. And from there, ethical values. Now, regarding a gender perspective, no, we do not have knowledge. And regarding health and international migrant policies, I know it exists, but not more than that. (Nurse 3).*
>
> *On human rights, receiving timely health care. And yes, of course, their rights are respected. For example, there is the issue of immunization, vaccinations. The socioeconomic part of the children is also evaluated, social vulnerabilities; there is a social worker in*

> *charge of that, and we go to visit them at their homes, we do home visits when it is believed that children are exposed to situations of vulnerability. Nutrition is also considered, the food given to them depending on their nutritional condition. (Nurse 4).*
>
> *Now, the gender and transgender aspects, that is not visible; I think it's due to a lack of training. And health and international migrant policies, nothing. (Nurse 7).*
>
> *[Translate by authors].*

The absence of training processes is a critical element for the interviewed professionals; however, the recognition of the lack of tools does not justify judgments on the mothering or responsibility practices of migrant women. Furthermore, the social and political context in the country and the media portrayal of migration as a problem do not facilitate its approach from a rights perspective, which is reflected in healthcare practices. In this sense, the nurses' perceptions of the migration phenomenon resonate with the scenario of restrictions on the entry of Haitian and Venezuelan populations into the country:

> *I feel that fewer people are entering now… My perception is that maybe, since there are people entering without papers or through unauthorized steps, maybe they do not come to the CESFAM. (Nurse 3).*
>
> *Well, since they recently started reopening the borders after COVID-19, the migratory pattern has changed too. I would say that currently, we have one Haitian family, the rest are all Venezuelans. (Nurse 4).*
>
> *There are conflicting opinions. Everything happening in the north, with people entering through unauthorized steps, living for months on the street, in tents, without basic services… and now we see that in the streets, here in the city, with Venezuelan children asking for money, and we did not see that before… I wonder, 'Isn't there an option for these children to go to kindergarten? Perhaps if they enter illegally, maybe they cannot, or they do not have the means… But when children ask for money, there is a violation of their rights. But I agree with migration. (Nurse 2) [Translate by authors].*

The nurses' narratives also show a lack of knowledge about the Policy on Health and International Migrants and the right to health care regardless of the migrant status of individuals.

4.4 Nurses' perceptions of motherhood among migrant women, in general, and, particularly, Haitian and Afro-descendant women

Perceptions of the interviewed nurses regarding the motherhood of migrant women remain anchored in the idea of birth control as a measure to reduce poverty, which is inherent in the state's modernization project (Álvarez Díaz and Aguirre Munizaga, 2021):

> *Mmm… Honestly, they do not take precautions. Look, they used herbs to avoid getting pregnant, and obviously, they got pregnant. The Venezuelans… oh, I've thought about it, but I do not want to think about it, but it's true, I think about it… Well, they do not have jobs and get pregnant, they cannot support those children, and later they are out on the street asking for help… I do not know. I find it very irresponsible. (Nurse 5) [Translate by authors].*

This occurs in a socioeconomic context which is perceived as critical for both locals and migrants. Despite Chile showing a significant decrease in local population birth rates, the notion of migrant-led fertility does not appear to be part of the predominant discourses, neither among healthcare professionals nor in the general society.

> *I feel that motherhood… that everything comes down to whether it is desired or not, in general terms… And that does not depend on whether they are Chilean or foreign, it depends on other things. Now, with the Haitian population, something particular happens to me; it happens with some mothers who do not have the same attachment. And talking to colleagues, this is related to the infant mortality rate in these countries. So, faced with these rates, it is linked to the lack of attachment. And I experience that with babies, but with older children, they do have a more affectionate relationship, they smile, they are happy. (Nurse 1) [Translate by authors].*

In this scenario, the image constructed of Haitian motherhood demonstrates xenophobic, racist, and classist treatment. The socioeconomic context is used to justify the overemphasis on their healthcare and that of their children. This justifies control while disregarding the women's own will regarding their maternal desires, parenting practices, and childcare (Álvarez Díaz and Aguirre Munizaga, 2021). This is under the unquestionable assumption that "migrant women are at risk if they do not adhere to the guidelines of the Chilean health system" (Martínez Pereira, 2021, p. 86) [Translate by authors], especially concerning their children who would not receive the "same attachment."

> *For instance, if the mother does not speak, that is, if the mother only speaks Creole and does not speak Spanish, how can you educate her? If they do not speak, they do not speak. They are so shy that they barely greet. So, you cannot provide any education because if she does not speak Creole and does not understand Spanish, you limit yourself to conducting health checks, weighing the baby, anthropometric measurements, and referring if necessary. But what can you do if they have been living in Chile for four years and still cannot say hello? Or say any phrase like "my child is sick," they communicate with signs. So, faced with that, what are you going to do? It's challenging if we used to have a translator, so it was more straightforward because you would go get Agustin, for example, to translate the Edinburgh Postnatal Depression Scale, it was much easier, but now we do not have a translator. (Nurse 5) [Translate by authors].*

This anchors the health professionals' imaginings of "correct" ways to be mothers. In the following account, you can see how Haitian women are viewed when they follow the recommendations and instructions given in health centers:

> *Good, in general, it has been a good experience. Haitian moms are very humble; they are receptive to what you tell them, they always comply, as you told them; they are always concerned about the children and always seem happy, pleasant. It's like they are always smiling, pleasant; I do not know what they see. But yes, the Spanish language is difficult for them. (…) for example, I do not know, the hip X-ray… but I think it's more because, since they do not understand that they have to come to certain check-ups or go here or there, ultimately, they do not go. So sometimes, you tell them to go, and there they go. So I think they get a little confused, but in general, the experience is good. (Nurse 9) [Translate by authors].*

Regarding differences between the health and psychomotor skills (or other skills) of Chilean mothers' children and those of foreign mothers, nurses comment, continuing to construct an image of migrant mothers without knowledge or conditions to do what is supposed to be the right way to be/do:

> *Yes, a lot. I've had to go see what they have for dinner, for example, ask more in that sense about what they eat. I also see it a bit socially; for example, if they are arriving at the kindergarten, if the babies are well dressed, sometimes they put too much clothes on them, and then they arrive sick at the health center. (Nurse 2).*
>
> *Honestly, I do not notice differences in health between Chilean and foreign mothers. Except in diet. Now, regarding psychomotor skills, yes, I have noticed that; all the referrals to stimulation rooms are children of foreign mothers. (Nurse 1).*
>
> *[Translate by authors].*

This is related to what Martínez Pereira (2021) points out about the Chile Grows with You program in family health centers, where there is an insistence and a mandate "to change habits and ways of life that are not considered normal for the local care culture" (2021, p. 85–86) [Translate by authors]. This adds to the idea that professionals must "convince migrant women" to adhere to the program because "she," "the migrant," does not see the benefits it offers, without considering underlying structural factors, such as absences from check-ups. The following narrative illustrates this very prominently:

> *…my experience was not very good in the sense that, well, there was the language barrier; she did not speak much Spanish. At one point, a six-month check-up came, and she was very emotionally labile. I had to apply the Edinburgh (test to assess postpartum depression), it came out altered, and well, to ensure that we have a good score, it was applied to her in Creole. The result came out altered, and we had to make a referral to a doctor; she went with the doctor, was referred to the psychosocial team, a social worker, a psychologist, but it was a completely ineffective intervention because, of course, she came, they did not understand her, like they could not achieve effective communication due to the scarcity of the language. So in the end, she did not want to come anymore, so she also stopped going to the psychologist, stopped going to the social worker. The child, also, being altered in Edinburgh, was referred to the stimulation room. He did not go to the stimulation room anymore, so he left all that aside. So when she later returned for a check-up, I had to apply the instrument again, also in Creole. There, a normal score came out, but even so, she tried to communicate with me and tell me that she had problems in Chile, family problems, everything that made her feel bad. Logical things. But it's complex because you try to explain, you try to communicate with them anyway. And they say yes, yes, yes, yes. But in the end, you realize that they are not understanding you. So, it's complex to address these check-ups. (Nurse 5) [Translate by authors].*

4.5 Cultural adaptations made by nurses to the National Child Health Program when working with migrant children

As for the question of whether the Program influences the quality of life of the children of migrant mothers living in Chile, the professionals state:

> *I think in a very good way. The mothers leave very grateful. What has happened to me is that sometimes they do not go to the referrals; but in general they feel good, because there is also the delivery of food for the children, for them; so that is very important for the women and their babies and their older children. (Nurse 9).*
>
> *The quality of life of children is related from before the child is born. And the National Child Health Program affects considerably; for example, the national complementary feeding program, which is now also considering poor nutrition due to deficit, because migrant children are underweight and before the nutritional problem of children in Chile was due to excess; but in the case of migrants, they are families who spend money here, who also send money to their relatives in their countries of origin. On the other hand, there are the vaccinations, the calendar is adapted to Creole; in addition, the test to evaluate postpartum depression is also adapted to Creole. (Nurse 1).*
>
> *[Translate by authors].*

As observed, the nurses, in general, have made adaptations more from their own initiative to better serve migrant children, especially those who are the offspring of Haitian women due to the language difference. However, they do not provide a critical assessment of the Program, let alone the normative, uniform, and overly vigilant behavior that it imposes on migrant motherhood, as illustrated in the following quote:

> *I do not really see any deficit in the program, but this center is such a small place, we do not have a large migrant population… besides, it is in a rather residential, old neighborhood, with a large retired population, so there are not many migrants. But there are, but I do not see any problems with them, so I have not had to make any adaptations. Everyone is treated the same here. (Nurse 2) [Translate by authors].*

Nor do the nurses discuss the logic of equality that underlies their discourse and that of the State. Much less do they consider how "treating everyone equally" when providing differentiated care is also a form of violence and discrimination, given the real and structural differences in the ways the image of Chilean society and family has been constructed, with a single form of motherhood and attachment at its core.

> *Let us see if the wife does not speak Spanish, I give her everything in writing. She'll have… she'll have the job of telling the husband, some friend or some relative and have him translate it. (Nurse 5) [Translate by authors].*

On the other hand, Program professionals state that it meets the needs of migrant communities and does not require adaptation or revision:

> *Here they are welcomed, visits are made to them, they are given the layette, the milk. Everything as it should be. (Nurse 5).*
>
> *I believe that the care we provide to migrants is really good. (Nurse 9).*
>
> *We provide equal care for all people who come here, we do not distinguish between Chileans and foreigners. (Nurse 3).*
> *[Translate by authors].*

Although there are professionals who recognize the need to change and evaluate the relevance of the Program in a dynamic social context, and who state that it is necessary to recognize the autonomy and agency of migrant and local women and mothers regarding care.

> *Yes, there are many things that I would modify, absolutely, starting with the facilitators; the training of professionals; the information available in Creole for children; training in language and also in culture, for example, learning about how health centers are in other countries, how the vaccine schedule is, etc., how families are there… And of course, understanding the appreciation that mothers have about the care we are providing them; what they specifically need. (Nurse 1) [Translate by authors].*

5 Discussion

As observed in the findings, concerning the experiences of migrant mothers in the Chilean Health System (objective 1), they generally have a positive evaluation. However, variations arise due to the diverse maternal experiences in their respective home countries. For instance, Venezuelan women express that they used private healthcare in Venezuela, which they perceive as superior to the healthcare system in Chile. Nevertheless, they acknowledge seeking care in the Chilean public health service, which is either free or involves co-payment. On the other hand, Ecuadorian, Colombian, and Haitian women evaluate their healthcare experiences in Chile much more satisfactorily than in their countries of origin. They highlight the constant monitoring during pregnancy, regular check-ups, and the provision of essential items for child rearing in the early months, such as clothing, cribs, milk, among others. Moreover, ongoing check-ups for their growing children contribute to a positive perception.

Regarding the objective focusing on the experiences of migrant women in the Childhood Health Program (objective 2), there is a positive acknowledgment of the program and its associated practices. However, from a critical standpoint aligned with Martínez Pereira (2021), it is crucial to recognize that "women are within a constant logic of observation and monitoring by different health professionals" (p. 82) [Translate by authors]. This continuous scrutiny, combined with material incentives provided by the program, functions as a means to encourage adherence to local care practices. These normalized program practices limit the possibilities of complaints or questioning from users, establishing a power hierarchy between health professionals and women. It is noteworthy that women identify negative elements in healthcare, particularly during childbirth, where their cultural practices are overlooked, and they are not heard or informed about their experiences. Parallel to the experiences of indigenous women discussed by Caro (2009) and Smith-Oka (2009), the control and execution of non-consensual practices, as indicated in the narrative production: "they take them away, they take them away, they do not let the mother be with the baby anymore," "they challenge women because they just want to wipe with a wipe and be with him" [Translate by authors], reveal an entrenched and normalized hierarchical operation within healthcare.

Addressing the incorporation of cultural knowledge and practices into the Childhood Health Program becomes imperative. The challenge is to avoid outright dismissal, infantilization, and violence against the knowledge and cultural practices of migrant women. They are not merely recipients of care but bearers of knowledge that can engage in meaningful dialogue with what Caro (2009) identifies as expert knowledge, in which women, and even more so if they are migrants or indigenous, are constructed as:

> a needy other, who does not know, therefore, that it is necessary to "educate," "inform" and "discipline." How is this "expert knowledge" articulated with the knowledge possessed by families and especially by women on parenting issues that have been transmitted intergenerationally? We want to model in front of a field in which there is a popular knowledge, close or far from "scientific knowledge," but which is necessary to recognize, contrast and dialogue with the expert knowledge. (Caro, 2009, p. 28) [Translate by authors].

Concerning the analysis of the experiences of nurses working in primary health care and specifically in the Childhood Health Program (objective 3), it is evident that these professionals do not perceive racialized migrant women as autonomous agents in their reproductive, nurturing, attachment, and motherhood processes. This aligns with Martínez Pereira (2021), highlighting an asymmetrical health professional-patient relationship where migrant women are not perceived as capable of understanding their health processes or conveying their needs. In this systemic logic, "women are continuously at risk if they fail to comply with the established guidelines in medical consultations and workshops" (Martínez Pereira, 2021, p. 87) [Translate by authors]. This is evident in various experiences described earlier, demonstrating how nursing professionals assume the responsibility to convince users to attend check-ups without considering the sociocultural, political, and economic context underlying the absence of migrant women from certain appointments. It emphasizes the necessity of analyzing the structures of inequality and power inherent in healthcare systems to comprehend the complexities faced by racialized migrant women. And while the possibility of risk is real, it is not due to complying or not with the Program's contents; rather, it stems from the structural inequalities experienced by racialized migrant women in various state services, and, of course, in healthcare institutions.

In relation to objective 4, regarding the perception of nurses toward migrant women, it is indicated that there is a bias concerning their birth rates, arguing that they do not use contraceptive measures, do not control their pregnancies, and in the specific case of Haitian women, it is not possible to provide them with instructions on care for themselves and their children because they do not master Spanish. Thus, healthcare professionals naturally assert that their "ways" of care, motherhood, and attachment are the correct, only, and definitive ones for all users attending health centers. Moreover, it implies control and monitoring of migrant mothers, primarily racialized, as if they lacked autonomy and understanding to decide what is best for themselves and their children. In this regard, the work of Reyes Muñoz and Chatelier (2023) illustrates how Haitian women are constantly mistreated in Chilean health centers due to the ways in which they exercise care toward their children, breastfeeding practices, complementary feeding, and especially attachment.

Regarding objective 5, concerning the adaptations that nurses make to the National Childhood Health Program when working with migrant children, it should be noted that some professionals are critical of the program's structure, perceiving it as stagnant. However, despite this reflection, they do not make relevant adjustments to the cultural reality of the users, repeatedly stating that they provide uniform care to all individuals who come to the health center. This is contradictory in a country that is becoming increasingly diverse and aspires paradoxically to less centralization, more diversity, and greater recognition. This may explain why autonomy and the inclusion of women, their knowledge, and experiences are not deemed relevant to the practices outlined in the program and by its implementers. In line with this, Martínez Pereira (2021) notes:

> that the Chile Grows with You program (ChCC) has a local perspective on pregnancy care, using persuasion and guilt as a means to operationalize these guidelines and convince migrant women to adhere to the Chilean health system and prevailing care practices. (Martínez Pereira, 2021, p. 82) [Translate by authors].

Naturalizing many practices from the national discourse on care, attachment, breastfeeding, nutrition, etc., as universal and immutable issues, without reflecting on them as specific to the national context and without considering the real involvement of women in decisions about the care of their children; in other words, without recognizing them as subjects with agency. In this context, the work of Gideon and Ramm (2020) is interesting. They precisely point out that the State validates women as mothers, and therefore, its actions and discourses aim at the "protection" of motherhood. However, these political protection actions have the effect of confining women only to their role as mothers, excluding men, and denying the existence of women as citizens, thus establishing a maternal ideology that overlooks the cultural diversity of mother subjects and limiting women to their reproductive capacity. Therefore, if Chilean women do not comply with this imaginary associated with care, sacrifice, and submission, migrant women will be even more questioned and invalidated in what the State expects of them.

6 Conclusion

The experiences of Afro-descendant migrant women who have become mothers in Chile and who seek healthcare services through the National Childhood Health Program are diverse. They range from a majority expressing gratitude for the services provided by the State through healthcare professionals to criticisms of the system, where they sometimes feel ignored and mistreated.

The National Childhood Health Program needs to be evaluated not only based on outcome indicators but also in terms of the rationalities that shaped its design and how these are replicated in its implementation. It tends to disregard the knowledge and agency of women and their mothering practices, further overlooking the inequalities in their position in the host country. For example, there are significant differences in how pregnancies are carried out between Haitian and Chilean women. The former are accustomed to physiological births accompanied by dancing, prayers, and songs during labor itself, with pregnancies monitored by both healthcare professionals and traditional healers. They also follow breastfeeding practices supplemented with ground foods after the baby's third month (Reyes Muñoz and Chatelier, 2023). This is viewed as incomprehensible by the Chilean healthcare system, where women are thoroughly controlled by biomedical professionals throughout the 9 months of pregnancy. There's excessive medicalization and pathologization of childbirth, with cesarean section rates exceeding 55% (Sadler Spencer, 2004), and "mandatory" exclusive breastfeeding for the first 6 months (Reyes Muñoz, 2023).

Considering these findings, it can be argued that the Program operates uniformly in the discourses of nursing professionals without distinguishing between the local and migrant populations, ostensibly under the umbrella of human rights. However, two evident contradictions emerge from the narratives. First is that the evidence indicates there is a distinction from healthcare personnel toward Afro-descendant migrant women and their children. Second, the uniformity of the Program and the normativity underlying it imply a stance that does not promote human rights but rather controls and closely monitors women and their reproductive processes based on an idealized form of motherhood assumed to be the only correct way, without recognizing migrant women as autonomous beings capable of deciding on the exercise of their motherhood and their own agencies in these realms.

Therefore, the Program, which enjoys high prestige and recognition at the societal level, like any program, has a normative mandate. In this case, it is based on the control and close monitoring of women, and concerning migrant women, it tends toward assimilation in terms of Berry (2003), toward health practices in the destination country. In other words, it functions as a mechanism for acceptance into the social body, gradually compelling migrant women to abandon the cultural practices of their own identity. In this sense, women who comply with the Program and assimilate – as Berry (2003) would put it – into local forms, are valued, respected, and recognized, along with their children. Moreover, all women are perceived and positioned as the exclusive and sole caretakers, adhering to gender mandates, contracts, and roles naturally. Similarly, women who experience motherhood differently, exercise it in diverse ways, or conceptualize it from alternative logics of separation, are quickly labeled as "unfit," "less affectionate," "inexperienced," and, therefore, subjects subjected to control and the reproduction of social norms.

In the same vein, it is argued that the monitoring of "instructions" and health control practices by the National Child Health Program on migrant mothers could influence expectations of inclusion and assimilation into the social body, both from the professionals who attend to them and the migrant women who visit healthcare centers. They are recognized as good mothers, as long as they behave like national women. However, this implies the acculturation of their forms of cultural identity, practices, actions, and desires.

Finally, this situated critical analysis cannot overlook the material conditions in which the National Child Health Program is implemented, as addressed in the findings, with few training opportunities for those providing care, but also with other deficiencies in terms of health coverage and suitable conditions for implementation. For example, the lack of intercultural facilitators, language mediators, experts in interculturality, gender diversity, human rights, among others.

In this context, medical anthropology and intercultural studies for addressing existing forms of acculturation could offer concrete actions to untangle critical knots involving the alteration of cultural practices and behaviors specific to certain communities. This includes addressing the differences and asymmetries that arise in the interaction between healthcare personnel and migrant women, along with their children, in various primary healthcare centers under the National Child Health Program.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding authors.

Ethics statement

The studies involving humans were approved by Comité de Ética de la Universidad Católica San Antonio de Murcia. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

YR: Writing – original draft, Investigation, Methodology, Writing – review & editing. VR: Writing – review & editing, Investigation.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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"*If I fall down, he will pick me up*": refugee hosts and everyday care in protracted displacement

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Around the world, refugees share shelters and homes with other refugees. Such household-level hosting relationships play a central role in the lives of displaced individuals and families, offering support to meet basic needs, safety, and a sense of belonging. Yet, the role of displaced people as refugee hosts is often overlooked, an omission that fails to account for the active role of displaced populations in supporting one another and the dynamic social connections between refugees. Thus far, hosting relationships have often been understood through hospitality. Instead, in this paper I develop an understanding of refugee-refugee hosting as constituted through care. Drawing on qualitative research conducted with Sudanese refugee men in Amman, Jordan, I demonstrate the value of this framework in explaining the emergence and experiences of their hosting relationships. I highlight the importance of everyday interdependencies for life in displacement, alongside the challenges and ambivalences of providing and receiving care in such contexts, and show how configurations of care shift and alter throughout protracted displacement. In doing so, I center informal and everyday acts of care among refugees in relation to external humanitarian care, arguing for a re-conceptualisation of the relationship between 'hosts' and 'humanitarians', and propose avenues for those working with displaced populations to engage with the vital support that refugee-refugee hosting provides.

KEYWORDS

refugees, host families, hosting, care, humanitarian, Jordan

1 Introduction

The generous welcome of refugees into citizens' homes has frequently featured in coverage of the response to refugees arriving in Europe, particularly since 2015 (Lyons and Grant, 2015; Cantor et al., 2017; Wade, 2018; Refugees at Home, 2019; Room for Refugees, 2019) and again following the start of the war in Ukraine (for example, the Homes for Ukraine scheme launched by the government of the United Kingdom in March 2022 (House of Commons Library, 2023)). Many of these reports on hosting in Europe rightly acknowledge that only a small proportion of the global refugee population comes to Europe, with the majority living in countries neighboring the conflict (UNHCR, 2022). Few, however, recognize that nationals and refugees in these countries of conflict, first asylum and transit are also hosting refugees in their homes, sharing accommodation and resources.

Data remains slim, but in humanitarian settings many forcibly displaced people have at some time resided with a host family (Davies, 2012; Caron, 2019). In such contexts, the distinction between host and guest, citizen and refugee, established group and new arrival, does not fully hold. Despite a continuing depiction of hosts as non-displaced residents and guests as refugees, in many cases hosting practices take place between refugees: individuals and households who have little to no formal claim over the space they inhabit yet nonetheless share their space and resources (Fiddian-Qasmiyeh, 2016; Yassine et al., 2021). It is these refugee-refugee hosting arrangements that are the focus of this work, and within my research, participants had only lived in hosting arrangements with other refugees (with the exception of one Sudanese man who had shared a room with a Jordanian man for a short period). Further, while the wider literature discusses refugee hosting at the neighborhood, city, or country level, I focus at the household-level, albeit with recognition that household level hosting arrangements have wider interactions with members' experiences of the cities and societies in which they reside, as will be discussed later in this article. In this article, I refer to these arrangements as refugee-refugee hosting at the household-level. Accommodation sharing exists in many forms and contexts: my attention here is on those household-level hosting relationships that are built between those that would not in non-displacement or non-humanitarian contexts be living with each other. The earlier stages of this research identified different types of hosting, along continuums of guesthood and independence (For further details, see Section 4 and Jordan, 2020). This article focuses on the 'shared group' hosting type, in which individuals shared both accommodation and resources in a reciprocal and collective manner with displaced people.

Refugee-refugee hosting practices are just one example – a particularly widespread example – of the ways in which displaced populations and affected communities care for one another, in negotiation with the assistance provided by host states and international organizations. Thus far, hosting has typically been conceptualized through hospitality. However, in this article I demonstrate the insufficiencies of hospitality for fully understanding such acts, instead focusing on the participant's descriptions of their relationships as a form of care enacted through sharing, and the value of such a reconceptualization.[1] I argue that a reconceptualization of hosting relationships as relations of care allows us to better see the multifaceted support that they offer, as well as the limitations and challenges. The centrality of care within this understanding of hosting contributes a sense of the interdependence of hosting participants, this distinguishes it from the independence of tenancy-rental and the dependence of guesthood, and moves the discussion of hosting away from one dominated by economic transactions and meeting of material needs, to a more holistic consideration of refugee well-being and social presence. An ethics of care requires recognition of the other as part of our world and ourselves, attention to everyday acts, and connection and participation in a real and everyday web of relations and human interaction (Staeheli et al., 2012; Yuval-Davis, 2013). For the men in my research, such acts are a vital response to marginalization and obscurity within the city.

In the following sections, I first outline the reality of life in Amman in 2017 and 2018 for the Sudanese Darfurian men who participated in my research. I then offer a succinct overview of existing literature on refugee-refugee hosting and the dominant conceptualisation through the lens of hospitality. I then present my methodological approach to the research. Drawing on qualitative research with Sudanese men in Amman, I propose a new conceptualisation of the refugee-refugee host dynamics, that centers a relationship of interdependent care. In the remainder of the article, I show the value of this framework in understanding how the men I worked with created and experienced care in their hosting relationships and how this shaped their experiences of urban displacement in Amman. I then interrogate some of these dynamics, in particular the ambivalences shared around receiving care, and how care dynamics have shaped, and are shaped by, the temporalities of displacement. In concluding, I reflect on value of understanding hosting as care, and the implications for humanitarian response.

2 Context: Sudanese displacement in Jordan

Jordan is a long-term host of refugees[2], having hosted a Palestinian refugee population for over 70 years. However, Jordan also hosts between 720,000–1.3 million non-Palestinian refugees, nearly all of whom are also living in protracted displacement.[3] In the last decade, Syrian refugees have been the primary focus of research and commentary, however at the time of my research in 2018 refugees from over 50 other countries were also registered with UNHCR in Jordan (recent conversation with UNHCR in June 2023 suggest this has dropped to 38 countries of origin). Among these, the largest populations are Syrian (656,762) Iraqi (59,814), Yemeni (12,784), Sudanese (5,068), and Somali (572) (UNHCR, 2023a). Despite the large and long-term presence of these groups, Jordan is not a signatory to the UN Convention on Refugees, and refugee presence, including adjudication of their asylum claims, is instead managed through the auspices of a Memorandum of Understanding (MoU) between the United Nations High Commission for Refugees (UNHCR) and the Government of Jordan (GoJ). Jordan presents itself as a transit state and there are extremely constrained options for long-term formal integration or citizenship. Many refugees -including the Sudanese – also see their time in Jordan as transitory, on route to a different country or while waiting to return to their country of origin. They therefore remain 'guests'. At the same time, the protracted nature of displacement for refugees of many nationalities in Jordan call into question this temporariness. Many refugees have created lives in Jordan, in some cases extending to multi-generational families, and hold long-established, albeit precarious, ties to their places of residence and to the country.

Sudanese refugees in Jordan do not have access to camps, and the largest proportion live in Amman. At the time of my research, the

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[1] A version of the arguments presented in this article first appeared in my PhD thesis, awarded in 2020.

[2] Some men participating in this stage of the research were registered with UNHCR as asylum seekers but had not yet undergone a refugee status determination assessment. I use the term "refugee" throughout this paper as it was the term used by the men to refer to themselves, and refugee recognition rates among Sudanese in Jordan are near universal.

[3] Refugee numbers in Jordan are contested. As of the end of 2023, there were 720,000 refugees registered with UNHCR (2023b). However, the Government of Jordan estimated that there were 1.3 million Syrians in the country (For example, King Abdullah II, 2018), in addition to those of other nationalities.

majority of Sudanese refugees in Jordan came from the Darfur region of Sudan. Darfur received international attention during the conflict in 2003, but has been suffering from on-going and renewed conflict in the intervening years (de Waal and Flint, 2008; Mamdani, 2009; Jok, 2015), and again in the current conflict in Sudan (Human Rights Watch, 2023; MSF, 2023). A large proportion of Sudanese refugees in Jordan are young men (estimated 70% at the time of my research), fleeing conflict and conscription into armed groups, though the number of women and children appeared to be growing at the time of my data collection. There was a Sudanese refugee population in Jordan before 2011, but numbers increased in 2012/2013 following the separation of South Sudan, economic collapse, and renewed fighting (Johnston et al., 2019). Following this, numbers of new arrivals remained low. The total number of Sudanese refugees in Jordan was severely reduced in late 2015 when more than 500 Sudanese people were deported, including those holding UNHCR documentation, following demonstrations outside UNHCR calling for increased recognition of their refugee status and response to their needs (Human Rights Watch, 2015). In 2017/2018, numbers began to climb. Between February 2018 and August 2018, 840 new individuals registered with UNHCR, bringing the total number of registered Sudanese up to 4,898, an increase of 21 percent in 6 months (UNHCR, 2018). Since 2019, the GoJ has requested UNHCR to not register people claiming asylum who enter the country through specified routes, including arriving at Queen Alia airport with medical visas, one of the primary entry routes for Sudanese nationals seeking international protection.

Since the deportations in 2015, there has been a noticeable increase in the attention of non-governmental organizations (NGOs) toward the Sudanese (Baslan, 2023), and a number of reports have been produced detailing their living situations (ARDD-Legal Aid, 2015; Baslan et al., 2017; MMP, 2017a,b; Johnston et al., 2019). These reports show that Sudanese refugees have acute unmet protection, healthcare, education, food security, and shelter needs, and extremely limited livelihood opportunities. Despite acute need, there were far fewer NGO-provided services open to Sudanese and other non-Syrian refugees. In recent years, there has been a shift toward a “One Refugee” approach, with the establishment of a working group, and with a larger number of organizations now providing humanitarian assistance to Sudanese refugees. However Sudanese refugees still report being underserved, and humanitarian funding levels more generally have been declining in Jordan in recent years. Further to the gaps in formal assistance, many Sudanese report frequent incidents of racially motivated harassment and discrimination from other urban residents, state institutions and the United Nations (UN) and NGOs, compounding formal exclusions and restricting access to some forms of informal societal support. In such a context, refugee hosting relationships are an essential and widespread response.

3 Literature review: refugee hosting as hospitality in humanitarian contexts

As the response to displacement increasingly engages in out-of-camp and urban contexts, refugee hosting has gained more attention within practice and research. However, while there is a growing body of important work on refugee hosts so far this has often focused on community and neighborhood responses (Jacobsen, 2002; Fiddian-Qasmiyeh, 2016; Rodgers, 2021). There has been much less work with host families, despite their prevalence and their importance to refugees. Where literature does exist, hosting at the household level (often referred to as host families) is typically depicted as a response to economic need. When motivations for participation are considered, they are often reduced to unproblematised notions of family obligation and hospitality (Chambers, 1986; Haver, 2008; Davies, 2012; Brookings-LSE, 2013; UN-Habitat, 2013; Argenal and Setchell, 2014; UN-Habitat and UNHCR, 2014; Caron, 2019). The following section briefly summarizes existing knowledge from within the humanitarian space on host families (from here referred to as hosting), before unpacking the notion of hospitality as the central framing of hosting practices.

3.1 Hosting in humanitarian contexts

Hosting is recognized as a core part of support mechanisms for displaced populations by humanitarian actors (Davies, 2012; IFRC, 2012), however there is relatively little sustained attention to these practices. Four main characterizations emerge (Corsellis et al., 2005; Davies, 2012; IFRC, 2012; Brown and Hersh, 2013; Argenal and Setchell, 2014; Caron, 2019):

1. The first is that host families and the displaced people they host have an existing connection, such as being distant relations or a pre-existing social or economic tie.
2. Secondly, that hosting a refugee places a burden on the host family, particularly as time goes on.
3. The third representation is that hosted refugees are at high risk of exploitation, particularly if they are women and children.
4. Finally, that host and guest are distinct roles. Although a guest may later reciprocate and host their former hosts, this does not occur within a given instance of displacement.

These characterisations hold some basis, and highlight relevant concerns within hosting. However, they do not represent the full picture. In particular, these characterisations do not fully recognize the active role of displaced populations in constructing hosting relationships and within hosting arrangements, and the relationships depicted are static. There is some recognition that they may deteriorate over time, and a concern that ‘guests’ may be asked to leave, but little other consideration of this as a dynamic relationship that alters and shifts in response to the wider displacement and socio-economic context over time. This is linked to the conceptualisation of the relationship as one of hospitality, as implied in the terminology, ‘hosting’ or ‘host family’.

3.2 Hosting and hospitality

Hospitality is very frequently used when discussing and analysing responses to refugee movements (Komter and Leer, 2012; McNevin and Missbach, 2018), yet hospitality practices among displaced populations themselves are rarely considered (Fiddian-Qasmiyeh, 2016). The centrality of hospitality in existing understandings is implicit in the language used to refer to and describe refugee responses. In Jordan, the Iraqi and Syrian refugee response has largely been framed around, and uses the language of guesthood with an emphasis on the value of hospitality (El-Abed, 2014). During my fieldwork, such language was rarely used to describe the response to refugees of other nationalities, either in official discourse or everyday conversation. Though hospitality is commonly understood as a positive action, with connotation of refuge, generosity, and friendship, such relationships also mask complex power relations and divisions between those who belong and those who do not.

On the surface, hospitality can be considered as the creation, celebration, and reinforcement of relationships between people. In the Derridean ideal of hospitality, it is unconditional, open to the not-yet-known and the yet-to-come, bringing guests – strangers – temporarily into the group (Derrida, 2000; Aparna and Schapendonk, 2020). However, this becomes unrealistic in application. The rituals and etiquette involved in hospitality bridge the boundaries between group and stranger, friend and foe. Yet in doing so, they also reinforce these boundaries, requiring an implicit drawing of boundaries between oneself and those within ones' group, and those who are excluded (Ramadan, 2008, 2011; Sobh et al., 2013). Once this contradiction between honoring the guest and keeping them at a distance is recognized, the tensions within hospitality practices become apparent. These considerations are brought to the fore in considering migration (Louise Berg and Fiddian-Qasmiyeh, 2018), particularly in Jordan which maintains itself as a transit state.

I find hospitality a valuable starting point in conceptualizing the act of hosting. In recognizing the collision between imaginaries of unconditional hospitality and the conditions attached to everyday practices, it draws our attention to the underlying tension of hosting practices. Similarly, it allows for the recognition that no matter how well treated or how warmly welcomed the guest is an outsider and does not fully belong. However, hospitality cannot fully explain hosting relationships.

Hosting relationships are not exclusively between established groups and new arrivals, and refugees very clearly demonstrate a wide range of hospitable practices. Yet, during this research I found that hosting practices, for the most part, take place between refugees, individuals and households who have little to no formal claim over the space they inhabit. As will be discussed further below, there was rarely a secure tenure residing in a singular individual within these spaces. Rather, they were collectively and precariously held. Opening your door to another suggests ownership of the home and control of the space and necessary resources with which to be hospitable (Brun, 2010) – something the refugees I worked with did not consistently experience. In these cases, hosting was less a case of extending hospitality, and more a question of sharing the space and resources available and caring for one another. In the remainder of this paper, I therefore build on these understandings to introduce a new conceptualisation of refugee-refugee hosting as a relationship of care. There is a growing body of work that concentrates on ethics of care in relation to migration and forced displacement, and its intersections with accommodation practices (Darling, 2011; Brun, 2016; Serra Mingot and Mazzucato, 2019; Boano and Astolfo, 2020; Yassine et al., 2021). As yet, however, care has not been used to conceptualize household-level hosting relationships.

4 Methods

The research that informs this article was completed as part of my doctoral research into everyday humanitarianisms and the act of refugee hosting. The key arguments presented here were initially developed through this work, and have been further refined through regular return trips to Amman and continued informal discussion with some of those who participated in the research.

The research was conducted in two phases: Phase One (2017) sought to capture a 'snapshot' of the different types of hosting arrangement existing in Amman at that time, encompassing semi-structured interviews with 37 individuals of different nationalities (Syrian, Somali, Sudanese, Iraqi) with a range of characteristics suggested in the literature as influencing hosting relationships (gender, age, marital status, family size, physical health and disability). This work was not intended to be representative, nor to provide indications as to the scale of hosting in Amman, but rather to delineate the wide range of types of hosting relationship at the household-level that exist under the hosting umbrella. As a result of this phase, nine types of hosting arrangement were identified. Phase Two of the research focused on one hosting type – shared group hosting arrangements – among one population – Sudanese men.[4] This focus was chosen as previous reporting had indicated that Sudanese men were a group most at risk of homelessness (Baslan et al., 2017) and initial interviews had shown that non-Syrian refugees in general, and single African men in particular were largely excluded from formal humanitarian assistance and assistance from wider society that, in some cases, provided support to individuals from other groups.

In Phase Two, I conducted multiple semi-structured interviews with nine men living in six different hosting arrangements (although, given the frequency of change between houses, some men at the time living in different houses had previously lived together). In the first phase, I had worked with two research assistants with strong relationships to the communities, built through long-term engagement and trust. Initial participants in the second phase came from these connections, and the assistance of a Sudanese community member who initially acted as an interpreter in Phase Two.[5] Further participants came through interaction at community events, chance meetings and, for one participant, a request to join the research having heard about it from a friend. As in the first phase, participant recruitment did not aim for representativeness, but rather an in-depth understanding of a small number of cases as a basis for exploratory research. Nonetheless, I sought to include a range of different perspectives through using multiple entry points in addition to snowballing. In addition to the interviews, I spent time 'hanging out' with the men, participating in community activities, joining them for dinner and other social events. However, our differences in gender and my position and visual appearance as a privileged, white and 'expat' European foreigner, as opposed to a refugee, conditioned our interactions. For example, although I frequently visited the men's homes, and was kindly and generously welcomed, I was rarely part of their daily routines or privy to domestic moments that could have shone greater light on their daily experiences. Other aspects were more overtly referred to in our conversations: the men's gender and

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[4] For further discussion of the range of types of hosting identified, please see Author (2020).

[5] I had prepared to conduct interviews in the Sudanese Arabic dialect, and had recruited an interpreter to assist with this. However, in the end, all the men except one preferred to communicate in English, to practice their language skills.

race has deeply shaped all aspects of their displacement and they clearly and repeatedly emphasized these points to me and explained these experiences that I could not share. Their attention to these issues has shaped the analysis presented. The analysis approach relied on thematic coding, based on detailed reading of interview transcripts and fieldnotes, in addition to attention to key themes raised by the participants in explaining their experiences.

5 Re-conceptualizing refugee-refugee hosting: from hospitality to care

In my work, I found that there is far greater interdependency within household-level hosting than has yet been recognized and which is not fully captured by hospitality. While I find some value in conceptualisations of hosting that start with hospitality, I also draw on notions of sharing and care to propose a more complete and nuanced understanding of hosting. These concepts have often been used in discussion of migration and humanitarianism (For example, in the Middle East and in relation to Syrian displacement see: (Ramadan, 2008; Mason, 2011; Rozakou, 2012; Thorleifsson, 2016)) but not in conjunction with one another nor in relation to hosting relationships at the household-level.

Hosting provides shelter, but also it can provide food, water, access to sanitation facilities, connections to work, a sense of safety and protection, as well as social and psychological wellbeing. In Amman, the high costs of rent and living expenses were frequently mentioned by the participants in my research, in conjunction with the uncertainty and informality of their employment. Ali, a young Sudanese man in his late twenties, described the situation in his household:

"We share all the food together, we share the things that there are, so when food is ready, we do not have to eat me and you, and we know that somebody else is here," he said, gesturing to the next room, *"hungry."*

For Ali and his housemates, their sharing goes beyond the sharing of food and accommodation. The central premise of sharing was prevalent in our conversations, but it was not only sharing of the financial and material resources they can access, but also a form of protection, and a practice informed by a shared experience of their lives in displacement, awareness of one another, and recognition of each other's position and need.

Here, Ali used the language of sharing, defined in the literature as the act or process of having a portion of something with another, distributing a portion of something to another, receiving or taking something from others, or the joint use of something with others (Belk, 2007). Further, sharing has been characterized by the creation and maintenance of social links to others, shared ownership or usage rights, the irrelevance of money, dependent relationships, social reproduction, and motivations of love and caring (Belk, 2007). Much work on sharing has emerged in the Global North, and looks at excess sharing or for-profit sharing. However, Waite and Lewis (2017) have written convincingly on the importance of sharing in situations of precarity as the "*social relations and ethical interdependencies [that] are brought to bear on economic practices to enable people to make a living; for example, trust, caring, sharing, reciprocity, cooperation, coercion, guilt, self-exploitation, and solidarity*" (p. 966). I find such work helpful in thinking about how sharing economies emerge in precarious and resource-poor contexts, and the interdependencies that sharing arises from and entails. Such work highlights the relational aspects - positive and negative - of sharing, and the role it plays in maintaining relations. As with hospitality, sharing is often uncritically celebrated, without consideration of relations of power. Sharing is embedded in social and moral contexts, and is contingent; neither fully benevolent hospitality, nor servility. It also helps us to see that sharing potentially engenders relations of dependency and coercive sharing. In the definitions provided above, care or caring is a central feature of sharing dynamics.

Recognizing care brings us closer to how the men described their hosting relationships. Othman, recounting his experience of living in a hosting arrangement, told me:

For me…since we became…4 of us, everything has been good. We care about one another, and we support one another. So that is one of the good things, that we understand one another, and we support one another. So when one is sick, we have to help getting the stuff with that. Take care of him.

As recognized in Othman's explanation, an ethics of care relates not only to taking responsibility to care of someone (caring for) and competent caregiving, but also caring about them – attentiveness to individuals and their needs (Tronto, 1998). Care can be understood to include "*everything that we do to maintain, continue and repair our "world" [including] our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web*" (Tronto and Fisher, 1990, p. 40). In developing this article, I have found it useful to think using Held (2006) framework of care. Her framework is centered around five key tenets: Firstly, the compelling moral importance of recognizing and attending to the needs of the particular others for whom we take responsibility. Secondly, the value of emotions, and their importance in ascertaining the actions morality recommends us to take in certain, contextually-nuanced, situations. Thirdly, an ethics of care does not aim for abstract impartiality. Rather, it is carefully attuned to the context of decision making, and understands the validity of particular moral claims, even if the judgment is not one that we would wish to generalize. Fourthly, an ethic of care reconceptualises private and public, recognizing how political, economic, and cultural power are already present in the private sphere, despite being proclaimed off-limits to politics and government. Finally, Held's fifth characteristic relates to a fundamental re-conceptualization of how we think about the nature of people, viewing persons as relational, rather than self-sufficient individuals (Held, 2006). Her work also calls for us to pay attention to context and people's everyday practices (see also Hanrahan, 2015). The following briefly illustrates how these facets of care are evident in the men's hosting practices through their accounts.

Samir explained the care that he provided for others, saying:

Samir: They need help. I do not have money to help. I call someone, I told him the story, and he told me 'I can help'. And he goes back through me. And I try to help people by talking to help, through emotion, talking.

Interviewer: Yeah, like some moral support, to let them talk about their situation.

Samir: Yeah, yeah, to make him down, to make him patient. If he need money, if I have, really - I'm not sure how to say, someone he did not give his money -.

Interviewer: It's slang, but we could say tight.

Samir: Yeah, tight. Not be tight, I give. We were born without money, money is nothing, you know. We must be kind with people.

Samir's brief description illustrates multiple forms of care that he provides, and his sense of duty or responsibility to do so: money, when he has it, drawing on social networks to find assistance, and by talking and providing emotional support. Other men offered further examples: accompanying one another to work, providing information about jobs, housing, and security crackdowns, and supporting each other's goals, such as further study. Their descriptions show multiple forms of care, which provide a specific response to particular needs and their responsibility toward others, that is attuned to the local context and to the social, political, and economic realities of their lives in displacement in Amman.

These responsibilities to one another stem from relationships developed during displacement in Amman, as well as broader socio-political affiliations of nationality and tribe. Returning to Ali, he described how he first moved into a shared group hosting arrangement from a larger form of shared accommodation:

Ali: We cannot decide, it just happens. You know, you find people in there so you have to.

Interviewer: But, like you do not decide who are your best friends and move with them? What are the different things you think about?

Ali: Well, we decide when we study together, or when we do something together, so you move together. But normally most of us we just came and find each other here. So you cannot decide. So if you find me, you cannot decide to move somewhere. It needs time, so if we sit with you one month, two month, three months, I know you, you know me, and then we got to move together.

As in many of the cases I saw, hosting arrangements were formed between specific individuals who had come to know each other. More broadly, however, Ibrahim described the help provided and received on the basis of being recognized as Sudanese. After recounting a story from his early days in Amman, where a Sudanese man who he did not know helped to cover an expense, he shared his own attitude:

"If I see you are Sudanese, for example, and if you came from anywhere and I am here in this country, when I saw you, I know you just as Sudanese. I'll ask you, do you need some help? Where you are going? Who are you are going to? Maybe I know these guys who you need and I can bring you to him."

This was shared elsewhere: other men spoke of hosting as contributing to a sense of belonging, to maintaining a sense of identity and connection to community, and to making a positive contribution to society. Further, hosting also provided a way to acknowledge and process emotions, offering a forum for explicit discussion of feelings between the men, and the importance of these emotions being recognized and shared.

However, their accounts also raised questions about access to hosting for those without such connections. Ibrahim's words above show the specific aid extended to those he recognized as sharing his community, via their area of origin and nationality, and in other conversations he spoke clearly about his assistance for all, based on their shared humanity saying *"I am first of all a human being, like him…If you have blood, I have blood. If you have feeling, I have feeling. Yes. I do not care about your colour, I do not care about your religion, your cultures, background, anything. Just if you have humanity, I have it too."* In later conversations, however, some of the men narrowed the range of people included within their typical hosting relationships to those from their tribe, and spoke about the differences in finding a place without such ties. This reflects the attention in Held's work to the validity of the moral claims of particular others, even where such judgment may be problematic if generalized. This is also not to say that emotions underpinning such claims are never harmful, and Held (2006) is explicit in her call for expressions of care to be subjected to moral scrutiny and evaluation, not just observed and described. Recognizing that access to the care enacted through hosting is not universally extended raises questions as to access for support from those not perceived to be part of a community of responsibility, and is returned to in the following section on ambivalences and limitations of hosting.

The preceding quotes also highlight examples of the expectations of support from one another and the requirements to do so. In a second conversation, Ali explained further how others found hosting arrangements via one of the Sudanese cafes (one of a couple of spaces downtown particularly frequented by the men), explaining that having a job or receiving assistance was not a condition for moving into a household "*If they a friend, they just say yes. Because we are all together. We are all together, we do not have anything*." Although Ali's words describe a certain expectation of assistance, his descriptions also show that hosting arrangements take place between those who have been recognized by the other participant's as a friend - as within their circle of affection and responsibility. Further, as Ali says: *This is the same situation that one day you are going to get the same thing. So I have to help you*." While Ali's statement could be read as requiring an exchange, further explanations from the men show that this a generalized or diffused form of reciprocity and a recognition of mutual interdependence. Where no return is expected in an immediate or future time period, such relations then become need-oriented, rather than profit oriented (Waite and Lewis, 2017), and the long-duration and vagueness of such claims can be the basis for the formation and continuation of social relations, creating the space for relationships to develop and be continued. Similarly, Othman, spoke about the men he lived with, saying.

"I found roommates but one of them is my best friend and also two very close friends. So they are 4. So far we been living together…We moved, we have been living in the same neighbourhood but in another house."

Interviewer: "But you stayed with the same guys?"

Othman: "Yes of course. I wish we are resettled somewhere, we would be the four."

Though not the focus of this particular article (see Jordan, 2022a), such relationships can also be the basis for wider political ramifications. Hilal explained why men lived together, saying: *"If you do not have work, that means you will be outside the house. You will sleep in the street. That is why it is so hard for us. So that is why we live together, and we help each other. That's why"* As Hilal emphasized, hosting is a domestic practice created within and against external practices of exclusion. In providing a means for the men to remain in Amman and to claim their rights as refugees and urban residents, it can further be read as a form of political engagement (See also Riga et al., 2020 on the political of forced displacement; Jordan, 2022a).

The care provided and accessed through shared group hosting confirms to Held's (2006) framework. The men's recognition that their survival in Amman depends on one another is based on a deep understanding that they could not, in the hostile context of Amman, be self-sufficient individuals – despite the humanitarian rhetoric of self-reliance -but are enmeshed in dynamic interdependent relationships. As expressed by the men, hosting was rarely a first choice, but a recognition of their shared positions and need for one another. The need did not necessarily have to be explicitly communicated nor assistance formally requested, but equally, not all needs may be able to be met through hosting. By recognizing these common vulnerabilities and sharing assets, the men could secure (albeit precariously) a life that would not otherwise have been possible.

Held notes that the extremes of "selfish individual" and "humanity" have been recognized and discussed, but what lies in between has often been overlooked. She argues that care does not equate to compassion or altruism, as both parties share an interest in their mutual well-being. This is a helpful entry point into understanding the hosting relationship, moving away from perspectives which seek to portray the hosting relationship as primarily a matter of financial and material gain, or as an altruistic and benevolent act. Instead it recognizes the interconnectedness of the different parties involved and their mutual support for each other, prioritizing the social relations and appearing to require a familiarity and sense of commonality between participants. As Samir explained, "*All the guys are like my brother. But the level - because I live with him [Ali] for a long time. And I know him, I know his mind, I know how he thinks. I know if I fall down he will pick me up. I know him well.*"

The previous section has demonstrated how care can contribute to understandings of refugee-refugee hosting at the household level. The following sections address the men's ambivalences around such interdependencies, and the challenges of relying on care in precarious and transitory contexts of displacement.

5.1 Ambivalences and limitations of care

Hosting provided many benefits to the men I worked with. Yet, hosting can also present a danger—overcrowding, poor living conditions, ill-health, stress and a lack of privacy, exploitation and abuse. As Hilal explained "*That [lack of work] is something difficult for us, and that forced us to live like this. It is not good for your health, and other things also. Sometimes you stay at home but you do not get rest because you want to sleep and there some person who is still not sleep.*" For the people I worked with, hosting was not a preference, but rather a way to confront the realities of their displacement in urban contexts.

As Held writes, "*Many of our responsibilities are not freely entered into but presented to us by the accidents of our embeddedness in familial and social and historical contexts*" (2006, p. 14). This is not to say that we do not have the agency to reconfigure these relationships, but that we do not freely enter into them. This was captured in the words of those of the men for whom it was simply 'what we do' to share with others. A few of the men, however, interrogated these dynamics further. Although the men were reluctant to discuss any hesitations they may have felt about providing care for others, they were more forthcoming in the challenges of being the recipient of care and not wanting to ask for help Jordan, 2022a. Much literature on care has focused on gendered and racialized relationships of care, highlighting the unequal 'burden' of care (Duffy, 2005; Hankivsky, 2014). However, there is also a growing literature showing that men, including migrant men, do care (Locke, 2017; Serra Mingot, 2020). The men's descriptions indicate that attentiveness to need, responsibility and providing care through various means – material, financial, emotional – are valued parts of what it means to be a young Sudanese man in Amman. Many of the men expressed similar sentiments to Samir, who described his own attitude to providing care, saying "*I do not know, like, I respect the people. If I meet Sudanese, I love him. You are Sudanese, you need help, I'll help you if I can. If I can, I'll try to help, if I cannot, I'll tell you Allah ma'ik, you know, god with you.*" However, receiving care was rather less talked about. While this was rarely discussed in conjunction with perceptions of masculinity, it suggests there is a still a hesitation as being identified as in need. Indeed, Samir, reflecting on his future plans explicitly articulated that he planned to "*work, to pay by myself, to help myself, I'll be like a good person for myself and for the community. I will go there [another country]. I'm not going to be a, like, shame…You must be independent, try to do something for yourself.*"

A second concern relates to who has access to and participates in which types of hosting, and under which conditions. Zooming out to the interviews conducted during the first phase of my research, Abdi – a young Somali man – moved from house to house at frequent short-term intervals, rarely remaining for more than a month in each household. Others contrasted their more stable position with his, and explained that in addition to his lack of work or low and unpredictable income, Abdi had not 'found his people'. They explained:

It depends on the people that he lives with, their personalities. The guys that I live with, we understand each other, and we have made it a home and we help each other even if someone left…he [Abdi] lived with people that worked all over Somalia but I live with people from [the same place as me], and we got to know each other well.

Unable to form these connections, Abdi was stuck in dependency. A separate conversation with Sudanese men focused on how people were admitted into a household with Hilal explaining the need for collective decisions, previous knowledge of the 'applicant' and, if they were unknown, for them to be vouched for by a known member of the group. Other conversations with those with long-term ill-health or physical disability revealed their fears about perceived lack of contribution to the household. In combination with the men's words in the preceding section, this suggests that while hosting can be a form of care for those who are recognized as having a particular moral claim, such care is intricately embedded within economic and social dynamics in the hostile context of displacement in Amman. It also reflects the non-binary nature of hospitality and care. As reflected in the typology of hosting (developed in Phase One of the research), guesthood-tenancy and interdependency-dependency are continuums, and both hospitality and care may be conditional social relations. As Hankivsky (2014) argues, care is inherently bound together with power dynamics that relate to our embeddedness within specific contexts and our positions understood in terms of the intersections of gender, class, race and other identities. Interdependence does not mean equality. Within the men's hosting relationships, power relations were linked to the men's economic and social standing within and outside of the hosting relationship, and the dependencies created through economic inequalities and the privileging of certain relationships (e.g., siblings) over other relationships of care.

This brings me on to the third concern raised by the men: the relationship between their caring practices and those of the humanitarian system. The Sudanese men I worked with are neither completely within the system, nor fully beyond its effects. Rather, their lives and practices are shaped by and in interaction with the formal care provided (or not) by the humanitarian system, their own various forms of mobilization (Baslan, 2023), and their gender, nationality, and race. Male, Sudanese experiences of refugee-hood and displacement in Amman, Jordan are characterized by the exclusions of state and international humanitarian response bureaucracies. As explained by Hilal, *If you go to the UNHCR and you talk about you do not have work and your rent is so high, they say to you: "you are guys, and you have energy, you can go to work." But also, there are no chances to work, because of the government."*

Interviewer: I see. So because you are guys, they say you are a young guy, you can go work?

Hilal: Yeah. UNHCR calls you, the employee of the UNHCR just told you something like this – 'yatik il afia' [may God give you health and all the good things].' 'So, yatik il afia, why you say yatik il afia?' 'Because you have energy.'

These exclusions are further compounded by pervasive racial discrimination and violence at multiple levels, from street level harassment to violent attacks, and reportedly from official actors of the state and the humanitarian community. Though accommodation sharing is common among many different groups, it is recognized as being particularly prevalent among Sudanese men in Amman (Baslan et al., 2017). In addition to the limited access to humanitarian assistance received at the time as a result of their nationality, single men are often de-prioritized for assistance in an over-stretched system that emphasizes the vulnerability of women and children (Turner, 2016). The single men I worked with were seen to be independent and able to work, and therefore in less need of assistance. The men involved in my research perceived women and families with children as having additional vulnerabilities that merited prioritisaion, however, they question a system that required them to work (in dangerous and exploitative conditions and without authorisation) yet provided little recourse when they were detained for working, and failed to take into consideration the difficulties they faced in finding work and in working conditions. Partly in response to this, the men developed their own way of providing care. Hosting continued to be shaped by the humanitarian system, from the intermittent arrival of winterization cash grants, to roles as students, volunteers and participants in various NGO activities, to the men's existing socio-economic positions and their aspirations for future resettlement through UNHCR or related bodies and their work toward these futures (Jordan, 2024). However, as previously noted, hosting was not a preference but a way of coping. As Ali explained, with particular reference to those who were injured, unwell or had a physical disability:

"*With the guys they help you. We have guys with the [wheel]chair also, we help them. We go to them and then we see what's going on with them, we help them, we take them to UNHCR if they have something to do. There are many injured people also we have here. But you know, we cannot help them with everything. We cannot."*

The support and protections provided by such refugee-refugee care are vital and yet limited in the face of ongoing systematic and structural exclusions. This therefore brings me to my final point, regarding care dynamics in protracted displacement.

5.2 Care dynamics in protracted displacement

All of the refugees I worked with in Jordan, with the exception of one young Sudanese man, had been in Jordan for more than 5 years and, despite striving for resettlement saw a near-term end to their displacement as unlikely. As they explained, protracted displacement had become protracted uncertainty (Brun, 2015). There is an existing and growing body of work on how refugees construct their lives in such uncertainty, in protracted displacement, and in everyday emergency (Dryden-Peterson, 2006; Grabska, 2006; Holzer, 2014; Brun, 2015; Horst and Grabska, 2015). As yet, however, little of this work has considered the role of household-level hosting arrangements within refugees' experience of the present and their work for the future [though see (Fiddian-Qasmiyeh, 2016; Yassine et al., 2021)]. Refugee-refugee hosting, and the care that underpins it, has important temporal considerations.

Firstly, refugee-refugee hosting occurs across timescales and can adapt. The care that is provided is not only a short-term response, but can last for years. Further, even though perhaps one specific relationship may not last for the entirety of an individual's residence in a given city or location the mechanism and relationships that have enabled hosting to exist persist, and people can move through different specific situations. For the men I worked with, and for many refugees, emergency is not a one-time short event, but something that repeats and extends. Holzer (2014) has spoken about the maintenance of life through emergency, it is not some brief blip, but something that people persist through. Hosting is one way that refugees engage with this, and in doing so in what Feldman (2012) calls a politics of living, of surviving, of claiming. One outcome is that hosting supports people to persist, and to remain open to future possibility (Simone, 2020).

Hosting thereby is a way that refugees can maintain their presence in urban areas and claim part of that space, which opens a question to how we understand urban citizenship and home in displacement (Jordan, 2022a,b). Returning to what care brings to an understanding of refugee-refugee hosting, and wider understandings of displacement, Darling has argued that "shifting attention from the ethical value of hospitality to the social fact of presence might be more productive for non-citizens and migrants who would otherwise be positioned as "guests" within a hospitable home" (Darling, 2014, p. 162). In recognizing care, we see the ways in which refugees are already enmeshed in their places of displacement through social and economic dynamics that shape, and are shaped by, their environments.

Recognizing care also adds to how we understand the development and maintenance of relationships in displacement. With regards to hosting, though these relationships do not replace biological family or kin, displacement does often reconfigure relations, perhaps with greater intimacy than in non-displacement settings. Ali described the new relationships created in Amman:

"The Sudanese community are the same whether here or anywhere else, so they, they, when you get to the place you get, you have to know some Sudanese, who's here, who's Sudanese here, so then you just immediately get in a relationship and then he can help you, you can help him. If you want work or something searching like that, so they give help, and they give the stuff."

This cycle can be self-reinforcing: perceived familiarity due to shared cultural or national origin can be further developed through familiarity with everyday practices in cohabiting. Particularly where such practices typically take place in the private sphere, this can result in intimate emotional ties (Heger Boyle and Ali, 2010). Further, practices of care can play an important part in providing meaning and maintaining traditions in displacement: such relationships can maintain a cultural idea of caring norms and provide a positive identity for participants.

However, what happens to relationships of care when the individuals within them move away? In the case of the Sudanese in Amman, the deportation in 2015 of between 500 and 800 individuals caused massive disruption in their systems of care for one-another, physically removing those who had been part of care dynamics in the community, from the intimate and familial, such as mothers separated from children, to the wider cycles of care and reciprocity that sustained the whole. For the men I worked with, the deportation and the attention that came with it substantially changed their living practices: large-scale houses were reduced into smaller groups, new groups emerged, and the men found it harder for landlords to agree to rent to them. At the time of my research, the community had perhaps recovered some stability, but the fear and repercussions of the deportation still reverberated.

Since completing my fieldwork, there have been further shocks, not least the economic and social impacts of the COVID-19 pandemic and associated restrictions. The effects of these regulations on informal practices of care such as hosting require further investigation in order to understand how such mechanisms function and can be supported in times of crisis. Finally, and more happily, a number of those that I worked with and in the wider Sudanese community have been resettled or traveled for further study. In many cases, these men played a key role in the community, within their hosting relationships and in their wider responsibilities. While their travel is a cause for celebration, it has in some cases left a gap in the relations that underpin everyday life for Sudanese refugees in Amman. The gaps – at home and in communal and public-facing life -further supports the contention that care crosses the boundaries between the private and the public, the domestic and the political.

6 Conclusions: refugees as hosts, care and humanitarianisms

This article considers the role of care in refugee's everyday practices of mutual support, understood through the exploration of one particular form of support: refugee-refugee hosting at the household level. In doing so, I contribute to the emerging literature on ethics of care in displacement and humanitarian contexts (Darling, 2011; Brun, 2016; Boano and Astolfo, 2020). In focusing on refugee men, I also add to a growing literature that explores the caring practices of migrant men beyond the financial, and the interaction between care and masculinity, repositioning care as an intrinsic part of masculine identity within displacement and crisis contexts.

As argued by Long, "we need to document the ways in which people steer or muddle their ways through difficult scenarios, turning 'bad' into 'less bad' circumstances" (Long, 2001, p. 14). Understanding hosting through care can help us to do this, and to begin to unpick some of the limitations and challenges of refugee-refugee care in protracted displacement. The existing understandings of hosting are too narrow, and they do not encapsulate the full range of support strategies that are being used. In reality, the hosting relationship is much more nuanced than allowed for by the characterizations currently commonly found in existing literature. The hosting relationship is a constantly evolving relationship, and both parties actively negotiate and adapt their relationship and roles within the relationship according to external and internal factors. This is not to deny the unequal power dynamics of many hosting relationships, but to question the inevitability of these arrangements implied in much of the current discussion of hosting. This reconceptualization has implications for humanitarian practice. In remaining within existing understandings, we limit ourselves to thinking primarily about material and financial interventions, rather than seeing these as part of a much richer tapestry of what is happening. The act of hosting is not a uniform act. Contextualisation is key, and the different elements proposed here will come to the fore in different hosting arrangements, depending on environment, supporting organizations and institutions, and societal norms. However, recognizing hosting as care has the potential to move humanitarian engagement with hosting beyond financial, material, and legal support for housing toward a recognition of the centrality of hosting practices in the experiences of displaced people and their hosts, and the wide-reach of these practices into socio-economic stability, protection, psychosocial well-being, and integration processes.

Aside from direct impacts on forms of intervention, the wide ranging and vital support provided by hosting suggests a need for an adjustment of the relationship between 'hosts' and 'humanitarians'. I position refugee hosting at the household level as a form of humanitarianism, in that it meets essential needs, thereby alleviating suffering. It is flexible and dynamic. It works in crisis and in protracted displacement and is motivated by humanitarian ideals of compassion, of solidarity of the need to intervene and to prevent suffering. However, it is different than the current understanding of humanitarianism enacted through the international system, which is experiencing ongoing tension between increasing bureaucratization and distance, and an impulse toward greater partnership, and localization – a marked difference to proximity and a shared recognition of the interdependence between us that characterizes hosting. Recognizing hosting, and the care it enacts, as a form of everyday humanitarian – following the burgeoning literature on alternative forms of humanitarianism (Rozakou, 2017; Olliff, 2018; Fechter and Schwittay, 2019; Vandevoordt, 2019) -has wide ranging implications. It further questions the social, geographic and power distances that exist between those who help and those who are helped; shifts the perception of response from exceptional rescue to one of ongoing commitment; requires a situated and contextual understanding of the social connections that exist in displacement contexts; and, vitally, reconceptualises refugees as both providers and recipients of care.

Data availability statement

The datasets presented in this article are not readily available because consent was not provided by participants. Requests to access the datasets should be directed to zjordan@brookes.ac.uk.

Ethics statement

The studies involving humans were approved by Oxford Brookes University Research Ethics Committee. The studies were conducted in accordance with the local legislation and institutional requirements. The ethics committee/institutional review board waived the requirement of written informed consent for participation from the participants or the participants' legal guardians/next of kin because in the context of research with refugees, written consent can create fear and mistrust. Verbal consent was sought and re-affirmed for those participating in multiple interviews.

Author contributions

ZJ: Conceptualization, Data curation, Investigation, Methodology, Writing – original draft.

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Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Traditional, complementary, and alternative medicine and the provision of health care to internally displaced persons in south Kivu, Democratic Republic of the Congo

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Introduction: Traditional, complementary and alternative medicine (TCAM) providers are central for many when seeking healthcare. Internally Displaced Persons (IDPs) are no exception. This paper seeks to better understand the use of TCAM by IDPs and its connection with the local integration of IDPs into the social fabric of the communities where they have taken refuge. We compare IDPs and non-IDPs access to TCAM providers and their level of confidence in having their healthcare needs met by these sources in Uvira and Kabare territories of South Kivu, Democratic Republic of Congo (DRC).

Methods: We draw from a mixed method, *social connections* design comprised of participatory workshops with 111 participants; a survey with 847 participants capturing exploring access and trust of TCAM and other wealth and demographic indicators; 24 interviews with traditional healthcare providers; and 56 in-depth life history interviews with IDPs. Collected data were analysed using both qualitative and quantitative approaches. Descriptive statistics (mean, percentage, and standard deviation) and statistical tests (proportions test and t test) were used as quantitative analysis tools whereas thematic content analysis was used for qualitative data.

Results: We show that IDPs use TCAM more than non IDPs. Access to and trust in traditional healers seems dependent on the exact nature of the services they offer, which varies across our sample. As such, processes of recognition and integration of both IDPs and TCAM providers into formal healthcare systems should be treated cautiously with an understanding of the socio-economic rationales that displaced people and TCAM providers operate under. While many of these TCAM providers are not highly trusted sources in South Kivu, their highly valued treatment of certain conditions such as what is locally known as "*mulonge*" (and bears similarities with the Buruli ulcer) suggest there may be potential specific areas where collaboration could be successful between biomedical health workers and TCAM providers.

KEYWORDS

social connections, integration, indigenous healers, spiritual healers, DRC, IDPs

Introduction

Since gaining independence in 1960, the Democratic Republic of Congo (DRC) has experienced several waves of armed conflicts in its eastern part among which the most recent can be traced back to the early 1990s. The two so-called liberation wars (1996 and 1998) and numerous rebellions and wars that followed had been responsible for massive population movements in this part of the country. Although various peace agreements repeatedly claimed to mark the end of war, and despite a series of elections organized in the country, violence remains widespread. Numerous small pockets of conflict, sometimes intercommunal or fanned by domestic and foreign armed groups, continue to feed this violence, increasing the number of displaced people in the country (Altare et al., 2020). In 2022, according to the Internal Displacement Monitoring Centre (IDMC) statistics, the DRC recorded 4 million displaced persons, most of them in the eastern provinces of the country (North Kivu, South Kivu and Ituri) following military operations carried out by the army against certain armed groups. For over a decade, the DRC has topped rankings of the countries hosting the highest number of Internally Displaced Persons (IDPs). Many IDPs, in general, and in South Kivu–the province our research focuses on–do not live in camp-type environments but are dispersed among host populations (Beyani, 2013; Jacobs et al., 2020).

IDPs typically find hosting arrangements with relatives, friends or through self-settlement for those with enough resources to rent a house. Those solutions are often unstable and return to places of origin often difficult before years or decades due to insecurity and damages. IDPs need, however, to be seen and understood as active agents within their host communities, looking for durable solutions for themselves and contributing to host communities' economies through various income generating activities and services. In Bukavu for instance, making use of their social networks in their place of origin, IDPs have been described as enriching the city's economy with honey, timber, palm oil, and charcoal (Jacobs et al., 2020).

Local integration is a long and gradual process. It goes smoothly for some and turns out to be challenging for others. It encompasses several dimensions that cannot been reduced to economic independence. Indeed, integration is also about being accepted by the host community, or trusted. Strong social connections and access to essential services are key to such integration and the well-being of IDPs. A key 'domain of integration', and the focus of the current study, is access to health-care (Ager and Strang, 2008).

Healthcare providers and IDPs in the DRC

The general situation with access to quality health is difficult in the DRC (Bapolisi et al., 2021), especially in rural areas (Ivlevs, 2019), for IDPs and non IDPs. The health system at both national and provincial levels faces major challenges. In a report published by the Ministère de la Santé, 2021, the analysis of health accounts showed that households remain the main contributors to current health expenditure in the Democratic Republic of Congo. Their financing of current expenditure increased by 29.3% (from USD 658,980,708 to 852,343,618, see Table 1) between 2016 and 2020. The government comes third after multilateral donors (Ministère de la Santé, 2021).

At all levels, citizens, whether displaced or not, typically pay a substantial cost of healthcare out of their own pockets (Gerstl et al., 2013). Like other citizens, the IDPs find themselves exploring different options, both informal and formal, to find solutions to their health problems. Traditional, Complementary, and Alternative Medicine (TCAM)[1] is one of the main, but also one of the least studied, options that displaced and non-displaced rely on when seeking healthcare. Most of Sub-Saharan Africa relies on TCAM to varying degrees, although a systematic review reveals that "there remains a dearth of research evidence […] on the drivers and facilitators of [TCAM] use, factors associated with TCAM use, and the impact of TCAM use on broader healthcare" (James et al., 2018, p. 1).

TCAM features prominently in the DRC, as with the rest of Sub-Saharan Africa. Over the past two decades, the World Health Organization (WHO) has recognized the important contributions of traditional and complementary medicines to healthcare worldwide and has developed a voluntary policy to engage member states in integrating locally important practices into their national health systems (WHO, 2013).[2] As a WHO member country, the DRC is committed to promoting traditional medicine by integrating it into the official health system through laws and governmental censuses of TCAM (WHO, 2002), despite lacking the funding and capacity to comprehensively do so to this point (Mutombo et al., 2022). The Ministerial Order n°1,250/CAB/MIN/S/CJ/KIZ/32/2002 of 25 October 2002,[3] identifies six different types of "traditional" healers: (1) phytotherapists are "recognized by their community as able to provide healthcare using plants, substances and other vegetal drugs"; (2) herbalists sell and utilize medicinal plants; (3) naturalists are "recognized by their community as able to provide healthcare using natural but non-vegetal substances"; (4) spiritualists are "recognized by their community as able to provide healthcare using religious or spiritual means"; (5) exorcists are "recognized by their community or religious hierarchy as able to provide mental or metaphysical healthcare by chasing away demons or evil spirits"; and (6) ritualists are "recognized by their community as being able to provide mental, metaphysical, or physical healthcare through incantations, dances, and other ritual practices."

The reality regarding this classification is, however, much more complex as those categories often overlap. For instance, the boundary between a phytotherapist and a herbalist is blurry and other categories that are used by the population such as "fetishists" (*féticheurs*) and witch doctors do not necessarily fit neatly into one sub-category. The same applies to "exorcists" and "spiritualists" to whom we refer as

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[1] We recognize there is debate about what labels these healthcare providers should be referred to, including informal, indigenous, or traditional healers. In this article, we refer interchangeably to TCAM and traditional. We use TCAM because much of the academic literature is this or something similar. Traditional providers are also used because this was the language most commonly used by informants and the DRC government.

[2] While this article addresses the integration and care of IDPs, there are separate debates in the global health field about the integration in the health system of actors considered outside of biomedical healthcare systems.

[3] This ministerial decree concerns the organization of the practice of traditional medicine. It represents the Congolese government's commitment to improving healthcare coverage through the development of traditional medicine and the harmonization of partnerships between the systems of modern conventional medicine and traditional medicine while guaranteeing intellectual property rights and the protection of indigenous knowledge.

TABLE 1 Trend in the main aggregates of the health accounts from 2016 to 2020 in DRC.

Indicators	2016	2017	2018	2019	2020
Current health expenditure (USD)	1, 608, 067, 026	1, 580, 569, 898	1, 556, 175, 105	1, 785, 685, 426	1,973, 487, 940
Total capital expenditure (USD)	62, 392, 433	42, 049, 509	29, 784, 889	52, 212, 864	66, 103, 260
Total health expenditure (USD)	1, 670, 459, 459	1, 622, 619, 406	1, 585, 959, 993	1, 837, 898, 290	2, 039, 591, 200
Government health current expenditure (USD)	197, 333, 273	151, 592, 283	229, 104, 864	277, 002, 167	312, 434, 280
Current household health expenditure (USD)	658, 980, 708	692, 243, 689	705, 921, 834	748, 996, 412	852, 343, 618
Current expenditure on health in the Rest of the World (USD)	701, 009, 122	671, 316, 578	548, 035, 877	693, 320, 427	739, 671, 290
Current expenditure on health from other sources (USD)	50, 743, 923	65, 417, 349	73, 112, 530	66, 366, 420	69, 038, 752

Source: DRC Ministère de la Santé (2021).

exorcists in this paper. We also found the "ritualist" category rather broad and find it useful to divide it into sub-categories: catholic faith healers, protestant faith healers, religious leaders (pastors, priests or sheik) and other communities of faith. However, considering the use of some rituals in some of their practices, they will be considered here as ritualists. Religious leaders are differentiated from faith healers by the fact that they do not engage in direct, explicit, healing activities. They lead services and prayers but do not offer explicit healing services. In this paper, we will mostly uses the categories established by the Ministry –with the caveats we just mentioned– for the sake of convenience, but our argument is not about the different types of TCAM in the DRC and, ultimately, a different classification would probably have limited incidence on our findings.

Existing research

Research on TCAM in post-conflict settings in general remains limited, with some of the more recent studies in Burundi and Northern Uganda (Falisse et al., 2018; Mwaka et al., 2023). There are even fewer comprehensive studies on TCAM in refugee and internally displaced contexts (Ojeleke et al., 2022). Much of the work that exists in displacement contexts either touches briefly on TCAM as a small part of a general health inquiry (Roberts et al., 2022) or explores TCAM healers' roles in combatting specific health crises, such as Ebola (Grant, 2018) and COVID-19 (Yesenia Olaya Requene, 2021). Roberts et al. (2022) focuses on differences between IDPs and refugees overseas development aid (ODA), stressing the relative lack of attention to IDPs. Possibly more directly relevant to our research and building on an anthropological perspective of spiritual beliefs around illness, death and health in South Sudan, Grant (2018) shows that traditional healers played an important role in the case of an Ebola outbreak in terms of surveillance and alerts within communities characterized by less trust toward the government system and where people use both traditional and biomedical health services. Traditional healers, although operating from an intricate and informal system, gained legitimacy within communities through demonstrated skills and compassion to the community. The present paper adopts yet another approach by directly engaging with displaced populations facing a wide range of medical issues.

The general reasons for using TCAM rather than biomedical health facilities (in non-conflict contexts) have generated an abundant literature [see for instance brief reviews in Uche (2017), Falisse et al. (2018), Mutombo et al. (2022)]. People consider TCAM less costly than biomedical health facilities (Uche, 2017) but trust, etiology (how people understand diseases), speed, and efficacy, among other factors, also matter (Mutombo et al., 2022). Overall, TCAM is likely to remain a key feature of African health-care for some time, with TCAM practitioners and biomedical health care providers existing and evolving in a parallel in a consumer-led delivery system (Boum et al., 2021). Indeed, even when in countries where major efforts for integrating TCAM into biomedical care have been made, such as Ghana (other examples include Nigeria, Mali, and Equatorial Guinea), a "power struggle" between traditional healers and biomedical health practitioners has been reported (Ampomah et al., 2020).

In the DRC, it has been found that recourse to traditional medicine is also shaped by limited access to the modern healthcare system (Shalukoma et al., 2016). In a study of Lubumbashi in the Haut-Katanga province of the DRC, nearly 80 per cent acknowledged having recently accessed TCAM, demonstrating the prominence of these healing practices (Mutombo et al., 2022). In South Kivu, however, another project reports much lower figures with only 5 % of respondents reporting TCAM as the first recourse of care (Bapolisi et al., 2021). Our main hypotheses is that it may be due to differences in the contexts –in particular, South Kivu had just seen a campaign against unregistered practitioners and side-effects of so-called "quacks" – but also in the exact question that was asked; the South Kivu project focused on "first recourse" (where do people go first), the Katanga one on "recourse at any point." Interestingly, the Katanga research probed explanatory factors and reasons evoked for resorting to TCAM were much more efficacy, speed in healing and low cost. No significant relationship was found between religion, tribal affiliation, and recourse to TCAM, but the study emphasized the ability of the population to distinguish diseases for which TCAM constitutes the only possible care source.

Our paper builds on studies in the field of health in South Kivu that have already started addressing questions relating to health behavior in rural areas, including the factors affecting first recourse in seeking care (Bapolisi et al., 2021), or the routes taken to deal with sexual and gender-based violence (SGBV) using social connections (Boeyink et al., 2022; a paper which also provides more substantial background information on the population studied in the present paper). We focus on under-studied populations of IDPs. We do this bearing in mind Kadetz's (2013) invitation to explore existing practices and preferences of patients in combination with a more thorough understanding of the characteristics of practitioners. Rather than focusing on levels of trust between TCAM and biomedical practitioners as in other studies (Akol et al., 2018; Krah et al., 2018), our point of departure is examining levels of trust and confidence patients have in TCAM practitioners.

The aim of this study is to document the use of non-biomedical healthcare by IDPs in South Kivu, and the extent to which the experience of displacement is affecting, or not, the use of such healthcare providers. Our study is guided by the following research questions, which will help us understand where care and access to social connections apply to integration processes: At what rates do IDPs and non-IDPs access TCAM? How much trust do IDPs and non-IDPs place in TCAM providers compared to formal healthcare providers? What are the types and characteristics of TCAM providers in South Kivu and what health services do they provide?

The rest of the paper is organized as follows. Firstly, we briefly review the literature on TCAM, identifying research on TCAM and trust between patients generally and among IDPs specifically. Secondly, we present our research methodology. The main discussion portion has two sections: The first section presents an overview of how our research participants access healthcare. This includes (a) the levels of access to traditional healthcare, (b) the demographic profiles of IDPs and non-IDPs who access TCAM; (c) the sources of health information people use to inform decisions; and (d) their level of trust and confidence they have in traditional healers. The second part of the results section (a) profiles the different characteristics of TCAM providers; (b) describes the services they provide and how they relate to IDPs' concerns; and (c) outlines the economic dimension of TCAM services. The final section summarizes the findings and analyzes the policy implications.

Methodology

Study settings

Kabare and Uvira territories constitute the two selected sites for the current study. The Uvira site on the one hand, is composed of both rural and urban settings namely Katogota for war IDPs and Uvira town for floods IDPs. The Kabare site on the other hand comprises two rural sites namely Kavumu and Katana.

Katogota is a village located on the road between Bukavu and Uvira (town) on national road number 5. Victim of a massacre perpetrated by the Rassemblement Congolais pour la Démocratie (RCD-Goma) rebellion in 2000, Katogota subsequently experienced a massive influx of displaced people around 2009. Local authorities offered them a place to stay, and non-governmental organizations provided them with support. The space they were once given has now become a neighborhood in its own right. As for Uvira, it is an urban administration located 121.9 km south-east of Bukavu (capital of South Kivu province). In April 2020, the town was hit by torrential rain and flooding caused by the rising waters of the Mulongwe river. This led to the loss of several lives and the destruction of several houses. The victims were housed in several camps set up for them across the city. Only the Kasenga camp was given access by the local authorities.

Kavumu and Katana are two villages located more than 40 km north of Bukavu in the Bugorhe and Irhambi-Katana groupings, respectively. They are home to many war-displaced people from the surrounding villages (Karhanda, Mulangala, Kabulungu, Kabushwa etc.) who live among the rest of the population. The presence of a national airport in Kavumu and the FOMULAC (Fondation Médicale de l'Université de Louvain au Congo) hospital in Katana make these two villages two major hubs in Kabare territory.

Conceptual framework

Studying IDPs' use of TCAM services within host communities as well as the role traditional healers play in the healthcare delivery system in South Kivu can be seen as studying the process of getting something valuable out of a society. It lays the foundations of IDPs' integration in host communities through social connections. This study is therefore based on the Ager and Strang (2008) conceptual framework presented in Figure 1.

As depicted in Figure 1, integration is made of four main domains: markers and means; social connection; facilitators; and foundation (for more details about each domain of integration, see Ager and Strang (2008)). There has been a lot of debate regarding domains of integration and the concept itself. However, the most prominent argument against the afore-mentioned framework is its normative understanding of integration. It emphasizes more on how integration should look like, and not what it is in actual sense (Spencer and Charsley, 2021). Other scholars argue that more qualitative data are required to help capture interactions between indicators and the experiential side of integration (Phillimore and Goodson, 2008). Moreover, this conceptual framework, although designed for refugees, can also be adapted to suit IDPs' context of integration (Bile et al., 2023). Thus, in the context of internal displacement, some domains of integration like foundation with citizenship and rights as main components are not usually considered since IDPs are in their own country. That is why the current study focuses on the use of traditional medicine among IDPs in their host communities by using the social connections tool.

Study design

A mixed research methodology was adopted for this study. The initial use of a quantitative approach aimed to identify the social connections to which displaced and non-displaced people often turn for help with their health problems. This methodology is based on the social-capital theory and was mainly developed to map and understand all kinds of social resources available to refugees or IDPs and how they are mobilized to protect and strengthen access to resources and their wellbeing (Strang and O'Brien, 2017; Strang and Quinn, 2021; Boeyink et al., 2022). These resources can be people or organizations IDPs go to in case of a problem or specific need, and which can play an important role for their integration in host communities. Based on real-life sample problems, this methodology can help generate a full list of potential social connections considered as relevant by IDPs and which can be considered as a proxy of their full range of connections.

It is worth mentioning that the "social connections" methodology does not impose any assumption regarding social connections or resources that would be considered as valuable in a particular context. Hence, information collected in this way would always be in relation

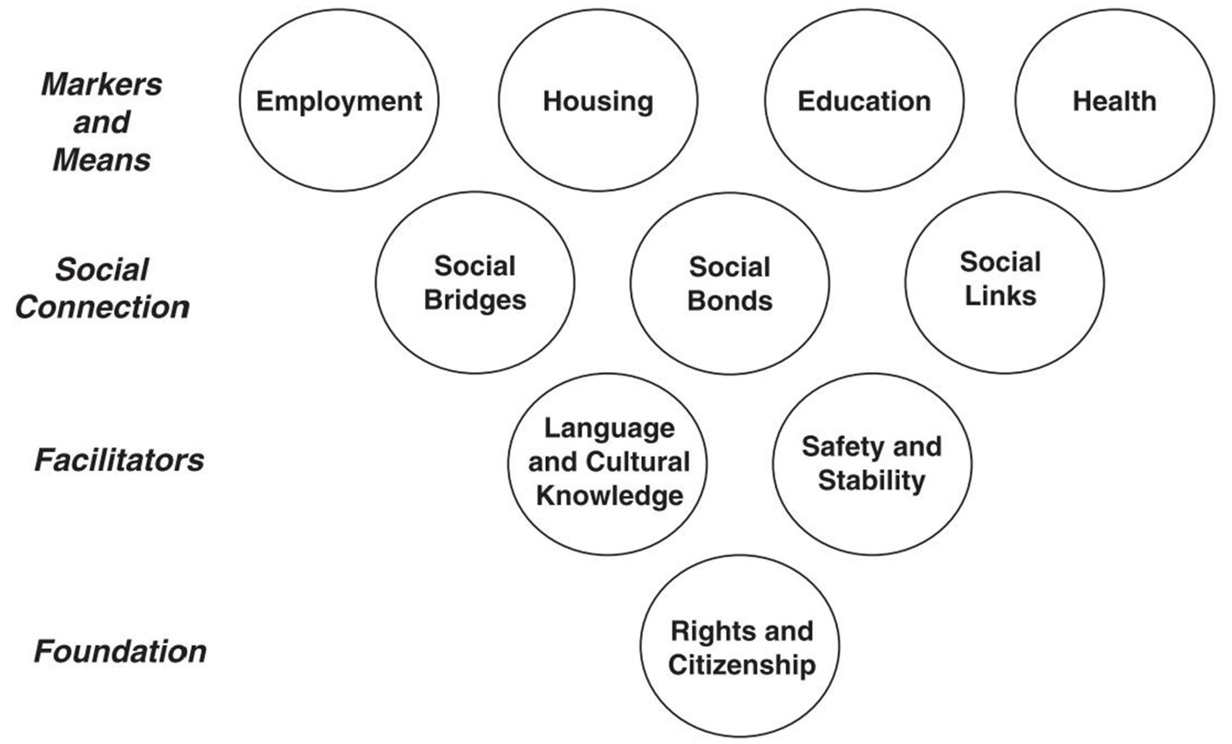

FIGURE 1
Ager and Strang's conceptual framework of integration, from Ager and Strang (2008).

to what is considered relevant by the collective participant group, and affected by cultural subgroups which different groups are made of (even within those living in close geographical areas) (Strang and O'Brien, 2017). The use of the social connections methodology in this study would not only provide general trends in this respect, but would also make it possible to quantify the relative importance of these connections and the level of trust placed in them. The same applies to non-displaced people. Incorporation of both displaced and non-displaced people would result from the fact that integration into a host environment is not a one-off process. On the contrary, it is seen as a two-way process that emphasizes mutual accommodation between displaced persons and members of their host community.

The use of qualitative methods, mostly interviews (including longer life histories) given the amount of time and resources available to us, enabled us to delve a little deeper into the lives of IDPs and the TCAM provider. It helped refine the explanations for the main trends identified with the quantitative approach and let emerge themes that were not integrated into the survey (because of our necessarily limited understanding of the topic prior to starting the research).

Sampling

As explained above, we started our research with a survey on a random sample of IDPs and non IDPs living in sites we knew hosted large IDP populations (see Study Settings above). The final sample size for the two target groups involved in this study is shown in the Table 2.

From the 640 IDPs sampled in this study, a total of 56 were selected from both areas (including 30 in Kabare and 26 in Uvira) for conducting in-depth interviews. They were purposefully selected based on their indicated willingness to talk more with us and their use of various health-care providers, including TCAM, and balancing gender, location, and age. As for TCAM practitioners, a total of 24 traditional healthcare providers were interviewed, including 13 in Uvira territory and 11 in Kabare territory. We started with a few contacts provided to us by the in-depth interview respondents and then used snowball sampling.

TABLE 2 Sample size distribution between Kabare and Uvira territories.

	Kabare	Uvira	Total
IDPs	304	336	640
Non-IDPs	99	108	207
Sub-total	403	444	847
TCAM Providers	11	13	24
Sub-total	11	13	24
Grand-total	414	457	871

Data collection

Quantitative data

Implementation of the social connections methodology began with a series of participatory workshops of 8–12 people. Participants were both IDPs and non-IDPs but were grouped by gender (men and women separately). A series of three questions were discussed within each group regarding where somebody in their community would turn if suffering from "persistent physical pain" and "deep sadness" which impairs their daily functioning, as well as following incidences of SGBV. The responses given then created a list of social connections that the research team distilled to 30. This list of 30 social connections informed the quantitative survey made it possible to assess the extent and importance of the main channels used by IDPs to use the services of traditional care providers, as well as the quality of these links through the levels of trust they place in them. After giving basic demographic and economic information, the researcher went through each of the 30 social connections asking who they had contact with in the last 6 months when looking for help/support with their health or well-being (mental or physical). Another question on the questionnaire assessed through a scale of 1 to 5 (where 1 indicates no trust at all and 5 total trust) how much trust this person or organization was able to help with health-related issues.

The surveys covered the two territories in South Kivu, including Uvira and Kabare. Their implementation was facilitated by prior contacts with the respective administrative authorities of the different sites visited. These gatekeepers allowed us access to the sites inhabited by the IDPs. Local facilitators were used to ensure effective identification and contact. Surveys were generally carried out at the homes of respondents, depending on their availability. Thus, purposive sampling was used to select respondents.

Qualitative data

The individual interviews, drawing from previous survey participants who agreed to engage further in research, were semi-structured, using an interview guide. The interviews targeted IDPs and traditional healthcare providers. Three themes were discussed: health problems in the community (displaced and non-displaced people), the health behavior of displaced people, and the provision of and access to health services for internally displaced people. The interviews generally took place at the interviewees' homes, and in some cases lasted more than an hour. Other individual interviews were conducted with IDPs in the form of life histories, gathering information on their origins, reasons for migration, migration route, living conditions and health problems encountered.

Data analysis

The qualitative data collected were subjected to thematic content analysis (TCA), which consists of "identifying in verbal or textual expressions recurring general themes which appear under various more concrete contents" (Mucchielli, 1996, p. 259). As for quantitative data, descriptive statistics were used mainly percentages and measures of central tendency. Comparisons of means and proportions have also been used to discriminate between IDPs and non-IDPs.

Ethics statement

The ethics committees of the School of Social and Political Science at the University of Edinburgh and the Université Evangélique en Afrique approved the project. Oral consent was deemed more appropriate and used for both the qualitative and the quantitative data collection. The research team was trained in ethics and safeguarding principles before the beginning of the research. The study was part of a larger UKRI-funded project 'Improving healthcare at the intersection of gender and protracted displacement among Somali and Congolese refugees and IDPs', which also considered displaced populations in Somalia, Kenya, and South Africa. More general cross-country findings that also pertain to TCAM will be published in subsequent publications.

Results and discussion

This section presents the results of the study. These can be divided into two main parts. The first focuses on the use of TCAM by IDPs. It presents data on IDPs' access to traditional healthcare, their socio-economic profile, their main sources of health information and the level of confidence attached to the TCAM. The second part of the results then focuses on traditional healthcare providers. These include a description of their profile, the services they offer and finally the economics of traditional medicine.

Access to healthcare for IDPs vs. non-IDPs

The preliminary work on the social connections allowed us to identify a set of key actors that loosely fit the category of the "traditional" healthcare providers. They were then integrated into the survey, and we were able to analyze the responses to the question "Which people or organizations you have had contact with in the last six months when looking for help/support with your health or well-being (mental or physical)?" Across our four sites, we find that 64% of the IDPs cited at least one traditional healer or traditional healing practice as a way to access healthcare. Conversely, only 54% of the host community had recourse to TCAM in the considered period of time ($p = 0.0095$). On average, the IDPs cited 1.21 traditional providers, versus 0.87 for the host population ($p = 0.0004$). The main traditional care providers used by the two categories of respondents in the two settings are shown in Figure 2.

These include phytotherapists, herbalists, fetishists, various religious communities (Catholic, Protestant and Muslim) and religious leaders. Connections with different healthcare providers showed that IDPs were more likely than their non-displaced counterparts to use phytotherapists (15% versus 8%, $p = 0.0323$), herbalists (19% versus 8%, $p = 0.0002$), and religious leaders (21% versus 14%, $p = 0.0167$) for their mental and physical health and well-being problems. There was no significant difference between the two groups in their use of other providers such as exorcists or fetishists. Fetishists had very low rates of use compared with the rest of the providers for both IDPs and non-IDPs (2 and 1% respectively).

Generally speaking, displaced people are more likely than non-displaced people to seek healing services from specific TCAM providers such as exorcists, phytotherapists, herbalists, and ritualists. There are several possible reasons for this attitude. Lack of financial resources is primarily seen as the reason why IDPs turn to TCAM providers. Modern health facilities are considered too expensive for health care forcing IDPs to turn to traditional medicine, perceived to be cheaper.

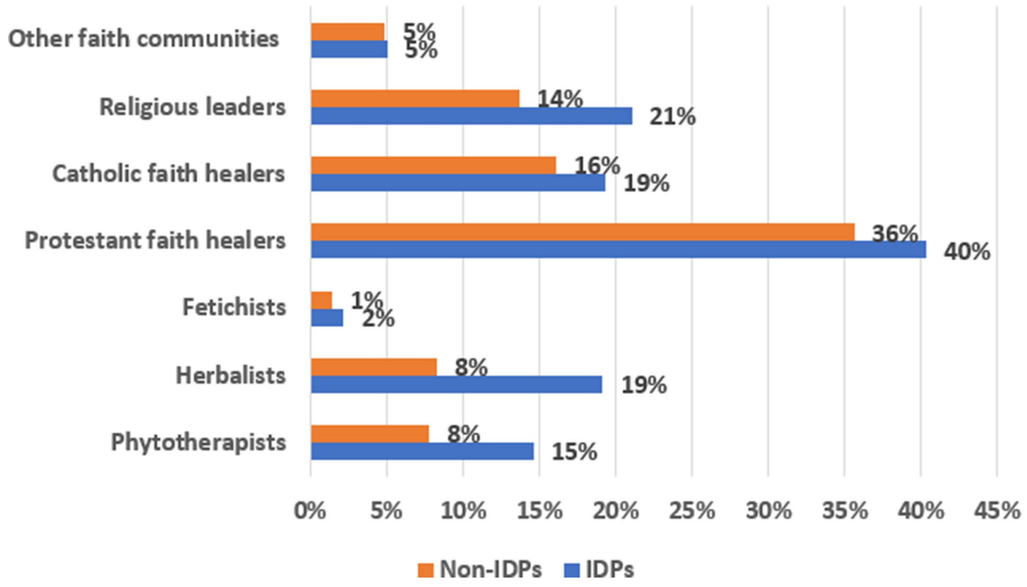

FIGURE 2
IDP/non-IDP access to traditional healers.

One displaced woman in Uvira explained to us:

> "My child has umbilical hernia. The disease started when he was 1 year old, and he is now 4. As far as I'm concerned, I think perhaps this illness is hereditary in our family because my biological brother suffers from this same illness… This illness has affected us a lot and we don't have sufficient funds to provide appropriate care for this child… I don't know the cause. It's not God's will, nor is it a supernatural illness… A friend of mine showed me a herbalist who tried using his amulets, but it didn't work. He had failed, moreover, he deceived us with his medicine. We went to another lady, also a traditional healer, who used her products to ease the pain. The child is sometimes relieved, but the illness remains. Relatives who came to see us advised to go to the hospital so that the child could undergo a surgery. That remains the only way of treating this illness. Due to a lack of funds, we stayed at home until then."

TCAM providers are also seen as more flexible in terms of payment than biomedical healthcare providers –sometimes, as we explain below, their services can be free of charge. This is despite the proximity of biomedical health facilities. Often, and in line with the existing peer-reviewed research on the use of TCAM, people go to different types of healthcare providers depending on their issues (including social problems) (Tabi et al., 2006; Ndetei, 2007; Mutombo et al., 2022). TCAM providers are, for instance, seen as able to cast out all sorts of supernatural spells (some of which are associated with situations that affect displaced people). One of the displaced people from Kabare explained this arrangement:

> "I was poisoned and have been suffering from stomach pains ever since (3 months ago). The pain is often excruciating but I can still walk. However, sometimes I can't get to work. Almost all my wages are spent on treating this illness. All my friends have abandoned me. Sometimes I think it's due to supernatural causes and other times I think it's God's will… At the hospital the treatment didn't work. I've never been satisfied because my illness remains the same. No change. I don't think they have the right medicines… I went to the pastors for prayers, but there too, there was no change. I thought it was witchcraft but there was no change. I went to the traditional healers, but again there was no change, and his medicine made the pain worse."

Profiles of IDPs accessing TCAM

Traditional healers explained that their patients come from different ethnic groups, social classes, religious denominations and levels of education. A faith healer in Kabare explains:

> "In the prayer rooms, we receive people of all religions, Catholics, Protestants and even Muslims. I recently had a young girl who had been a Muslim for 17 years. But she came to us, and we prayed for her. She even converted and married a Protestant boy. So we welcome everyone as they are. We have men who come to us, women and children so that we can pray for them… In my ministry, I also meet displaced people from places like Kahungu, Ziba and Bunyakiri who come here for various reasons such as security problems or other reasons."

As for other TCAM providers, their patients include men and women of various levels of education and of all ages (children, young adults and the elderly). They are also of different professions (soldiers, footballers, aid workers), and originate from different tribes (Shi, Bembe, Fuliru, etc.) in South Kivu. Contrary to the way they are perceived by members of society, the clients or patients of the fetishists (and other non-Christian TCAM care providers) include people of different religious denominations, such as Catholics, Jehovah's

Witnesses and Protestants. According to the interviewees, however, Protestants hide when they go to the fetishists because of their religious convictions. This attitude is confirmed by studies by Koya (2016), which indicate that for many of the current generations in South Kivu or Bukavu, consulting a fetishist is going against their religion.

Our quantitative data also helps cast light on the socio-demographic characteristics associated with the use of traditional healers (see Table 3). Generally speaking, we find very few differences between users and non-users –be they IDP or not. Data in Table 3 below shows that women are slightly better represented among non-users in the IDP group. In terms of education, it can be observed that despite a significantly higher rate of illiteracy among non-users than among users of traditional medicine, the latter had relatively lower rates of school dropouts than TCAM non-users. This is consistent with the literature that finds that contrary to popular perceptions, the use of TCAM is widespread among all categories of the population (e.g., Falisse et al., 2018). The calculated wealth index (composed of the number of assets out of 20 items) shows that both groups of displaced people own fewer household assets, but again there are no differences between TCAM users and non-users. Information on maternal languages shows that IDPs speaking Swahili and Kifuliru as their mother tongues have a higher proportion of TCAM users. Although Swahili is a national language, and presumably second language for many, there are an increasing number of people who only speak Swahili without a good knowledge of other local languages (especially in urban areas). Catholic believers, as shown in the Table 3, are less represented among TCAM users.

Information on housing show that some IDPs have been able over time to own some plots within host communities. Statistics show that 38% of TCAM users (against 33% for non TCAM users) own places where they live. Others, on the other hand, either rent (21% of TCAM users compared with 29% of non-users) or live in places arranged for them by religious communities (31% of TCAM users compared with 18% of non-users). Another group live in places that do not belong to them but for which they pay nothing in return (9% of TCAM users compared with 18% of non-users). The relatively high proportions of displaced people living in places arranged by religious communities or charitable organizations can be explained by the presence of people displaced by disasters (especially in the territory of Uvira). The latter live in a camp, unlike the war-displaced, who live scattered in different communities.

Data on living conditions show that more than half of IDPs and many non-IDPs live in houses with tin roofs and composed of three rooms on average. Others live in houses with canvas roofs or made of thatch. This could be explained partly by the presence of people displaced by disasters living in Kasenga camp in Uvira and by the fact that data was also collected from rural areas. Although not included in Table 3, the data collected indicates that reasons for displacement remain numerous. However, the most dominant are war and intimidation for the most part (72%) and natural disasters (19%). Most war IDPs displaced from their place of origin came from neighboring villages to their current locations. In Kabare for instance, war IDPs came from Karhanda, Kabulungu, Cahoboka or Kabushwa, villages located a few kilometers away from Kavumu and Katana. The latter are two big cities in North Kabare where IDPs mostly relocated to. Many of them fled war, atrocities and lootings from the Forces Démocratiques pour la libération du Rwanda (FDLR). As for Uvira territory, Kamonyi was prominently the place of origin for many war IDPs in Katogota (village where IDPs relocated to).

Sources of health information

Displaced and non-displaced people have many sources of health information. The most common are friends and neighbors, the media (radio), and biomedical sources (nurses, doctors, health centers). These are followed by community meetings, family members, community relays and places of worship. Only a few sources of health information are significantly different between IDPs and non-IDPs (Figure 3). The non-displaced made greater use of community meetings (13% versus 7%, $p = 0.0007$) and places of worship (21% versus 15%, $p = 0.0773$) as sources of information about their health problems. Displaced people were more likely to obtain health information from family members and relatives (21% versus 13%, $p = 0.0145$), which may also be an explanation for why they would more easily orient themselves toward TCAM providers who are known within the community but rarely advertise publicly. The awareness-raising campaigns provided on the radio and television are, as the data shows, likely to be of limited efficiency among IDPs given their low usage of such media for health information purposes.

Confidence level

In most cases, traditional healers, namely fetishists, phytotherapists, herbalists, and exorcists are reputed to have relatively cheaper services than modern health structures. Table 4 shows the levels of trust that IDPs and non-IDPs place in them to deal with their health problems in the territories of Kabare and Uvira.

The Protestant and Catholic community organizations seem to be more trusted than the rest of the TCAM providers by both displaced and non-displaced people in finding solutions to their health problems. At the other extremity of the spectrum, the fetishists benefit from a low level of trust. These findings are, however, not different for IDPs and non-IDPs. The main difference, as the table shows is in the increased confidence IDPs have in herbalists, physiotherapists, and other faith communities outside the Catholic and Protestant communities.

Characterizing TCAM providers

We now turn to the data we collected among traditional healthcare providers to try to better understand how IDPs relate to traditional healers. We start by describing the profiles of the healers and their areas of activity. As the introduction sections of this paper pointed out already, TCAM providers refer to a wide range of practices. Categorizations are always hazardous, but in our 24 interviews, 17 people described their practice as close to what the official classification would call herbalists, 3 as ritualists, 3 as exorcists and 1 is best qualified as "mixed" –a category of TCAM providers who, by their practices, can be considered to be herbalists but who also engage in seances similar to those of the fetishists (ritualists) or faith healers (exorcists) found in religious communities (Protestants in particular). Men overwhelmingly dominate (18 of our respondents), and the average TCAM provider was aged 48 (standard deviation: 11.25) and had family responsibilities. On average, they have been in the profession for 22.5 years (standard deviation: 10.97), suggesting that TCAM providers start early.

TABLE 3 Socio-demographic characteristics of IDPs and non-IDPSs.

		Displaced			Non-displaced		
		TCAM user	Not TCAM user	Diff.	TCAM user	Not TCAM user	Diff.
Age	Average	39.45	38.35	1.1	36.96	37.75	0.79
Proportion of women (%)		73	79	6.3*	67	74	7.2
Level of study (%)	Literacy	2	2	0	3	1	-2
	None	30	37	6.9*	16	28	1.19**
	Certified vocational training	1	0	0	2	0	-2
	Non-cert. vocational training	1	0	−1	1	0	−1
	Degree completed	1	1	0	1	1	0
	Graduation not completed	1	1	0	1	1	0
	Primary completed	6	5	-1	11	6	−4
	Primary not completed	26	21	−5	29	21	−8
	Can read and write	2	2	0	4	4	1
	Secondary completed	7	7	0	7	6	−1
	Secondary not completed	22	21	−1	25	26	1
Employment (%)	Shopkeeper food	18	19	1	14	15	2
	Shopkeeper non-food	4	6	2	7	6	−1
	Services hairdresser tailor	2	1	−1	4	5	1
	Housewife	5	5	0	6	10	4
Wealth index	Average	0.025	0.019	−0.005	0.048	0.03	−0.017
Mother tongue (%)	Kibembe	4.3	2.6	−1.7	3.5	4.2	0.63
	Mashi	56.6	56.2	−0.40	54.5	54.7	0.27
	Kivira	1.9	1.3	−0.62	2.7	2.1	−0.57
	Kifuliru	23.6	16.8	−6.8**	16.9	17.9	0.93
	Swahili	53.9	43.8	−10.1**	51.8	45.3	−6.5
Religion (%)	Catholic	27.9	35.1	7.2*	25.7	41.1	15.4**
	Protestant	60.2	53.8	−6.4	62	46.3	−15.6**
	Neno	2.7	2.2	−0.4	2.6	01.05	1.6
	Muslim	0.97	1.8	0.8	4.4	3.1	−1.3
Housing (%)	Arranged place	31	18	−13***	9	11	2
	Rent	21	29	8**	21	16	5
	Own place	38	33	5	58	54	−4
	Somebody place	9	18	9***	12	19	7
Rooms	Average	3	3	0	3	3	0
Type of roof (%)	Canvas	30	29	−1	5	43	38***
	Tin	58	50	−8**	74	44	−30***
	Thatch	12	19	7***	21	13	−8

Difference: $^{*}p < 0.1$, $^{**}p < 0.05$, $^{***}p < 0.01$.

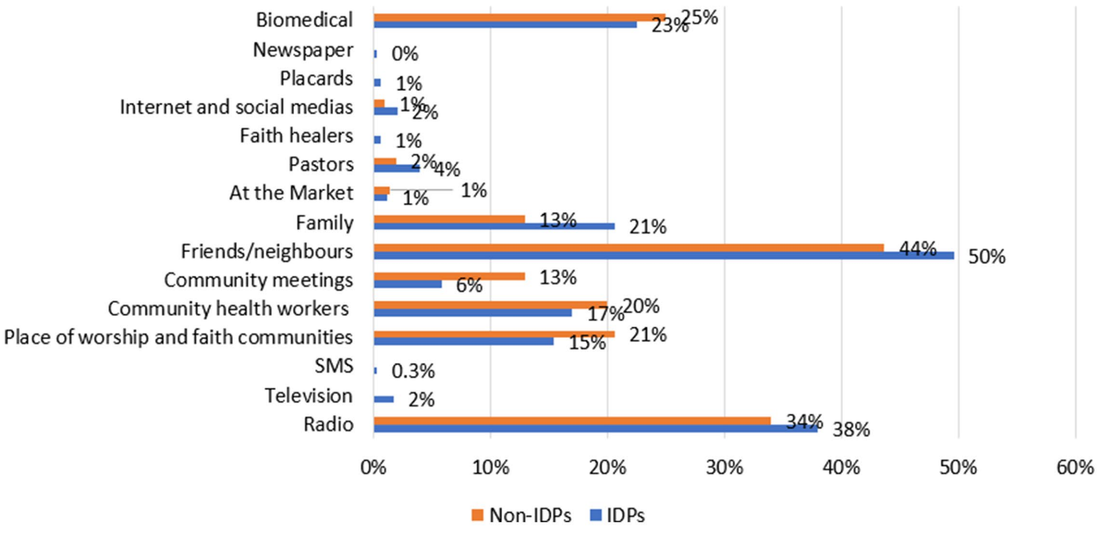

FIGURE 3
Sources of health information among IDPs and non IDPs.

TABLE 4 Confidence level toward traditional healthcare providers (from 1 no trust at all, to 3 very high trust).

Traditional healthcare type	Status	Total		
		N	Mean	Diff
Faith healers (Catholic)	Non-IDP	129	2.08	0.23
	IDP	365	2.16	
Faith healers (Protestant)	Non-IDP	173	2.2	0.006
	IDP	494	2.19	
Fetishists	Non-IDP	19	1.42	−0.35
	IDP	67	1.77	
Herbalists	Non-IDP	96	1.75	−0.183**
	IDP	330	1.93	
Religious leaders^{+}	Non-IDP	162	1.89	−0.08
	IDP	471	1.97	
Phytotherapists	Non-IDP	79	1.64	−0.18*
	IDP	283	1.83	
Other faith communities	Non-IDP	65	1.6	−0.29**
	IDP	225	1.89	

Difference: $^{*}p < 0.1$, $^{**}p < 0.05$, $^{***}p < 0.01$ | +.

TCAM services

TCAM providers (ritualists, herbalists, and exorcists) offer a range of services to those who consult them (whether displaced or not). From a simple abscess to conditions of so-called supernatural origin, the healing services offered by these care providers vary greatly depending on their specialty and the profile of the person seeking help.

Physical and mental healthcare

Services offered by TCAM providers include care for a wide range of physical and mental conditions, sometimes depending on the patient's profile such as age, sex, or profession. For women, for example, there are a lot of services offered for gynecological conditions such as infertility, painful periods, or care for contraceptive measures. For children, the focus is typically on common ailments such as malaria, bronchitis, epilepsy (although also seen in adults), and certain pediatric illnesses. Men, on the other hand, seek treatment for sexual impotence, prostate problems, and tuberculosis. For most categories and different ages generally, we record healing services for mental health conditions. These include for instance psychopathology, mental disorders as well as nerve problems, and headaches. TCAM services are also requested for chronic illnesses (diabetes, high blood pressure, hemorrhoids, stomachache), toxicological complications (poison), orthopedic illnesses (fractures) and internal medicine conditions (rheumatism).

Exorcism

TCAM providers also offer exorcism services for victims of demonic possession –conditions that are more difficult to relate to those described and accepted by biomedicine. This is often the work of pastors, evangelists, servants of God, and even certain ritualists or fetishists. The latter practice exorcism, rituals or healing prayers for illnesses that they describe as having a supernatural origin. Exorcists from the Catholic and Protestant communities often work in prayer rooms or visit hospitals to pray for the sick. A pastor in Kavumu commented:

> "…In terms of the illnesses we see most often, we have cases of demonic possession [with behavioral problems], people with problems linked to family curses [following magico-religious practices within their families]. In view of these problems, we hold deliverance sessions for them…".

Certain physical (such as premature death) and mental conditions are also associated with or interpreted as situations of demonic possession. In the absence of psychiatric facilities in the area, recourse is often made to traditional care providers, particularly ritualists (fetishists) or herbalists. This practice is very common in the area and is thought to be an integral part of a set of cultural practices with well-known social referents (Koya, 2016). A TCAM practitioner explains:

> "Wars that make living conditions very difficult are at the root of many problems. Demons very well exist, and we see them. Some tribes, like the Bashi, have the *Muhima* [a spirit or demon] that never leaves them. We have a cultural practice whereby, to cure a person with this type of demon, the latter is given a girl from the same family to be his wife, and when the girl marries, another girl from the same family is sought to prevent premature death or illness among other family members. There are also hereditary diseases that need to be properly identified/diagnosed in the traditions. These diseases are transmitted from one generation to the next. *Mulonge yenye ina ozesha ata ma moelle épinière* (a disease that rots the spinal cord) comes from the bad faith of people with bad intentions. As fetishists, we break *mizizi* (amulets)."

Although culturally accepted, the role and use of traditional medicine also seem to be reinforced by the living conditions of the population, and those of displaced people in particular. The daily stress experienced by displaced people and the personality disorders they cause can be attributed to supernatural causes. In addition, diagnosis and treatment of hereditary and congenital diseases are sometimes beyond their means, given their poor living conditions, leading IDPs to turn to TCAM and its methods. Some of these illnesses are considered taboo and taken to fetishists. The latter is said to help counter the effects of certain enchantments or amulets, as well as curing certain supernatural ailments such as the "muhima" and "mulonge." However, in the absence of suitable testing equipment, it is only the persistence of the disease that can enlighten healthcare providers as to the true origin of the disease and whether it requires biomedical monitoring. An exorcist explains:

> "We see people coming here with cases of malaria and high blood pressure, but we deal much more with cases of demonic possession because these are the problems for which people seek us out. As for mental illness, we have three types of problems. There are those who are disappointed by life's problems (too much stress in life, either husband, wife or financial problems). Others are victims of demonic possession (paranormal activities). They may even undress in public. The third category is those with mental health problems linked to heredity (this third category often resists prayer)."

This explanation shows not only how difficult diagnosis of specific diseases can be in their early stages but also emphasizes the assumption that TCAM providers have earned a reputation of being "jack-of-all-trades." Even for cases that would require biomedical treatment, some may retain patients in their prayer rooms or facilities. This usually ends up aggravating their situation or revealing their inability to help patients, particularly in the case of mental health conditions, malaria or anemia. Such an attitude has often tarnished the reputation of TCAM practitioners and aroused distrust among host communities, including IDPs. However, they are recognized as having a certain effectiveness in overcoming certain physical health conditions such as "mulonge," which is widely recognized as being of supernatural origin in the area.

Illnesses of "supernatural" origin: Mulonge

Testimonies gathered from displaced people show that, although some traditional healers can offer healing services for illnesses that can easily be treated in a hospital, their specialty remains the treatment of poisons and *Mulonge*. *Mulonge*, or Buruli ulcer, is one of the neglected tropical diseases reported in certain countries in sub-Saharan Africa, South America and the Western Pacific. In the DRC, it was first reported in the 1950s and is known by different names depending on the region. In the west of the country, the disease is better known as "*mbasu*" or "plague due to a bad spell." *Mulonge* or *Mbasu is a* disease characterized by skin lesions resembling a nodule, papule, plaque or oedema. These lesions can progress to ulcerations of various sizes and shapes, which can even reach the bone (Kibadi et al., 2009). If not treated effectively, the disease could lead to the death of the patient or the amputation of certain limbs.

The causes of Buruli ulcers are still the subject of much debate between the scientific community on the one hand and the lay community in South Kivu on the other hand. People do not understand why a person would be affected and not those around them, despite frequent contact (including the environment in which they live with their loved ones; Nendaz and Sordet, 2015). Scientific studies carried out on the disease show, however, that the main cause of the illness is linked to contact with the microbial agent transmitted by drinking or coming into contact with non-drinking water: *Mycobacterium ulcerans* (Kibadi et al., 2009; Ackumey et al., 2012).

The ineffectiveness of biomedical treatment in the advanced stages, caused by delayed care and negligence on the part of the patient (or those around them), as well as the mortality associated with this disease, reinforces its mystical nature. The literature therefore shows that many people with the disease in other African countries would be more inclined to resort to traditional treatment. Studies by Webb et al. (2009) showed that in Ghana, 71% of Buruli ulcer sufferers resorted to traditional treatment, but much more for reasons of proximity. Other factors could be a lack of empathy on the part of biomedical staff or delays in finding appropriate treatments (Ackumey et al., 2012).

Mulonge occupies a central part in narratives on accessing TCAM providers in South Kivu. It is also the preserve of certain fetishists. One of the internally displaced persons from Kabare explains:

> "There are illnesses that require treatment by traditional healers, such as Mulonge, and even poisons can only be treated by herbalists. I remember once asking for water to drink. However, just as I felt the water was cold in my mouth, I felt it warm in my stomach. So I rushed to hospital. A friend had taken me to an herbalist who had given me some medicine that I used for six months. When I took these medicines from herbalists, I vomited if I took cold water and had diarrhea if I took hot water."

Cases of poisoning and *mulonge* are very common in South Kivu, both in urban and rural areas. The suspected motives behind them are said to be varied. They may be economic (sudden retirement, dismissal at work followed by promotion in favor of someone else), land-related (land disputes), or motivated by pure jealousy (also known as the evil eye) of people who are not happy to see others prosper. There are many ways of poisoning people or throwing *mulonge* at them. In the case of poison, this can be done by the most mundane means possible, such as physical contact like shaking hands, drinking water, food or other beverages. As for *mulonge*, often-used means are contacts with clothes, locks, chairs or tables in offices on which its microbial agent had been deposited.

Amulets and protection

Finally, less related to the main healthcare topic of this article, those who are not ill also seek the services of TCMA providers. Some service providers such as fetishists would even offer amulets to improve their luck in their profession such as drivers or fishermen. As one fetishist in Uvira put it:

> "I also give amulets to drivers and motorcyclists so that their work is too profitable. I also give them to fishermen so that they have lots of fish."

It is important to point out that in the context of Bukavu and its outskirts, fetishists (who are included under the ritualist category) are perceived as multifaceted sorcerers whose remit go well beyond what is typically described as healthcare: the fetishes they use can also be used to protect against evil spells, to bring good luck, or even to punish or take the lives of certain people (criminals) (Koya, 2016).

TCAM healthcare access costs

The services offered by TCAM providers are not always free. There are different forms of remuneration, depending on whether the services are provided by fetishists, herbalists, or exorcists. We argue that while IDPs struggle to pay for biomedical as well as traditional healthcare. However, the more flexible modalities of payment that are found among traditional healers make them a potentially attractive option. IDPs are sometimes forced to work as farm laborers in the fields to earn 2,000 Congolese francs (less than USD $1 a day) a day to cater for their families and cover other expenditures.

When a person seeking care requests services from traditional healers or fetishists, they are usually first asked to offer either a goat, a chicken or a sum of money (ranging from USD $2.08 to USD $50) depending on the health condition they are experiencing. This process is known as "Kiingia pori" or "Kingiya pori." According to the practice of traditional healers and fetishists in particular, this sum is a form of deposit that gives them the funds to go fetch in the forest (*pori* in Swahili) ingredients to be used in their treatment. It can also be used to pay those who will collect plant leaves on their behalf. In certain circumstances, the "Kiingia pori" can also be seen as a donation made by the patient or their relatives to appease the spirits and open the door to healing, blessings, or protection from the ancestors (Koya, 2016). In this case, the donation, either in kind or in cash, is the sole consideration for the services received. Providers may receive an envelope of money or a goat as a token of appreciation, or a thank you from the patient.

This type of payment is not the only approach found in our research. Some traditional healers charge (mostly) at the end of the treatment, and the bill can be as much as USD $100. Importantly, the bill depends on the illness treated, but also the patient's socio-economic profile or the illness. Practices vary widely, but in some cases, in a fashion similar to biomedical healthcare, fees are clearly set in advance and publicly displayed. For instance, a traditional practitioner in Kabare had advertised:

- Migraine, chronic headache USD $10;
- Stomach: USD $15;
- Fractures: USD $30,
- External hemorrhoid: USD $30
- *Mulonge*: from USD $150 to USD $300
- Malaria: from USD $25 to USD $41.

We could not find any strong evidence that IDPs and non IDPs are treated differently, but the relative flexibility around payment suggests that specific vulnerabilities are taken into account when charging the patient.

Exorcists work with a different approach. Officially, their services are free as they act on "divine instructions." In practice, though, "divine grace" seems to require a little nudge and a donation for exorcists to start working. Their attitude is one of "wait-and-see" what the patient actually has to offer (this is generally in keeping with the economic functioning of many churches in the DRC). This applies to all categories of the population, including IDPs. Among exorcists, some openly recognize that this approach to payment constitutes a barrier for IDPs to access their services. As one of them put it: "The problem I have with IDPs is their poverty. We can pray for them, but they do not have enough money to give us even a glass of milk."

Other traditional healthcare providers share the same point of view. Interviews revealed that one of the major difficulties they face arises from IDP patients. Many of those who seek treatment from traditional healers find it difficult to pay their bills. The poverty in which many IDPs find themselves means that some ask to be treated free of charge. Others can start the treatment and then, once their condition begins to improve, disappear without paying their bills. We also have cases where IDP patients are fed by their TCAM providers in order to receive their treatment. An herbalist in Kabare explains:

> "For IDPs, most of the time when they arrive, they don't even have the strength to stand up. What's more, they don't even have enough to eat. So there are medicines that we can't even give them in this state. So first we have to see how to find them something to eat and then treat them, or simply reduce the dose given to patients to prevent the treatment from causing harmful effects,

> which will also delay their recovery. Afterwards, as the treatment progresses, and especially when they notice that they are beginning to heal, they disappear before benefiting from the final dose. In particular, we have a case of a patient who was brought here on Tipoye after being poisoned. We took care of him. Now he's recovered, but he hasn't gone home yet. He now lives here with us. He leaves in the morning to go to work and comes back in the evening."

The way TCAM providers offer their services to their patients, and IDPs in particular, appears somewhat unusual compared with current biomedical practice. While in modern health structures, patients benefit from regular follow-up in sanitary facilities, this is not often the case for some traditional healthcare providers. Because of the lack of adequate sanitary facilities, the patient becomes intertwined with the healthcare provider's family. Some care providers even start to fetch food for patients to help them take their medication. We see patients who, once cured, enjoy the hospitality of their hosts, and become adopted by their families, using this environment to carry out their normal activities. The lack of financial resources is the most plausible cause of this situation (and explains why IDPs disappear before the end of treatment as they cannot afford it), but so is the lack of a purely professional framework on the part of TCAM providers.

On the supply side, TCAM providers report serious financial problems and tax red tape. Many of the treatments used by TCAM providers (herbalists, phytotherapists, but also ritualists and exorcists) come from plant extracts. Preserving and processing these extracts requires appropriate equipment, which they struggle to afford. This problem also affects their working conditions, such as the confinement of patients, who are sometimes obliged to live with their family carers. Another problem faced by TCAM providers is institutional: official and *de facto* taxes and tax harassment by government officials hamper their activities. As one of them put it: "We receive a lot of taxes and receipts from the state, and this is not proportional to our income. Just imagine, we can have a daily income of 5000FC [USD $2] but they will give you taxes of USD $250 per month."

The main sources of income for TCAM providers are their clients, including displaced persons. Given the flexibility of their pricing system, the low level of income of their patients, and the *de facto* taxation, the income of traditional healthcare providers remains low. As the plant extracts they use become increasingly scarce due to population growth and deforestation, they are forced to turn to pygmies living in the vicinity of the Kahuzi Biega National Park or to other suppliers living in areas that regularly access the forest. Additional financial resources are then needed to pay their suppliers for the plant extracts to be used in their treatment. However, their patients, who sometimes lack the means, would not provide them with enough money to cover these expenses.

In the course of their work, many TCAM providers report being victims of jealousy on the part of their colleagues. Jealous of their performance, progress or clientele, rivals use amulets or other means to curse them. A traditional care provider in Uvira says:

> "Some people even come and put charms on my house so that patients can no longer come to me for help. To do this, I also put grigris in my house to protect myself, because I remember one day, I was treating a patient and a snake appeared to intimidate me and interrupt me, fortunately, I caught it and cut off its head too."

Some TCAM providers use negative criticism to try to destroy their rivals' access to clientele and win the sympathy of customers. As for formal healthcare providers, they have little contact with traditional healers and other TCAM providers. In this separation, there is often enmity between them, seeing each other as "*mbanda*" or rivals. An exorcist from Kabare recalls:

> "We are also victims of certain stereotypes on the part of people who are not in the same profession as us. This is particularly true of front-line healthcare providers. Often when we fall ill and go to the health facilities, they tend to tell us: "*You are exorcists and intercessors. May the prayers that you are used to saying help you*".

This rivalry between traditional and modern medical care providers stems from several deaths that have already occurred either in prayer rooms or in their health facilities. Some illnesses that are not treated in time can get aggravated by treatments based on so-called "speculative" diagnoses by traditional medical care providers. Even among IDPs, recourse to traditional healthcare providers is not always unanimous, for various reasons mentioned above or simply because of a lack of trust.

Concluding remarks

This study addresses the role of traditional healthcare providers in the provision of health services to displaced and non-displaced people in Kabare and Uvira territories. In their search for healthcare, displaced and non-displaced people turn to TCMA providers for various healing services. This strengthens the emphasis on this category of healthcare providers whose services are reportedly cheap and recurrently requested. As part of the healthcare delivery system, traditional healers constitute an entry point for IPDs' integration in host communities as social resources that can be mobilized in case of health problems. Thus, focusing only on the use of TCAM among IDPs would not tell the whole story about both supply and demand of traditional healthcare services in South Kivu. From this research, it is important to take away that TCAM providers are not monolithic but fall under multiple subcategories. Surveys carried out among this population in South Kivu reveal several types of traditional healthcare providers, including phytotherapists, herbalists, ritualists (including fetishists), and exorcists from different religious communities (Catholic, Protestant, Muslim, Church of the Faith, Neno, ministers of religion); including a mixed group of healthcare providers whose practices touch on all three of the above categories.

Furthermore, traditional healthcare providers are not universally turned to or trusted to adequately treat people in South Kivu's needs. Therefore, before advocating for the integration of traditional healers into larger healthcare systems, it requires a comprehensive understanding of the role these actors play. In this sense, this article heeds Kadetz (2013) caution against the universal approach to healthcare integration of TCAM. He argues that the WHO's valorization of Mao Zedong's integration of traditional Chinese medicine into modern healthcare obscures the often violent politics of the Chinese integration process. Moreover, attempts in places such as the Philippines, where healthcare is decentralized and privatized as in DRC, the integration of TCAM has led to unintended consequences such as the increase of healthcare costs. Important lessons can be learned from this research:

> There is a marked difference between the normative representation of integration as a purposeful intervention of the biomedical State apparatus and the practice of integration that occurs organically through practitioner application; through the natural syncretism of practices shaped by sociocultural factors over time; and most of all through the patient's own plural and integrated use of their local practices and practitioners (Kadetz, 2013, p. 55).

Conflict and displacement complicate these processes further. As the results show, the use of these different care providers is much more pronounced among displaced people than among the non-displaced. More than 60 % of the displaced people questioned said that they had used at least one traditional healthcare provider. Analysis of the social connections established showed that phytotherapists, herbalists and exorcists were more frequented by IDPs than by non-displaced people. The main reason for using their services was the flexibility of their method of payment. Other reasons include where people turn to as sources of healthcare information and the level of trust some IDPs put in traditional healthcare providers, especially exorcists. Despite the presence of formal sources of health information, namely biomedical and radio, statistical test results showed that IDPs would more rely on family relatives for their health problems. Traditional medicine plays an important role in the treatment of certain illnesses in South Kivu. The government has made several efforts to integrate traditional medicine into the health system, but there is still a long way to go. This study highlights a variety of services provided by TCAM providers and how they are perceived. The services provided by traditional care providers are numerous and varied. There is also a high variance in trust people in the area have that they will receive the desired treatment through TCAM. The level of trust placed in certain traditional care providers remains relatively low, particularly for fetishists, except Uvira who have relatively high confidence in this group of care providers. Only phytotherapists, herbalists, and exorcists (including both religious leaders and religious communities) enjoy a relatively high level of trust among both displaced and non-displaced people. Despite these variances in trust and confidence in traditional treatment, certain conditions of Buruli ulcer, known in DRC as the supernaturally caused "*mulonge*," are locally perceived to be effectively treated by TCAM.

Due to the high level of demand for traditional treatment for *mulonge,* this specific condition could form a bridge for collaboration between traditional and modern medicine in South Kivu, especially as many providers do not have adequate equipment for accurate and appropriate diagnoses. In the case of Buruli ulcer, it is recognized that once the causative agent has been eradicated, the wounds it leaves behind can easily be treated in modern medical facilities. As for poison, working together would make it possible to distinguish real cases of poisoning from cases of stomach ulcers. It is therefore in the interests of the government and political decision-makers to facilitate this collaboration by putting in place a rigorous system for monitoring and registering traditional medicine providers, to avoid cases of abuse. Secondly, the state and health systems should build on the trust that certain types of providers, such as phytotherapists, herbalists, and faith healers have to find additional potential convergences where partnerships can be built. Another example may be the prevention, treatment, and seeking of justice for SGBV that may be disclosed to these sources.

Structures for supervising and training traditional medicine providers in urban and rural areas would be the second step toward their integration into the national health system, where traditional and modern practitioners would work in close collaboration. These will be followed by the establishment of traditional medicine centers specializing in the treatment of supernatural diseases such as Buruli ulcers and cases of poisoning. However, understanding the economic incentives of TCAM providers and IDP/non-IDP patients is crucial. The formalization and institutionalization of traditional providers may push out those providers who do not have the means to be integrated and may change the flexible payment structures that have allowed TCAM to flourish in South Kivu. Any attempts to integrate traditional healthcare providers into the formal healthcare systems of IDP situations holistically and equitably must first consult a wide range of local stakeholders including TCAM providers, IDPs, and non-IDPs as we have done in this research.

Data availability statement

The raw data supporting the conclusions of this article will be made available without any reservation.

Ethics statement

The studies involving humans were approved by Ethics Committees of the School of Social and Political Science at the University of Edinburgh and the Université Evangélique en Afrique. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

MK: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Software, Writing – original draft, Writing – review & editing. AK: Conceptualization, Formal analysis, Investigation, Methodology, Writing – review & editing. JB: Conceptualization, Investigation, Methodology, Writing – review & editing. EK: Conceptualization, Data curation, Formal analysis, Investigation, Software, Writing – review & editing. J-BF: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Software, Supervision, Writing – original draft, Writing – review & editing. GF: Conceptualization, Funding acquisition, Investigation, Supervision, Writing – review & editing. DM: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Software, Writing – review & editing. CB: Conceptualization, Funding acquisition, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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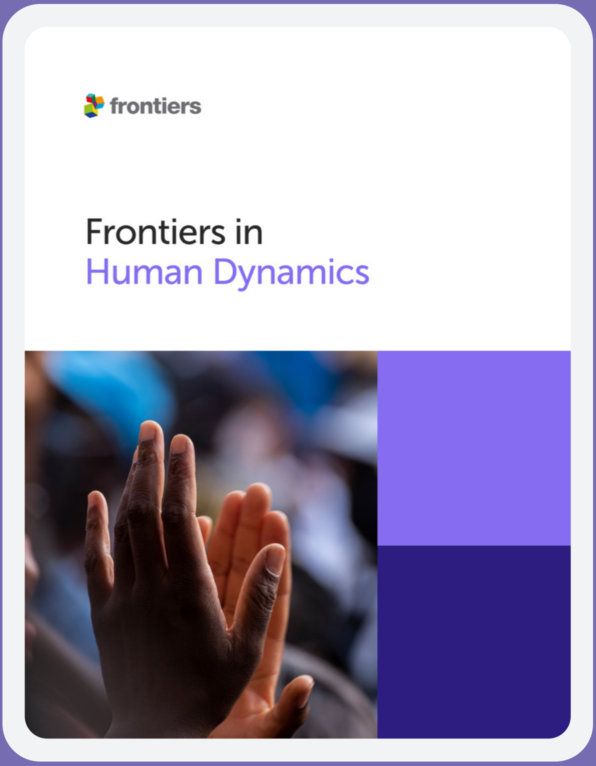

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