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The Impact of the British Immigration Acts (Immigration Control) on Health and Access to Health Care.

(Case study on black sub-Saharan African of English-Speaking Cameroon and Nigeria in England and Wales resident in Birmingham and Cardiff).

(Ernest Acha, PhD Thesis)

The impacts of British Immigration Acts on health and access to health care.

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Table of content.

Appendixes.

Figures.

Abstract.

The right to health is a fundamental human right enshrined in both national and international instruments to which Britain is a party. Some of these instruments do consider refugees and other forms of migrants as a vulnerable group of persons and emphasised on the protection of their right to health. The Impacts on migrants' rights to health is presented by this research via the role played by the immigration control processes put in place by the British state, specifically in England and Wales, and on a group of sub-Saharan African, and this research uses the outcome to commend, recommend and advocate for a better life for the migrants.

Generally, I argued in the thesis that in England and Wales, the British state uses its immigration control policies and the platform of international instruments to exhibits its imperialist tendencies on the migrant population and their states of origin and thereby infringing their rights to health.

The theoretical background of this thesis is drawn from African Marxism through concepts specific to Africa, to facilitate the interpretation of the practical experiences of participants of the health impacts of the British immigration control, with the prime motive in assessing the extent to which migrants' right to health is respected in the UK. This is done through a qualitative data being analysed using Marxism as a cardinal approach to get a deeper interpretation of the instruments involved. It should also be noted that this research happens to be one of the rare attempts in gathering empirical data from African asylum seekers and refugees in England and Wales.

The researcher uses a mixed method which places the migrants at the centre by employing the inductive approach in data collection for a better understanding of the impacts of the immigration control on them. The researcher is part of the research, on this ground, the participatory approach is used to assess and understand the experience of other migrants like him. To concretise and fill the gaps of the data collected from participants, the research further explores the positions of participants through interaction within a focus group.

Twenty-eight migrants of sub-Saharan African origin and of different categories (categories of migrants) were selected amongst the inhabitants of Cardiff and Birmingham of Wales and England to take part in this research and two focus group conversations with one from each town and made up of both migrants and professionals were organised to help the researcher explore the position of participants as a group. Six professionals from the fields of law, health and social work were also involved for the purposes of juxtaposing the data collected from other participants.

of the interviews were carried on using the theoretical thematic analysis and the ontological positions of the participants, which triggered the utilisation of a multi-perspective analysis which requires the sampling of both ontological and Marxist perspectives.

The research came out with the findings that migrants' right to health in England and Wales is affected as a result of their origin, the status accorded to them, migrants' housing, racism and discrimination. The research in its' conclusion arrived at the position that this approach of the British immigration control is aimed at restricting and limiting migrants who are in the UK and those in the process of coming over to the UK and recommended the need for a revision.

Acknowledgment.

I like to initially acknowledge my supervisory team made up of Tom Vickers, Linda Gibson and Blerina Kellezi, all of Nottingham Trent University for the endless effort invested in making this research a reality.

I wish to thank the migrants and professionals who contributed data for the research, most especially during this trying moment of health crisis (Covid-19 pandemic). It is clear that without their contributions, I wouldn't have had the materials for this research.

I also acknowledge the love from my family members who gave me a sense of belonging throughout the period of my research.

Declaration.

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature: Ernest Acha.

CHAPTER 1 - General Introduction.

The research is working on the topic ‘’The impact of the British Immigration Acts on health and access to health care’’, with focus on participants from the Black Asian Minority Ethnic Group represented referred to in the thesis as the BAME group with data collected and analysed from participants who originate from the English-Speaking part of Cameroon and Nigerians and who are all based in Birmingham and Cardiff of the UK.

This chapter generally introduces the steps and stages involved in the research and how the impacts of the legislations would be deduced from the data earlier announced in this research, and this will be assessed and referred from the impacts of the British immigration control on the migrant population of England and Wales.

The chapter consist of two sections of which the first section lays down the background of the research, beginning from the facts finding phase to decision arrived at by the researcher to conduct the research. This in essence introduces the insider outsiders’ perspective of the researcher to the general perspective of other participants. The section also outlines the contributions of the research to the specific persons pointed out by the researcher and the migrant community in Britain with case study of England and Wales. To further justify the research question and approach, the research lays its’ complimentary role to the research community by outlining the role it complements in other researchers’ work.

The second section of the chapter looks at the research question and objectives vis-à-vis access to health care and other related services by migrants in the UK. Migrants as would be considered in this thesis are foreign born nationals who have moved to another country and in our case, the UK for one reason or the other for a defined or undefined period, (Anderson et al, 2015). And the categories of migrants I shall be looking at in this thesis would be the documented and undocumented migrants from the English-Speaking parts of Cameroon and Nigeria as would be explained later in the thesis. And finally, the chapter lays down the approaches taken to answer the research questions, the timeframe and types of data needed, and the precautions put in place to avoid deviating from the objectives of the research.

BACKGROUND.

This section lays the background on which the research is conducted and projects the researcher's position as an insider-outsider to facilitate the understanding and response of the research question. It is also in this section that I am going to lay down the reasons for using Marxism in answering the research question and this will help in exploring the instruments from a deeper angle.

As a refugee and former asylum seeker in the UK, and as a human rights activist campaigning in the streets of Birmingham, Wolverhampton, Coventry, Walsall and Nottingham UK during the periods of 2016 to 2018, I had started nurturing the intention of carrying out research to clarify my doubts on the impacts of the Immigration control on health and access to health care in the UK which is one of the main problems encountered by many migrants including myself during the asylum seeking process.

During the process of my activism, I started laying the foundation by contacting potential participants to discuss what I intended to do. It is also during this stage that I did the assessment to know the possibility of successfully conducting and concluding the research.

It is in one of the street campaigns against racism in Birmingham that I met one of my supervisors and director of studies, Tom Vickers and from there, we worked the way forward for this research. I also contacted some few persons I met when I was in the asylum process and whom I saw to be important in the research process and got their opinion on participating in the research.

While clarifying the worries I had with regards to health and access to health care in the UK, this research will act as an educational path, campaign outlet and a request for the restructuring or reform of the legislations concern and to make recommendations to that effect. Prabhat, (2016), considers this approach ‘’legal mobilisation’’. As per Prabhat, the concept of legal mobilisation entails a ‘’purposive invocation of a legal norm’’ aimed at protecting basic rights. The basic rights that have instigated this research is migrants right to health in the UK, and by invoking the education and

recommendations of this research, would be aiming at protecting migrant's right to health.

Why Marxism.

In justifying the research question and presenting the complimentary aspects of this research to other previously conducted research, or the differences between this research and other previous research of similar topic. A PhD research was conducted at the University of Sussex by Randhawa, (2014) on the topic ''illness and Healthcare experiences of recent Low-Income international migrants in a UK city'' with a similar research questions and concluded that one of the reasons for the illness and health experiences was the introduction of the 2014 Immigration Act which implemented health charges as a measure to prevent abusive usage of the NHS services. My research is going further to interrogate why and how the government is carrying out the prevention processes and the method chosen to carry out this interrogation is by Marxism.

Applying same comparison with a different capitalist state other than Britain, a similar research was conducted in the United States of America by Derose et al, (2007) on the topic ''Immigrants and Health Care: Source of Vulnerability'', and with a similar research question as mine, with the conclusion that migrants' vulnerability to health is caused by them having lower rates of health insurance, and that they use less health care, and receive lower quality of care than U.S.-born populations. However, Marxism will look at this from a further perspective or go beyond these points to get the real or further causes of the health indifferences.

Applying Marxism to further explore the research topic in this thesis will help in adding more value to previously conducted research and providing a unique contribution to the literature and to take further steps in this research question as earlier noted.

As a legal practitioner, with the Cameroon Bar Association, I have always been drilled to practice by applying the laws in respect to the institutions of the state, as expressed in the Cameroon law organising practice at the Cameroon Bar in its' section 15, (Law No 90/059, of 19th December 1990, Organizing practice at the

Cameroon Bar)[1] which is in line with the conventional norms, but after being inspired by the literature on Marxism and some quotations listed herein after, I found need for a therapeutic interpretation, application and orientation of the laws towards the needs of the general population, (Wexler, 1996), and to assist me answer this research question.

Examples of such quotes are.

> "Political power, properly so called, is merely the organised power of one class for oppressing another." by Karl Marx, as referenced in Sanderson, (1963)

Interpreted as; The main aim of the ruling class in a class struggle is to oppress the working or the weaker class.

The ruling class use instruments such as the laws (via immigration control in our case) to oppress the working or weaker class of which the migrants belong.

> "Political Economy regards the proletarian like a horse, he must receive enough to enable him to work. It does not consider him, during the time when he is not working, as a human being. It leaves this to criminal law, doctors, religion, statistical tables, politics, and the beadle." by Karl Marx as referenced in Hay, (1999).

Interpreted as; The ruling class would only consider the working class when they are profiting from their labour. With Marxism, and with the present immigration control of the UK, this can be interpreted as using the immigration laws as an instrument to exploit labour force of the migrant.

These quotations can be interpreted in line with the different societal classes created by imperialism and dealing with issues concerning Human Rights and Equality, and upon digesting the quotations, and taking into consideration the research question, I came to the consideration that there is a deeper meaning to the impacts of the British immigration control through the legislations on health and access to health care of migrants, and this concretized my convictions that Marxism is one of the ways to get to this interpretations.

[1] Section 15, ''I Swear as an Advocate to perform my duties as counsel for the defence or as a Legal Adviser in total independence and with dignity, conscientiousness, probity and humanness, in accordance with the Ethics of my profession and with due respect to the Courts and Tribunals and to the Laws of the Republic''.

Furthermore, the research deals with social science and a topic that is of the social determinant of health while Marxism which is an essential part of social science is very relevant. In Gamble et al, (1999), it is argued that in social sciences, Marxism continues as a living tradition, a system of thought that remains relevant and instructive to other theoretical positions and contemporary world changes. This idea will help our research in using the literature and the data to give an interpretation of the immigration control via the instruments under investigation.

For a proper understanding and application of the principles in Marxism, the three relevant and component parts such as Dialectical Materialism, Historical Materialism and Marxist Economics will be applied in this research.

By materialism, Marx and Engels meant the independence of nature to mental or spiritual reality. To them, the material world which is perceptible to the senses has an objective reality which is independent of the minds, (Ruben, 1979). The dialectical materialism is a philosophical approach to reality based on the teachings or the developments of Karl Marx and Friedrich Engels from the approach of Hegel. By Dialectics, Marx means seeing history as progressing through conflict between opposing forces or contradiction in the very essence of things or the struggle of economic forces, (Sherman, 1976). It is called dialectical materialism because its approach to the phenomena of nature, its method of studying, which is specifically sociological and apprehending them is dialectical, while its interpretation of the phenomena of nature, its conception of these phenomena, its theory, is materialistic. This aspect of Marxism will help the research understand the conflicts and difficulties migrants undergo during the processes of accessing health care in England and Wales of the UK.

Historical materialism on its' part is the extension of the principles of dialectical materialism to the study of social life. To Marx, all objects, whether living or not are subject to changes and that the laws of the changes are subject to dialectics, (Marx and Engels, 1855-56). This theory holds that ideas and social institutions develop only as the superstructure of a material economic base, (Jakubowski, 1936). Focusing on changes mentioned in this citation, Marxism is helpful in understanding processes of change in migrants' health and access to health care, including the difference or changes introduced by immigration control and what it might take for their situation to be improved in the future.

By Marxist economics, it is referring to the role of labour in the development of an economy and is based on the classical approach to wages and productivity, focusing on the struggle between capitalist and the working class. This aspect of Marxism will permit the research to identify the role played by the ruling or political class of Britain and particularly of England and Wales in exploiting the labour force of the migrant working class, and the difficulty faced by the migrant in accessing the health care system.

Marxist approach as a choice to this thesis will make it different from other approaches in that it will be assessing the laws and other instruments involved in this research from a deeper perspective to answer the research question. It looks at the law as an instrument shaped or put in place to favour the ruling class at the expense of the proletariats. Marx relates the ‘’acts of the law’’ to that of the state and referred it to that which protects the interest of the ruling class at the expense of the working class.

The choice of Marxism, to answer the research question is an option to better explore socio-economic structure of the UK for an appropriate answer to the research question. Vickers (2012, 2015) suggests that Marxism offers one of the approaches to understanding how socio-economic structures and legislation interact to influence the provision of care for migrants, by connecting the British state’s treatment of migrants to international divisions of labour within contemporary capitalism. This research will apply and test the Marxist analysis through consideration of the British Immigration laws.

Relying on the history of the events that led to the creation of these legislations as discussed in chapter three, and the interpretation of dialectic materialism and Marxist economics, this will help contextualise the narratives and interpretation of these instruments and provide readers with a necessary knowledge and background of the legislations. This also goes in line with the Marxist materialistic views of history which relates or situates every phenomenon of social life within a particular historical framework in terms of the process of its’ origin, development, and causal determination, (Petrova-Averkieva, 1980).

The research deals with the approach of the British system of immigration control on migrants and the Marxism gives us an elaborate view of how this system and its principles operate, Taylor, (1979). Marxist dialectics which is considered a theory that

shows the path taken by events in general, Bloch et al (1977), would give us a better understanding of the history of how migrants are being treated vis-à-vis access to health in the UK. Vickers, (2019, page 6) refers to this approach as ‘’ an interplay between discourse, policies, and material relations to draw material connections between different forms of oppression within international capitalism’’.

The research question is straight forward to the impacts of the British immigration acts on health and access to healthcare facilities, and I have decided to use the philosophical approach of Marxism to get the response. In order to get an understanding of the law from a Marxist position as desired by the research to answer the question, I shall be looking at the nature and characteristics of the said legal instruments as well as the right to health and other related services of those to whom the laws are applicable.

In general, Marxism is useful in determining and studying policies and other determinants of health as noted by the Marxist political economist, Vincente Navarro, (Coburn, 2015). This helps us to understand why some nations have universal health systems and others not and to understand the fundamental causes of health status and health inequalities in the UK and specifically England and Wales.

In answering the question on why some nations have universal health and others do not as well as the cause of fundamental health inequalities in the world, the Marxist political economist, Navarro used Marxist theories of the mode of production and class which he referred to as ‘’the social relations of production’’, (Coburn, 2015, page 406). Navarro believed that this relationship is the principal determinant of whatever condition faced by people in a society. Vickers, (2012, pg) on his path argued that Marxism remains an important tool for social workers and service users in mastering the structure of oppression they are facing in order to be able to build a resistance.

In line with the Marxist approach, Vickers (2019) has written on some aspects of legislative restrictions on access to health by migrants and this research will be making an extension by setting the effects of these legislation in a wider context of other factors that interacts with legislation to affect migrant’s health and access to healthcare.

As explained in chapter six, migrants are often constructed as exclusively from poorer countries in Africa, Asia and Eastern Europe, (Vickers et al, 2018), while Marxism hold

that it is constructed from countries occupying a relatively oppressed position within a capitalist setup in an imperialist country, that the roles accorded to these migrants are racialised, which affects them, (Vickers et al, 2012).

In addition to the choice of Marxism, I shall be considering the impacts of the Immigration Acts on health as the impacts on the human rights to health, buttressed by the explanations given in Chapter 3 on the importance and reality of human rights as practiced in the UK with special note taken on England and Wales.

This aspect of human rights would be considered from the position of the UK ratifying international instruments and promulgating national laws pertaining to this right. And in that regards, I shall be from time to time referring to this right as part of the obligation of the state of the UK.

Contribution of the research to the society.

This research is principally going to serve as an enhancement to my career as a legal practitioner, by providing me with the tools in further continuing my career. It would help me in assisting those clients who are reliant on my expertise in the domain of the human right to health.

Further, it will also serve as an instrument to many groups that do not find the present legislation friendly and if possible, used as a milieu of expressing their views through participating.

The research will also serve as a tool to Immigration Organizations, health care providers, Human Rights campaigners, and British policy makers in the fight and restructuring of instruments that are negatively affecting the lives of migrants and other vulnerable group of persons in both UK and other parts of the world.

Finally, the research may have a transferable impact, to countries with similar legislations and experiencing immigration as Britain. The countries referred here are mostly those of the commonwealth organization such as Cameroon, Nigeria and others, that have copied almost all of the British tradition including that of policy making.

Researcher's choice of area of the research and participants.

As earlier introduced, the research will be conducted on migrants from the English-speaking part of Cameroon and Nigeria residing in England and Wales.

In the research, there will be a reoccurrence in the usage of ''United Kingdom'', which will be referring to the United Kingdom of Great Britain consisting of England, Wales and Scotland and the Northern Ireland. In this case, it will be referring to the principles or situations that are applicable to these four countries especially in the literature. Specific references will be made to those situations that are peculiar to England and Wales as the research, while the data will be entirely collected and analysed based on the experiences of migrant participants residing in the two towns of England and Wales (Birmingham and Cardiff). As for the professionals, data will be collected based on the experience they have had with their clients and or service users in their respective fields of work in the UK with focus on the England and Wales.

The reason for choosing England and Wales is because the two countries of the UK with separate cultural identities including some legislative differences. This will enable us to get a comparative approach of how these instruments are applied and to measure the extent to which their impacts are felt by the migrants involved.

The comparative approach will also develop our understanding of how the different structures of the laws of the two countries are maintained and how this affects the different patterns of social changes vis-à-vis the migrants in the countries concern.

To be specific in the data collection process and to avoid cultural misrepresentation and to foster the mastery of the subject, the researcher focused his attention on people who are of the same and or similar cultural heritage as him. The researcher is a Cameroonian, born and raised in the English-Speaking part of the country which shares a common boundary with the Southern part of Nigeria where there has been lots of cultural exchanges between the two countries through intermarriages, (Konings, 2005, Kleis, 1980). These countries are also believed to share some cultural similarities emanating from cross border integration and coexistence of ethnic groups, (Nsemba et al, 2021), and this all put together puts the researchers in a better place to apply his insider-outsiders' experience.

The relationship between these group of persons is further explained from the events that unfolded during the first world war, when Germany suffered a defeat and some of its territory including the German Kamerun (as it was referred to during the reign of the German over that territory) were partitioned. The German Kamerun was partitioned among France and Britain through the League of Nations agreement of 1916, (Dze-Ngwa, 2015). The southern Cameroons was handed to Britain under trusteeship and to be administered as an independent state while Britain decided to administer this territory jointly under the federations of Nigeria, (Adig, 2017, Dze-Ngwa, 2015). The union was broken in the 60s during the processes of independence or decolonization leaving the two countries with this colonial bond.

For the purpose of narrowing our research and to attain efficiency, the researcher limited the data collection to Birmingham and Cardiff, to enable him pay attention to specific local characteristics of cities that have experienced significant levels of migration in recent years, Migration Watch, (2021).

Birmingham in the UK is considered as one of the towns proven to be more diverse from 2017 than before with data from the office for National Statistics, (2017) revealing that one in every three people in the Birmingham area were either black, Asian or from another ethnic minority. An overall statistic shows that there were 829,822 people in Birmingham from the ethnic minority in 2017, compared to 735,168 in 2011, (Cachia et al, 2018). In Wales, Cardiff is the main town with ethnic diversity with a population from all over the globe, (Mohamed, 2017) and this would play a good role in providing the needed population for the data collection. This also takes into consideration the Welsh government's argument that they need more of a say in immigration to Wales (Shipton 2014), and local contexts that include discussions by the Conservative and Labour leaders of Birmingham City Council about the city offering home to refugees from war-torn countries (Elkes, 2016). This would help the research in getting the needed participants for the research.

Another factor that called for the research to be conducted on these two towns was from the data collected from the 2011 censor which shows that 81.5% of the population of England and Wales were likely to live in Urban areas while 18.5% were likely to live in the rural areas. That 98.2% of black population were most likely to live in Urban areas of England and Wales while people of white ethnic group are less likely to live in Urban area of England and Wales of which Birmingham and Cardiff are two major

cities of both countries, (Gov.UK, 2018). This aspect gave me the assurance of recruiting the required number of participants needed for the research.

Health inequality could also be a determinant to access to healthcare in a society. Health inequality here stands for inequality on migrants' health and access to health care and related services in the UK. The inequality here is assessed from the quality of health and related services provided to these group of persons, the conditions attached and or related to accessing these facilities.

Access, however, is a highly variable issue and yet it is a term used when referring to different aspects of admittance to, and use of, health services. Dixon-Wood et al, (2006) have reviewed the meaning of access and offered the concept of 'candidacy' to suggest a broad definition of access which conceptually takes account of structural and social factors, rather than focusing only on practical barriers. Candidacy here describes how people's eligibility for healthcare is determined between themselves and health services. By structural and social factors he meant the wellbeing of individuals influenced by the allocation of wealth and configuration of services while practical barriers here would imply to the actions of street level bureaucrats and other actors involved in the dispensation of these health services. While in line with the position of Dixon-Wood, I would also want to put the same question as to the eligibility for healthcare in the UK. And following Marxism, it would be reasonable to question whether it is determined by the rules shaped out by legislators.

Chow et al, (2009) on their part have included 'access' into their concept of patient satisfaction as the two (Access and Patient satisfaction) are seen as overlapping. The two concepts need to meet at a certain point to consider the attainment of a positive impact. When conducting research however, it would be easier to focus on practical barriers, such as the use of particular health services or the length of waiting times and so on. These are legitimate aspects of access and are relatively straightforward factors to measure. However, other factors are also connected to access such as the quality of communication and education around access, (Bhatia and Wallace 2007). Communication and education will find out the awareness of the migrants or patients as to the services available to them.

Situations migrants encountered during the Covid-19 Pandemic and other emergency situations in the UK.

In period of crisis such as that of the Covid-19, every concerned government tries as much as they can to put in place rules to contain the virus but the situation of irregular migrants in the UK was so challenging, (Guadagno, 2020).

During this period, one of the peculiar situations with some of the undocumented migrants is the extension and continuation of them not having access to public funds as regular migrants and other citizens of the UK and this creates a serious barrier to these individuals in combating the difficulties related to the pandemic.

Another main issue faced during this period of pandemic is that of housing. During this period, the Home Office took certain measures in remedy to the pandemic including special housing for asylum seekers. The housing measures involved the extension of the section 98 short-term housing to a longer period. It is also explained that the measures were not sufficient to look after this vulnerable group of person and as a result it had a huge impact on their health, as evident in the case of JM and the Secretary of State for Home Department ref-[2021]EWHC2514(Admin). It was held in this case that using the section 98 support during the period of Covid-19 crisis was illegal, and insufficient to support the applicants in their situation.

Other examples occurred with the Napier Barrack in Kent and the Penally Barracks in Pembrokeshire which were meant to be used as initial accommodation or section 98 for short-term, but people were being kept there in unhygienic conditions for more than the time required by the law. This caused some healthcare professionals to raise concern on these barracks that housing refugees in military barracks do provoke flash back to some refugees fleeing from war thorn areas and getting them into more mentally instability. That the barracks do look abandoned and lack adequate medical and other care facilities with overcrowding and far from the needed healthcare facilities during the covid-19 period, (Grierson, 2020).

Another vulnerable group that emerged from my preliminary analysis were identified to be pregnant women, children and detainees, all of the ethnic minority group. Being particular on pregnant women, studies have pointed out lack of or delays for antenatal care in the UK. For example, Van den Muijsenbergh, found that pregnant

undocumented migrants faced payment barriers at hospitals and lacked referrals to gynaecologists, (Van Den Muijsenberg, 2007).

General rules in accessing health care in the UK.

Free services provided to migrants who are registered as NHS patients or temporary NHS patients by the primary healthcare includes treatment provided by a GP and other primary care services.

The controversy here is that some GPs do require identification document as a prerequisite condition to register with their practices while others do not, and this keeps the migrants treated differently in the UK.

To access secondary healthcare, you must be living lawfully in the UK on a properly settled basis to be entitled to free healthcare.

The measure of residence that the UK uses to determine whether someone is entitled to free NHS healthcare is known as 'ordinary residence', (section 39 of the 2014 Immigration Act). To be ordinarily resident in the UK, people from countries outside the European Economic Area (EEA) who are subject to immigration control need to have the immigration status of 'indefinite leave to remain. It therefore implies that if you are not an ordinary resident in the UK, then there is possibility that you pay for the services provided by the secondary healthcare of the NHS.

In the category of persons subjected to this rule are refugees (people who have made application for asylum, humanitarian protection or temporary protection under the immigration rules) and their dependants, asylum seekers, failed asylum seekers, student. Also in this category are children looked after by a local council, victims and suspected victims of modern slavery or human trafficking as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse or civil partner, and children under 18 provided they are lawfully present in the UK. Prisoners and immigration detainees who are not considered as ordinary residents of the UK and who are our focused for data collection in this research.

Despite the explanations of the earlier paragraphs, the NHS (Charges to overseas visitors) regulations 2015 and the government guidance on overseas visitors' hospital charges regulations makes provisions for some services which could be accessed free by those categories of persons who are not ordinary residents. The secondary healthcare services presumed to be free to the category of person listed above are;

Accident and emergency services, such as those provided at an A&E department, walk-in centre, minor injuries unit or urgent care centre (not including emergency Services provided after being admitted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt)

Services provided for the diagnosis and treatment of some communicable diseases, including HIV, TB, and Middle East Respiratory Syndrome.

NHS services provided for COVID-19 investigation, diagnosis and treatment.

Services provided for diagnosing and treating sexually transmitted infections.

Family planning services (does not include termination of pregnancy or infertility treatment).

Services for treating a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence.

Palliative care services provided by a registered palliative care charity or a community interest company.

Services that are provided as part of the NHS 111 telephone advice line.

The elaborations in this section have laid the foundation required to conduct the research. It is from this foundation that the structure of the entire research would be derived.

One of the tools of the foundation is the three principal parts of Marxism that will be applicable in the research and this would assist the other parts of the research in line with the research question.

From this structure, an elaborate presentation of the research question would be arrived at in the next section of this chapter.

It is also from this section that the chronology of events in the research is set out.

Research questions and Objectives.

This section brings out the research question and guides on answering the question including the time frame and area of conducting the research.

Focus of the research.

From the research topic stated at the beginning of the previous section and considering the approach of Marxism in answering the question, the central research question would be to determine ‘’of what interest is it to the power that be in shaping immigration and controlling access to health in the UK’’. Here the research question is assessing the role played by the laws through immigration control in British capitalism and this objective is very difficult to proof that is why Marxism is being applied.

To answer the above question, this researcher made the choice of carrying out primary research, where data collection from selected participants would be made available to;

Analyse the nature of laws, their approaches to health care for migrants in England and Wales, their implications to migrants’ health and other related services such as housing.

Assess the modification and application of these laws by street level bureaucracy practices and wider contexts of ethnicity and discrimination.

Explore the implications of the different legal perspectives for an assessment of the legislation under investigation, and the potential to integrate them with a Marxist analysis of the wider context in which these laws operate.

Show the existing clear cuts between primary, secondary and emergency healthcare as provided by the British Legislature to the migrant population in general with specific emphasise on the position of failed asylum seekers, those awaiting determination of their files, and those who have gone ‘’underground’’.(Underground here refers to those migrants who have decided not to make themselves known to the government and whos’ details may not be known to the state).

Look at the international context of applying the laws on migrants in the UK and their impacts on access to health care.

Research time frame.

In addition to the explanation given for the research question, the thesis would be looking at the impacts of the British Immigration Acts on health and access to health care of the group of persons indicated previously and within the period of 2010[2] to the period of November 2020, just before the putting in place of the Brexit institutions.

The time frame given would be for the purpose of data collection and consideration during analysis. As explained in the recruitment section of chapter four, data would be collected from migrants with regards to the impacts of the immigration control on them within this period. The participants may have come to the UK before this period, but their experience(s) would be assessed between the period between 2010 and 2020.

On the other hand, literature, and other instruments with regards to British immigration control will be considered from periods prior to 2010 in order to provide information of the longer history of British immigration control and to prove their applicability and effects during this period.

In Smith et al, (2014), While ascertaining how the British immigration control policy was carried out in the nineteen-seventies to filter immigration, by addressing the perceived problem of 'non-white' colonial migration, it was held that recent position of the government, suggest and directs that the immigration control system be viewed as a series of inter-connected institutions and actors that operated under the influence of a number of different, and often contradictory, factors. In Griffiths et al, (2021) it is argued that the hostile environment is a specific policy approach with a profound significance for the UK's immigration control and that the phrase was traced exposing its origins in other policy realms, evolving into immigration legislation. These literatures situates the research to the period from the 1970s to present date and gives the researcher an idea of the policy approach in immigration control and builds the foundation in responding to the research question.

After building the research question and objectives in this section, this has paved the way for the other sections of the research with regards to how and when the said question should be applied as well as the continuation of the research.

[2] I started from 2010 because of the change of government from labour to the Tori and ended in November 2020 just before the putting in place of the Brexit regulations to accommodate those migrants who have left other European countries to the UK and are being impacted by the Dublin regulations.

The chapter generally brings out the structure and approach through which the research question would be answered and laying foundations for other chapters and sections of the research.

From the two sections in this chapter, I have been able to introduce the research and lay the foundation on what is required for the research.

The first section of the chapter lays the foundation of the research by introducing the approach to be used in conducting the research. It also brings out aspects of the researcher's preliminary actions before the inception of the research topic and the decision to continue with the research.

The second section of this chapter is very instrumental in bringing out the research question, objectives and throws light on the required path through which the research question would be answered. The time frame for this research directs the attention of this research on what is needed.

The next chapter will cover the theoretical aspects of the research with its foundation taken from this chapter through the structure. The literature and other aspects of the second chapter would be discussed on the spirit of the research structure and question introduced in this chapter and this would help situate from the literature, the context of Britain's approach in the application of the legislations under investigation and to pave a way to respond to the questions raised.

The discussions or foundation made in this chapter would also be instrumental in situating the context of application of certain concepts of the research in the UK which is in the third chapter of the thesis.

Conclusion

This chapter also acts as a reinforcement to the fourth chapter which covers the methodology of the research as well as the fifth chapter which covers the empirical aspects of the research.

The introduction of this chapter also guides and creates a good foundation to the sixth and seventh chapters made up of discussions and conclusion(s) of the research drawn from analysed data.

In chapter six Marxism will be guiding the usage of the literature involved in interpreting the data and this would be by drawing inference on all the themes arrived at during analysis in chapter five of this research.

In general, this chapter is very important as it opens the research in general and introduces all aspects to be used from the start to the end of the research.

Chapter 2 - Theoretical Approach.

Introduction

This chapter will be providing the theoretical framework of the research which starts by laying a groundwork on the origin and nature of British legal instrument and their Marxist implications. It goes further by elaborating on principal concepts to this research and that are traced to the existing form of the British state and its' social structures, such as capitalism, neo-colonialism, and the law as well as their Marxist implications. The imperialist relationship between Britain and its' former colonies with focus on Cameroon and Nigeria is part of our theoretical framework to establish Britain's' continuous control over these countries.

Another aspect of theoretical framework is that of the Marxist and Socialist movements in Africa in line with specific concepts, to help establish the root of the participants of this research who are originally from Africa. The evolution of sociology of health in the UK is an aspect to be discussed here to help understand the research topic from the British context.

Discussions on the origin and nature of British Laws and Marxism.

Given that the focus of the research is ''the impact of British Immigration Acts on health and access to health care and related services'', this section will be to lay down the nature and characteristics of the British legal system in general. In elaborating on these characteristics, and their Marxist implications to migrants' health and access to health care, this will permit the research to get a deeper understanding of their application and implications.

To begin with, the English or common law is derived from customs and procedures derived from the legal reforms of king Henry II in the 12th century. It is traced and referred to be the instruments used by the then kingdoms to control their subjects, (Wormald,1999). Brooks et al, (2005) in tracing the history of British law and their relationship to the imperial state, termed them to be ''instruments used by colonial and imperialist administrators over their colonies'', and this could be justified from the implantation of the system in the former colonies of Britain even after decolonization[3].

[3]Most British Colonies inherited and are practicing the Common Law system of justice, including Cameroon and Nigeria.

The characteristic of the British legal instruments portrayed during the introduction of the immigration control of the 1905 Aliens Act and via the Commonwealth Immigration and other related Acts, aimed at consistently restricting and controlling migrants from entering the UK, as described in chapter three of this research, reflects imperialism and neo-colonialism, (History and structure of British Immigration Control).

In the UK, the conventional understanding of the law presents the law to be that which is ‘’in accordance with what is generally agreed on’’**,** (Bingham, 2011). Marxism on its part, considers the law to be instruments of class suppression. Reading from Brown, (1973, page 203), conventional instruments are understood to be ‘’acts adopted by an institute or group of persons even when such instruments are ‘’no binding per se’’, and that they are used frequently to reflect the interest of the forerunners’’ or the capitalist.

The role of the law is demonstrated by Marx’s explanation of the socio-economic structure of the United Kingdom, coming from his theory of class structure, where Britain was a case study, (Rubinstein,1977), with the British structure made up of the Elite class or the wealth owners (Bourgeoisie) and the Proletariats, with the Bourgeoisies owning the means of productions while the proletariats providing the labour, with the assistance of the law to maintain the status quo, (Marshall, 1988).

Britain has a history of championing the ratification of international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights, (ICESCR). The ICESCR general Comment number 14: The Right to the Highest Standard of Health (Art 12), The 1951 Refugee convention, The 1967 protocol to the 1951 Refugee convention, The Statutes of the Universal Declaration of Human Rights (UDHR), as presented on reports of its solemn participation in the establishment of international convention in that regard[4]. With all its’ participation in the world of law making and human rights defence, it still holds that the reality of British immigration control system and its’ application are more of violating than protecting the rights of migrants, (Welch et al, 2005, Anderson, 2010, Stewart et al, 2014, and Webber, 2019), while attacking, punishing and exploiting the said migrants. In line with Marxism, Kinsey, (1978) and Nicol, (2010), while aligning with Lord Hailsham on the

[4] Looking at their participation in the creation of the UN which is the umbrella human rights organisation of the world. Their role was seen in the Declaration of St James’s Palace or the London declaration of June 12th 1941, that of the Atlantic Charter of August 14 1941, that of the ICCPR of December 16th 1966, The Universal Declaration of Human Rights of December 10th 1948.

conspiring and deceptive nature of the law, hold that both the national and transnational laws of the UK are designed for the purpose of protecting capitalism and the ruling class.

The above foundation demonstrates the role of the British styled laws in creating a capitalist/imperialist system and their Marxist reflection which will help the research in identifying the impacts of the immigration Acts on the health of migrants and access to health care. With the complexity of the research question, this framework, will help in interpreting the data collected.

The above will also permit the thesis to assess the immigration instruments and to get their impacts on migrants' health and access to health care.

The next section will be talking on the Marxist implications of applying the law in a capitalist state such as Britain, and the foundation from this section will assist in carrying out that assessment.

Marxism and the Law in Capitalist and Neo-Colonialist Britain.

Having talked of the origin and nature of the British laws and their Marxist implications in the previous section, this section will go further to lay down the Marxist implications of applying the law in a capitalist and neo-colonialist Britain, which I feel is going to further lay a foundation on the requirements to answer the research question.

This foundation will be drawn from the perspective of different Marxist scholars inclusive of those from Africa to lay a foundation of what the law implies both in Africa and the West, and for purposes of better understanding the concepts from the point of view of Africa where the research participants are from.

Britain being one of the advanced capitalist countries, (Labini, 1982), I shall be looking at its' approach in immigration control and how this affects both the residents (migrants) and the countries of origin of these migrants, to permit us to assess the instruments under investigation and their impacts on migrants' health and access to health care.

As deduced from Marx's teachings in the Communist Manifesto, the law is viewed as a working tool for the realisation of the objectives of capitalist in an advance capitalist economy such as Britain. Marx considers the law from the same angle at which he looks at the state by considering the deeds of the law as that of the state. (Andrew,

1993. Akhtur, 2015), in constructing an argument of the characteristics of law in the context of sociology of law, considered the critical race theory to project the law and the state from same angle as Marxism.

The Law is also termed a crucial part of the intellectual hegemony of a capitalist society by Marx. Marxists such as O'Connell (2018) while looking at the teachings of Marx on the nature of law in contemporary capitalism, focused on three principal teachings from Marx's work, which are the importance of dialectical materialist analysis, the historical specific and transitory nature of capitalism and the centrality of class antagonism and class struggle. In the teachings, Marx's representation of the law and state are explained with the position of the law better understood to play a crucially important role in the maintenance and reproduction of capitalist mode of production in a state.

Pashukanis, (2017) on his part held the position that Capitalist Societies project themselves in endless chains of Legal relations via international instruments as a form of protection to their collection of wealth. This position confirms the role plaid by the law in maintaining capitalism at the detriment of the working class.

The role of the law in capitalist Britain and other parts of the developed world could also be identified in its' participation in the post-world war era of globalisation, a foundation which could be traced from earlier periods prior to the war, (Grewal, 2014). During this era, the international law is believed to have played an unprecedented role in British capitalism through the establishment of congealing inequities or the establishment of institutions used to manifest or implement inequalities. Done through the protection of the interest of the capitalist at the interest of the working class.

During this period, there exist as legal frameworks for border control (Chapter 3**),** laws which from the face are structurally placed and presented to be in control of illegal entering of migrants into the British soil, while in practice, it is meant to suppress the migrants who are already in the UK and to prevent further entrants. Principally, some of the groundworks for border and or immigration control were put in place between 1945 and 1960s, (as discussed in section seven of Chapter Three), when there was an increase in the growth of commonwealth citizens into the UK and which triggered the promulgate legislations for the control and reduction of this inflow, (Marshall, 2021). In 1962 and 1968, the commonwealth immigration acts were put in place to curb the

increase of the Asian population migrating from independent Uganda, Kenya, and other parts of East Africa.

The frameworks listed in the previous paragraph are done through the adoption of networks of both national and international Laws which seeks to put in place a legal international framework encouraging the acquisition and accumulation of capitals. Chimni, (1999), holds that changes in international law making over the decades have put in place an instrument for the safeguarding of transnational capitals reflecting the domination of the Bourgeoisie over the working class for profit making. The less developed countries and countries of origin of the main participants in this research are those feeling the effects of this network via the process of brain draining, institutional racism, institutional imperialism, and other forms of neo-colonialist approaches.

The literature cited in the previous paragraphs demonstrates aspects of immigration control of Britain in both England and Wales and also helps us understand how imperialism in Britain help create a post-war social structure that compels the minority group to stay perpetually in the working class while the legal instruments are positioned to see these objectives go through. Examples are the 1996 Asylum and Immigration act, meant to restrict employers from employing asylum seekers and refugees seeking work in the UK, the 2014 Immigration Act, restricting migrants from accessing healthcare facilities and charging them for services provided by the NHS, the 2016 Immigration Act, restricting Landlords and Homeowners from renting out their houses to asylum seekers.

African Marxist held the position of the law being an instrument of colonial rule, (Mendy, 2006), with authors such as, Amilcar Cabral of Guinea Bissau, Kwame Nkrumah of Ghana, Senghor of Senegal, Nyerere of Tanzania making their various contributions to that effect.

Capitalism in Africa is seen as inherited and in alignment of their various colonial parentage, exported from the developed countries to other parts of the world through Neo-colonialism as intimated by Kwame Nkrumah, (Wallerstein, 1967). On recognising the deep impact of capitalism on the African society, Kwame Nkrumah, Nyerere and a host of African leaders resolved that socialism was the way forward to

giving the people a life free of segregation inter alia underemployment and marginalisation.

Earlier in 40s, the creation of the national liberation movement in the African colonies, and Kwame Nkrumah in 1946 came about with his contribution because of the continuous economic and political exploitations on these colonies by the foreign oppressors, (Mazrui, 1966). Nkrumah considered so cialism to be the best system for Africa and that a capitalist system is destructive to the continent, (Yeros et al, (2020). In Wallerstein, (1967), Kwame Nkrumah asserted that the strength of capitalism in the developed world today is the consequences of sacrificing basic principle of early capitalism such as dominating the working class and no state control of capitalist corporation. This, he meant the implantation of structures by the capitalist for future economic or dominating effects, (Structural Capitalism or Structural Racism), and through this process, welfare states such as Britain transfer their internal conflicts between the rich and the poor to the international scene which results to affecting poor countries through the process of Neo-Colonialism and effectively done by the continuous exploitation of these less developed countries.

The Egyptian Marxist Samir Amin on his part associated capitalism with monopoly over the economy and based its foundation on the economic surplus concept as elaborated in the 50s by two American Marxist Economist, Paul Mario Sweezy and Paul Alexander Baran. His interpretation was based on three points; The first one being that in a capitalist economy, there is a centralised control of the economy, and second that there is growing globalisation including relocation of manufacturing industries to the periphery and finally, the process of financialization, where the capitalist takes advantage of, (Amin, 2014). This expression of Samir clearly explains the steps put in place by the imperialist in building capitalist structures. It explains how the capitalist focuses on monopolising the system be it economic or political to exploit the benefits.

From the explanations earlier in this section, Imperialism could be seen as a form of attack directed by the British state and other capitalist states of the world on the migrants through impoverishing their states of origin. Imperialism in Britain is the highest stage of capitalism with its development or advancement of the productive force(s) achieved only by attacking the working class, stepping up exploitation and intensifying oppression at all levels, (FRFI, 2011). It could also be seen from the angle

of establishing capitalist and racial structures in these states for future economic and political exploitation.

The application of the laws in an imperialist Britain as well as their Marxist implications unfolded in this section has made a foundation for the research to better understand the atmosphere on which the laws under investigation are considered and to better answer the research question.

The Marxist implications with regards to applying the laws in a capitalist and imperialist state will guide in the analysis and interpretation of the data and lead to answering the research question. This will also facilitate the assessment of the imperialist relationship between the UK and the two colonies which is the next section of this chapter.

The imperialist relationship between Britain and its' former colonies with focus on Cameroon and Nigeria.

After discussing the various concepts of Marxism, Capitalism, Neo-Colonialism, and the Law in the previous section, I shall in this section be looking at some neo-colonial approaches used by the British government in controlling or suppressing its' former colonies with example on English-Speaking Cameroon and Nigeria where participants are selected to provide data for this research and its' impacts on citizens of those countries. This will permit the research to identify the Economic and Political relationship that is being used as a tool of imperialism and its health impacts on the Migrants.

To expand on the neo-colonial impact of Britain on these countries, I would like to reiterate that these two countries Cameroon and Nigeria have been politically unstable for some time now, (at least 10 years in conflict) which have let to series of blood battles and human rights abuses, (discussed in Section Three of Chapter Four**)** recorded and condemned by big nations of the world including Britain as well as some international organisations. The instability has been for more than a decade now with Nigeria being hit by continuous attacks from the Boko Haram insurgency and other religious groups, (Falode, 2016), and Cameroon with the Anglophone crisis, (Okereke, 2018), causing the lives of millions of people and making them vulnerable.

International organisations have assessed the situation of the crisis in Cameroon and have accorded the moral responsibility on Britain to solve or cause these problems solved based on grounds of colonial and historic ties, (Oxford Human Rights Hub,

2019), (Ndi, 2021). These condemnations have called for suggestions from international organizations such as the Transparency International and the United Nation. Suggestions such as economic sanctions amidst others were meant to be solutions to the problems of which Britain, America and other world powers made their contributions, (Lunn et al, 2019).

Despite the identification of the problems faced by these countries and the responsibility accorded to Britain to the required resolutions, the instability keeps aggravating with deteriorating outcomes, while Britain keeps creating and advancing business links with the countries than seeking solutions for the crisis as discussed in the next paragraph.

Information taken from the government webpage on trade and investment factsheets for Cameroon and Nigeria shows that, for both countries, from the years 2014 to 2019, Britain had been in continuous trading with an increase in trade surplus value in favour of Britain.

With data taken from Trade and Investment Factsheets, Cameroon, (May, 2022), Fig; 2.1 and Trade and Investment Factsheets, Nigeria (May, 2022), Fig;2.2, demonstrates how Britain has been making surpluses benefits on trade from these two countries between 2014 to 2019 amidst the instability affecting the countries. With the case of Cameroon on Fig 2.1, Britain was able to make a move from 21 Million Pounds to 75 Million pounds surplus from 2016 to 2018, and it is between this period when the armed conflict in Cameroon was at its peak with at least 1500 people killed, (Borgen Project, October 2019). Fig 2.2 for Nigeria shows that the surplus benefits for Britain within this period was from 0.1 billion pounds to 0.9 billion pounds between 2015 to 2017.

Fig: 2.1: Britain’s surplus on trade with Cameroon between the year 2016 to 2018 in millions of pounds.

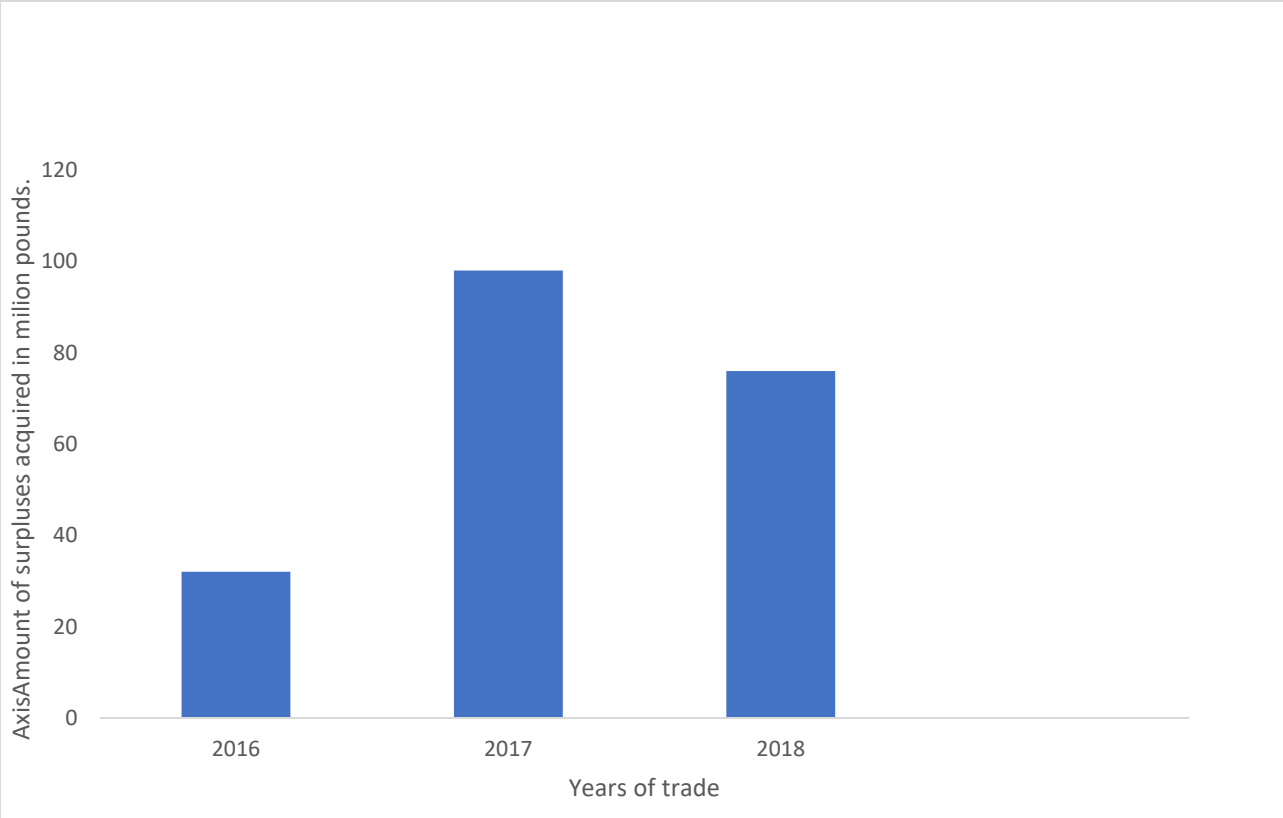
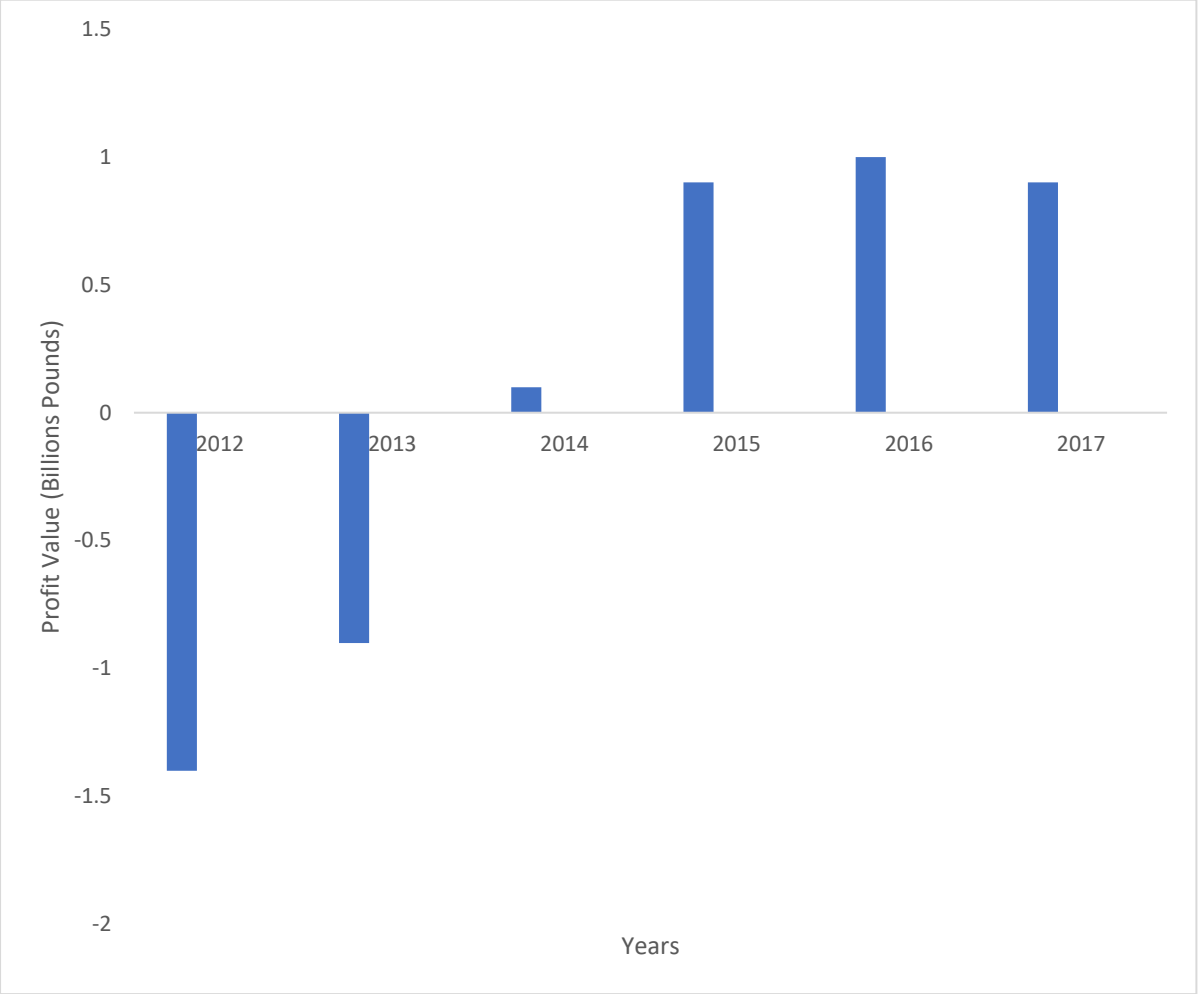


Fig: 2.2: Britain's surplus transaction in trade with Nigeria between 2012 to 2017 in billions of pounds.



The record presented in the factsheets referenced in the previous paragraphs further demonstrates the role of the capitalist who focuses on taking advantage of the less privileged. As seen in the Trade and Investment Factsheets, Cameroon, (May, 2022), the UK buy raw materials such as vegetables, crude oil, wood, iron and steel from Cameroon possibly at a very low cost and in return export the finished good from these raw materials such as cars, refined oil, beverages and industrial machines to Cameroon at a possibly higher cost. In some cases, it is even believed that capitalist Britain uses these trade deals to destabilize these countries whom they trade with in order to benefit more. Britain for example has no regards for the wellbeing of the people of Cameroon and the abuses committed in these countries that is why they keep on selling arms to these countries despite the embargoes placed on arm deals with these countries by the department of International Trade, (DIT), (Sabbagh, 2021), With this continuous trade deals with the government of Cameroon and Nigeria, one would be forced to believe that the escalation of the Boko Haram insurgency in Nigeria that has taken lives of many and that of the Cameroon Anglophone crisis in between 2016 and 2021 with separatist taking up arms to defend themselves from the marginalisation and wanton killing is encouraged by the UK government.

These presentations of British rule over these two countries including other activities (Diplomatic and other forms of Business transactions) demonstrates their indirect rule over these countries and this is done through the implanting and interplay within international institutions or organizations (imperialist structure through international organisations) that would permit a smooth and continuous control over these countries, (Ewing, 1976).

In addition to the neo-colonialist role of Britain in financially extracting money and other forms of resources from the African continent, Zajontz, (2021), considers the huge indebtedness, dispossession and distress of the African continent by the imperialist including Britain to be an impact of neo-colonialism, which occurs when the colonizers transformed themselves into technical assistance to the African continent to exploit the continent.

This approach of the British rule is aimed at keeping those colonies in an inferior economic level for a long period and to cause the countries to keep relying on them.

In the course of collapsing the economy of these colonies, the citizens are forced to leave these countries to the West for greener pastures where they are being subjected to harsh immigration policies and other instruments.

With the explanations of capitalism and neo-colonialism in relations to its application by the UK on the two former colonies which are our two sample research countries, this would facilitate the next section of this chapter which deals with Marxism and socialist movements in Africa and provides a deeper understanding of the British immigration control.

The explanations given in this section of the research, will help to determine root causes of some of the ills faced by some of the migrants and how imperialism uses the approach to exploit the less developed world and the international working class.

It also helps in interpreting how the imperialist tendencies are incorporated into the system and how it affects the health and access to health care of migrants.

This section is also helpful in preparing the stages of data analysis with the necessary materials relating to the application of the Marxist concept in Africa and the West.

Marxist and Socialist Movements in Africa.

In this section, Marxism and socialism will be discussed jointly and identified in the course of the discussions, and this will be done through the identification and elaboration of concepts of African origin.

This approach is taken to show the similarities between Socialism and Marxism from an African perspective. It is also aimed at showing the meeting point of the two concepts which is aiming at equality by its analysis of the effects of class struggle on the individuals, their society and the economy.

Another reason to interweave these ideologies is due to the fact that they have always been used by the African actors in a skilful manner to represent the African context with the actors avoiding being tagged as Alien vis-à-vis practicing Marxism. This is as a result of the fact that most of the actors faced insecurity from the imperialist who were capable of tagging them to elimination. This approach got misunderstood by some authors who took the African Marxist to be deviating from the course. To Rodney, (2021), these actors seek to come out with purely African concepts and refusing to pursue them to their logical conclusion of Marxism. He considered Kwame

Nkrumah as an example whom he took to be one of the most skilful and intelligent authors of the concepts of Marxism who relied on the perception to come out with a concept that suits the African context. According to Rodney, this aspect could be seen in the Ghana of Nkrumah presidency where he steadfastly refused to accept that there was class contradictions or class struggle in Ghana, that these class contradictions were fundamental. He came to the conclusion that Nkrumah only accepted the Marxist concepts after he was overthrown and while on exile in Guinea Conakry. That while in exile, he accepted there was an existing class struggle in Africa through his book '' class struggle in Africa.

The socialist and Marxist movements in Africa are seen from all corners of the continent with leaders such as Kwame Nkrumah of Ghana, Sekou Toure of Guinea Conakry, Julius Nyerere of Tanzania and Leopold Sedar Senghor of Senegal, championing the Sub-Saharan part of the continent while Muama Gadaffi of Libya, Samir Amin of Egypt and a host of others represented the northern part of the continent.

Marxism being mainly an art of examining the effects of capitalism on labour, productivity and economic development, by arguing for worker's evolution to overturn capitalism in favour of communism, African scholars embraced this with main aim of building a United States of Africa through fighting the anti-colonial, anti-racist and to topple the pro-west regimes of the continent, (Harshe, 1984).

African concepts to explain Marxism and Socialism.

To better understand the concepts of Marxism and Socialism from an African perspective, it would be better to outline and digest some principal concepts that are purely African as introduced.

Africans are noted for living a communal life which stretches to their extended family ties, (Mawere et al, 2016, Kanyoro, 2001) this implies that there is a possibility of an impact being felt by an individual to spread to the entire community. A typical African community is that which is linked by the customs and tradition or by faith such as Christianity, (Mwaura, 2015). An example of such community in the UK is that of my Cameroonian community in the UK who live in family groupings and attend monthly or quarterly meetings to get updates of their wellbeing in the country. Studying these concepts will make an understanding of the way of life of the African community even

when they are outside the continent and most important the aspect of how they experience things as a community.

These concepts were developed by Africans of African origin and aimed at countering the effects of neo-colonialism in the African continent. The impacts of neo-colonialism were so enormous that provoked these leaders to embark on the reconstruction processes and nationalisation of all capitalist institutions of the African continent as noted in (Kwame Nkrumah, 1967), through Pan Africanism.

As introduced by Kwame Nkrumah, Pan Africanism is one of the concepts he started with the inspirations of Marxism while studying in the United States of America. At his youthful age, he formed the African student organisation through which the liberation of Africa from Western influence was being preached, (Paladon, 2020).

His movement that was supported by a host of other African leaders such Julius Nyerere of Tanzania, Sekou Toure of Guinea Conakry, where the preaching of the political independence and the liberation of all people of African descent.

Like other African concepts, Pan Africanism is the umbrella concept of African unity that is built on Marxism and socialism, as it advocates for the oneness of the African states for the interest of the entire continent. The concept as per Nkrumah's teachings, advocated for a unified Africa with a common goal of bringing their resources together for the advancement of the continent and the people therein. Other concepts such as the Consciencism, Ubuntu, Ujamaa and a host of others will be discussed to demonstrate the existence and manifestation of Marxism and Socialism from the African perspective.

Elaborating on these concepts is helpful to the research as it identifies the existence of Marxism in Africa as well as presenting a peculiar situation of Africa origin.

It would also present African concepts to be creating a base for the African struggle. This presents the communal nature of African who always act as one people to be able to battle the oppressors through Marxism and Socialism and to facilitate my assessment of the research question from an African angle.

Consciencism.

The philosophical idea of one of the most renown African leaders in the person of Kwame Nkrumah who was at the centre of the African revolution.

This is his personal philosophy which provided the intellectual framework of his political actions.

In this philosophy, he drew three main traditions that made up the African conscience, such as the Christianity, Islam and the Traditional African religion which he characterised as essential and egalitarian. He argues and urges here that the new united states of Africa should draw its inspirations from these three African traditions which to him are essential and bound to equality.

In Kwame's ‘’Class struggle for in Africa’’**,** he acknowledged the Marxist concept of ‘’class struggle’’ in Ghana which let to him being overthrown, quoted as follows,

> ‘’But I know your courage and determination: I see the extent of your indignation against this wanton rebellion. I know that at the appropriate time you will take the initiative to crush it. The Party's dynamism will rise up again to save your dignity and personality. As far as I am concerned I will do my very best to crush this criminal rebellion, (Nkrumak,1970).

The integral wings of the Convention People's Party, the Farmers Co-operative Council, the Trades Union Congress, the National Council of Ghana Women, the Young Pioneers, the Workers' Brigade have been established by the Party and the spirit that motivates these organizations cannot be destroyed. They now suffer in silence but they will rise up again and speak. The present rebellion has not only committed treason against the sovereign state of Ghana but has attacked the very foundation upon which our culture was based - the position of Chieftaincy which has been irrevocably enshrined in our Constitution.’’

In the above quotation, Nkrumah confirms the existence of a class struggle, in his country which is a Marxist concept of the suppression of the lower class in Ghana and Africa in general and the need to overcome this for the interest of all.

Kwame Nkrumah, in (CENCSA, 2012), believes the traditional African society is built on the principles of egalitarianism and that Socialism should be premised on this principle.

> ‘’We know that the “traditional African society” was founded on principles of egalitarianism. - - - - - - . Its humanist impulse, nevertheless, is something that continues to urge us towards our all-African socialist reconstruction. - - - - - - - - - - - - we accept the necessity of guaranteeing each man equal opportunities for his development. The implications of this for socio-political practice have to be worked out scientifically, and the necessary social and economic policies pursued with resolution. Any meaningful humanism must begin from egalitarianism and must lead to objectively chosen policies for safeguarding and sustaining egalitarianism’’ (Nkrumah, 1967).

This quote of Nkrumah is an expression of his belief in egalitarianism being inborn in African. And that this aspect of egalitarianism should be the basis of socialism in Africa. That this nature of African should affect their socio-political practices for positive results.

Ujamaa

One of the concepts is that of ‘Ujamaa’ of Tanzania, put in place in the days of the father of African Socialism Julius Nyerere and based on the principle of Collectivisation projects that herded peasants and others into socialist groups, (O’Connor, 2007).

In a paper presented by Julius Nyerere on the Ujamaa in 1962, he outlined the specificities of this concept (Ujamaa) that ties the concept to the principles in Marxism. In concluding the paper, he said.

> ‘’UJAMAA’’, then or ‘’Familyhood’’, describes socialism. It is opposed to Capitalism, which seeks to build a happy society on the basis of exploitation of man by man: and it is equally opposed to doctrinaire socialism, which seeks to build a happy society on a philosophy of inevitable conflict between man by man’’, (Nyerere, 1962, page, 8)

As outlined in this part of the thesis, the Ujamaa is aimed at fighting capitalism for the interest of the working class or everybody.

From the teachings of Ujamaa, socialism and Marxist tendencies have been in existence even before the coming of the West into Africa during colonization, and to confirm this assertion, Nyerere (1962) in his publication ‘’Ujamaa the basis of African socialism’’ considered socialism as inborn to the African and that which runs through the roots of the African society. He meant that an African being is by nature a social

being. These values is what African needs recognised and express themselves in order to be liberated by the oppressors, (As expressed in the manifesto of the South African Students' Organization (SASO), to represent black consciousness).

In one of Nyerere's write-up during his days, his love for socialism was expressed in this extract,

> ''socialism -- --like democracy ---- is an attitude of mind --- ---- --- --- we in Africa, have no more need of being ''converted '' to socialism than we have of being ''taught' democracy. Both are rooted in our own past -- -- -- in the traditional society which produced us. Modern African socialism can draw from its traditional heritage the recognition of ''society'' as an extension of the basic family within the limit of the tribes, nor, indeed of the nation'', (Nyerere, 1962, page 1).

This quote is part of Nyerere's expression intended to examine the attitudes of the minds which to him distinguishes a socialist from a non-socialist and which has nothing to do with wealth. The socialism which is not influenced by wealth is what he considered here to imbedded in the Ujamaa.

Ubuntu.

Like the Ujamaa, there is also a traditional concept of ''UBUNTU'', peculiar to African Socialism and also known as the African Humanism. It is typical concept of African origin which moves in line with Marxism in both practice and inspiration as described in the next section on page 46. The Ubuntu originated from Southern Africa and based on the principle that the welfare of an individual human being is inextricably bound to the welfare of the community, (Caromba, 2015). The Ubuntu like Marxism shapes the society for the benefit of everyone. The oneness philosophy of Ubuntu is the one aspect understanding of the interconnectedness of everyone. It is considered as the essence of being in a typical African society and that which guides the society.

These two concepts of Ujamaa and Ubuntu are two traditional concepts of African origin with foundations on Marxism. This like other concepts of African origin, are helpful in responding to the research question which is reliant on the applicability of the British immigration acts on African migrants. This ease the assessment of the environment from which these migrants are coming from to where they are now.

Negritude.

Negritude is one of the socialist concepts championed by Leopold Sedar Senghor of Senegal. This is a framework of critique and literary theory developed by Francophone African writers and politicians aimed at raising and cultivating Black consciousness across Africa and the globe. Started by three persons, Aime Cesaire, Leoplod Cedar Senghor and Leone-Gontran Damas who met as students in Paris France in 1931 and started writing for a journal devoted for Negritude.

From the inception of Negritude in the thirties, negritude has been transformed from a revolt of against the intellectual of French assimilation to a positive assertion of a newly found identity to an abstraction of cultural values of African origin, (Senghor, 1961). Senghor's concept of negritude antedates his followership of African Socialism but connected intimately through his early emphasis as a militant on the primacy of Africa then of African cultural values, (Senghor, 1961). Just like his counterparts of African socialism, Senghor's teachings were on selflessness, moving in line with the African cultural values for the interest of all through the withdrawal from colonial ideologies. Because of his emotional and intellectual commitment to African values and realities and from thorough investigation of western and communist thinkers, he became the major contributor of the African Socialism, (Skurnik, 1965). Senghor's concept of negritude antedates his followership of African Socialism but connected intimately through his early emphasis as a militant on the primacy of Africa then of African cultural values, (Senghor, 1961). Just like his counterparts of African socialism, Senghor's teachings were on selflessness, moving in line with the African cultural values for the interest of all through the withdrawal from colonial ideologies. Because of his emotional and intellectual commitment to African values and realities and from thorough investigation of western and communist thinkers, he became the major contributor of the African Socialism, (Skurnik, 1965).

Black Consciousness.

Black Consciousness is another concept that originates from South Africa in 1969. The concept recognises the importance of the mind of the oppressed and defines the word Black to mean a new sense of unity, (Gibson, 1988)**.** In line with other concepts discussed in this thesis such as the Ubuntu and Ujamaa, am exploring the role in how my participants makes sense of this. In dealing with a group of persons in this research

who identify themselves as black, this concept will help in identifying and moderating the approach towards getting the data. It will also help in identifying the peculiarities of these individuals during the process of analysing the data and how they are being affected by the immigration control during the processes of accessing health care in the UK**.**

This emerged in the 1972 Policy Manifesto of the South African Students' Organization (SASO) where Black Consciousness was defined as "an attitude of mind, a way of life whose basic tenet is that the Black must reject all value systems that seek to make him a foreigner in the country of birth and reduce his basic human dignity". In this direction, the concept of Black Consciousness would therefore imply or represents an awareness and pride in their blackness by Black people and implies that Black people should and must appreciate their value as human beings. In essence, it would also imply people of this race (Black People) should be aware of the significance and importance of their values as blacks. This concept was introduced in South Africa during the period of Apartheid as an approach to get liberating the black population from being segregated. It was therefore an approach of the black population to being aware and appreciative of their socio-economic culture, political and cultural values as blacks by rejecting foreign values imposed or attributed on them by the oppressors, (Nengwekhulu, 1976).

Negritude and black consciousness are two concepts advocating for African values as blacks, it is used by the authors in exposing the imperialist/colonialist French approach affecting especially the black African race through the imposition of their colonial rule over this race. The concept was introduced to back the existence of an African concept of socialism, and the concept is important in the present research in establishing one of the characters African Marxism that are peculiar and related to the race and most importantly in defence of the race from imperialist attack.

The concept of Depersonalisation as expressed in the Independence speech of Sekou Toure.

During the independence of Guinea Conakry, on the 2nd of October 1959, and as leader of the Democratic Party of Guinea, and president of the republic, Sekou Toure made his independence speech, by expressing and stressing on the need for de-personalization in the republic of Guinea Conakry at independence. This he meant

working together for the interest of the masses through the eradication of capitalist tendencies.

Sekou Toure who was also a fan of the Kwame Nkrumah's' Pan-Africanism appealed for the need for de-personalization on grounds that colonialism had implanted social disequilibrium that needs amended, (Fisher, 1959), in his own words, Sekou Toure said this "We for our part, have a first and indispensable need, that of our dignity, now there is no dignity without freedom… We prefer freedom in poverty to riches in slavery'', (Sabukwe, 2020). This was as a result of the proposal made by the French president Charles De Gaulle for a French African joint community upon independence, and this was seen by Sekou Toure as an approach for a continuous imperial and colonial control over Guinea and Africa as a whole.

Sekou Toure's doctrines were for an independent Guinea and Africa as a whole through the doctrine of depersonalization for ways to better the lives of their inhabitants. In one of his outings, he said that ''Guinea and African will keep their dignity in freedom rather than join the neo-colonial Franco-African community'', (Sabukwe, 2020). This he meant an outright separation of the French African colonies from whatever has to do with the colonial master France.

Inspired by the French Socialist Party, Sekou Toure was one of the leaders of the French colonies in Africa who refused to follow the stereotype ways of life of his French counterparts of Cameroon, Gabon, Central African Republic and Tchad but decided to hit hard on the French imperialist. He held fast on the controversial Soviet style of governance that earned him, Kwame Nkrumah of Ghana, Julius Nyerere of Tanzania, Modibo Keita of Mali, and Ben Bella of Algeria the name ''Radical Marxist Leaders' of Africa, (Rajen, 1984).

As part of Sekou Toure's independence speech he addressed the issues looming the colonial interference of France in Guinea Conakry and tendered his will and that of his people to correct same.

> ''On behalf of the Revolutionary People of Guinea, we would like to convey heart-felt and militant greetings to you and make our contribution, however modest, to the success of this Sixth Pan-African Congress, on which all peoples of African descent have earnestly pinned their hopes for their historical rehabilitation through the recovery of their individual freedom,

> responsibility and dignity that have been wholly or partly undermined by the objective and subjective behaviours of the imperialist, colonialist and neo-colonialist powers who support all the racist, segregationist and Zionist movements which, by brute force, constitute a serious threat to the human, historical and material values of our people'', (Toure, 1974, page 23)

This abstract is from a speech outrightly directed to the imperialist France by one of its' colonies to allow them carry on with their internal affairs. Sekou Toure pointed fingers at France for retarding the growth of Guinea and Africa through imperialism and vowed to take his people out of the French system. At a certain point in his speech, he made the utterance that, ''We prefer poverty in freedom to wealth in slavery''. His concept of depersonalisation was geared towards overcoming capitalism to instil a communal way of life.

Haven discussed the main African Marxist and Socialist concepts; I was able to lay the foundation of Marxism as well as the position of African Marxist. This foundation has given the perspective of what it takes in most of the countries of the countries of origin of the research participants so as to give better ground for the assessment of the application of these laws on these migrants on a foreign ground which is the UK.

The next section would be that of the evolution of sociology of health in the UK which is very crucial to this research in the sense that it would be laying the foundation of the contributions of British philosophers in the construction of the health domain.

Evolution of Sociology of Health in the UK and the Marxist view of sociology of health.

As mentioned in the previous section, this section will be laying the foundation on the contributions made by actors of sociology in the building of health in the UK. The Marxist principles outlined therein helps in understanding the Marxist view of sociology of health and facilitate the assessment and application of the underlying principles in relation to the research topic and question.

This approach will also permit us to understand the complimentary aspects of the research to other research conducted on same or similar topic with different approaches.

It is in this section that I will outline the theoretical presentation and usage of the sociology of health in the protection and functioning of the NHS.

Marxism (the Marxist dialectic approach) is the fundamental sociological approach to be taken in this research, and from the explanations laid down in section one of chapter one and part of this section, a tangible understanding of the sociology of health is put in place to permit us answer the research question.

The section start by briefing on the history of sociology of health of the UK and continue by bringing the concept of sociology of health from a Marxist direction for a better understanding of what applies in a capitalist society such as the UK.

Evolution of sociology of health in the UK.

Historically, the British Sociology of health is traced from the early part of the post-war Britain starting from 1945 to 1960s, through 1960s to 1970s and from the 1970s to present day.

The first part of British sociology as classified by this research is characterised by the establishment of the Welfare state, including the putting in place and funding of the NHS, with medical researchers and sociologist laying the basic foundations of the sociology of health in the UK. The second phase of this stratification that occurred from the 60s to the 70s was concerned with the development of more critical sociology with the reshaping of the NHS. While the third part started from the 70s to present date where British sociology of health got its development.

The early part of the Post-war WWII period is characterized with the institution of welfare state including the structuring and funding of the NHS. During this period, sociologists, medical sociologists, researchers, and funders of medical institutions were preoccupied with two basic sets of questions, relating to the era of the development of the sociology of health in Britain made up of study of poverty and community life and surveys of the impact of class-based irregularities and on the second part was on the policy-oriented work, which was preoccupied with sharing equitably, and welfare services with scholars such as David Glass of the London School of economics linking the two aspects with investigations of social mobility and commitment to research directed towards policy ends (Bulmer, 1989).

During the early post-war period beginning from the 1945 to 1960s, health care among other related issues which were at the top of political and policy agenda in Britain did stand at the meeting point of a range of social conflicts emanating from the excitement of the radical democrats that resulted in a profound change in the social, economic,

and political map of the country. In this regard, sociology of health and illness impacted explicitly, the analysis of policy-related problems in the UK, (Stacey, 2002).

Cox, (1991), on his part characterised this post-war social reconstruction period of the NHS with underfunding as well as regional and sectorial disparity of resources. Discussions on the issues at this period were focussed on organisation and managerial solutions with the introduction of organisational changes such as the Department of Health and Social Security 1983 (DHSS, 1972) introduced in 1974, the Department of Health and Social Security, 1979, (DHSS, 1979) introduced in 1982 and the Griffith Report of (DHSS, 1983) of 1984 which introduced the general management.

In this period, the British empirical traditions had challenges from more theoretically informed American sociologists, notably Edward Shills and Talcott Parsons who did not only point out the limits of an empiricist sociologist but challenged the substantive preoccupation of British sociologists. The challenges ranged from the unwillingness of the government support sociological teachings and independent researchers to declining trickle of graduate studentship and the remorseless chill about received opinion about sociology of health, (Halsey, 1989).

Parsons who did his studies in both sociology and economics based his critiques on his famous theory of Structural Functionalism, which was highly criticised by Robert K, Merton's Middle-range theory. The Robert K. Merton theory starts with an empirical phenomenon as opposed to the structural functionalism of Parson, (Bailey, Kenneth, 1991). This critic of Robert K. Merton came as a relief to the British sociologist and for them to put more attention to fundamental issues such as conflicts and power (Rex, 1961), and it is from this point that the British medical sociology started defining its task with consistency and in sociological terms.

To the editors of the first two volumes of papers of the British Association of Sociologist 1976, Sociology of health and illness in the UK is a discipline that got its development rooted from practical concerns than sociological and general theories, (as referenced in (Stacey and Homans, 1978, page 281-282). To these authors, actors such as medical practitioners, researchers, patients, health administrators, health financing agents, feminists and other forms of movements have been the moving forces that pushed the British sociologists into focusing its' attention on health and illness. In the

words of these sociologists, ‘’the present state of the sub-discipline is one of great activity but little theoretical or methodological unity’’.

During this period (Between 1945 and 1960s), medical sociology existed in its embryonic stage while the concern of sociologists with regards to health and health care was under development.

According to Gustafsson, (1991), the second part of the post-war in Britain beginning from 1960s to 1970s, saw a rapid development of critical sociology that was based on the reshaping of the National Health Services by continuation of policy institution for its’ control. This policy approach is in reference to the continual reshaping by the policy makers to either institute financial control of the services provided by the NHS or other health service providers of the country. During this period, Structuralists Marxist thought from France, in the guise of ethnomethodology **(Analysis that explains how individual used everyday conversation to construct common sense)** and symbolic interactionism from the United States came to challenge the dominance of structural functionalism and empiricist British sociology, (Halsey, 1989).

It is during this period that the Frankfurt school of sociology and phenomenology that created an innovative brand of philosophically oriented radical social science known as critical theory. And this theory had a huge influence in social science over the globe including Britain and other countries in Europe, (McLaughin, 1999). At this period, the Frankfurt School was instrumental in the British Sociology of health because of their critiques of their political landscape and to the British form of culture and society because of their intersection between technology and culture and the economic situation of contemporary capitalist country, (Kellner, 2002).

The above-named group is made up of critical thinkers aimed at interrogating the structures and discourses of power by casting a broad net to include interdisciplinary thinkers ranging from cultural studies, Marxism, linguistics, sociology, philosophy, psychoanalytic criticism, and others, (Garlitz et al, 2021).

The third part of our analysis of the development of sociology of health in Britain began from the late 1970s to the present date. At this moment, ‘’sociology in Britain operated in a cold political climate in the face of hostility from neoconservative politicians **(Proponents of foreign intervention)** who looked upon proponents of the discipline as ‘Folk Devil’ responsibility for reducing moral panic’’ (Halsey, 1989).

This developmental phase of sociology is being faced with a political atmosphere biased of its existence, a situation representing a modified form of traditional capitalist viewpoint. This is all as a result of continuous change of government and political actors with different agendas, leading to atmosphere where the government support for sociological teachings and independent research was lacking (Gustafsson, 1991).

The history or evolution of sociology of health in the UK prior and post war periods, is characterised by the draconian immigration control directed towards the restriction of migrants from benefiting from the British government including accessing healthcare facilities. This period is further characterised by the isolation, dehumanisation and disenchanting effects of the working class within the capitalist system of the UK. One of the effects of this period is the continuous and inhuman treatment of people of the ethnic minority group by the immigration system put in place with most focus on exploiting and restricting them from coming into the UK.

This first part of the section is important in that it gives a theoretical establishment and foundation of the existence of the Sociology of health in the UK as well as the concerns in the establishment and reinforcement of the NHS to permit us to use the second part to explain the reality and practicality of the sociology of health in a capitalist British state.

Marxism and sociology of health in a capitalist system such as the UK.

Effective health care service meant for humanity need not be associated with hardship such as restriction and other forms of barriers for profit making as the case with the NHS and its numerous reforms imputed by British ruling class, (Routledge, 2012). Profit making at the NHS could be seen from standpoint of the British government through the then secretary of health mentioned in the next chapter, who used it as a means to propagate economic advancement and protection of the state institutions, via billing migrants to pay for healthcare services, and to some scholars, this is exploiting than helping the migrants. Furthermore, Britain has a history of immigration control that restrict and deprive migrants of their right to health as would be discussed in Chapter Three of the thesis.

Sociology of health in this case help us understand how the society functions, and from a sociological point of view, the experiences of sickness and diseases is the outcome of the societal organisation or the outcome of the organisation of a society.

For a Marxist, the experiences are the outcome of class stratification, the actions of the ruling class and professionals, (White, 2017).

To better understand Marxism in the direction of health in a capitalist society, I shall be throwing some light on the alienation theory of Marx. Which is a concept describing the dehumanising, isolating and disenchanting effects of working within a capitalist system.

Marx's alienated labour as discussed in Economic and Philosophical Manuscripts, (1884), refers to forced or involuntary labour in which the worker finds no purpose or contentment or no independence, no development. It is the experience of an individual or groups that feels disconnected from the values, norms, practices and social relations of their community. This describes the continuous exploitation of the working class by the ruling class, in a process which deprives the working class of their rights to the choice of what they deserve including the right to health.

Marx identified four dimensions of alienation, the product of labour, the process of labour, others and self.

The alienation concept of Marx explains the live experiences of people in a capitalist society such as the UK. As per Marx, alienation does not only squanders, human labour and human beings, (Alienation from one's own specific humanity), but also squanders flesh and blood, as referenced in (Yuill, 2005).

This explains the effects of the hardship that people of the working class undergo in a capitalist society that influences both their physical and mental health and why this hardship is concentrated on the migrant working class and specifically those from the ethnic minority group. The job and health insecurity of the working class such as the migrants from English-Speaking Cameroon and Nigeria in a capitalist society such as that of the UK has a huge influence on both their physical and mental health. This aspect of insecurity is suggested by Karlsen et al, (2002), to be focused on this group of persons in the UK as a result of racism and the perception of Britain as a racist society. Before and during the Covid-19 pandemic, the aspect of insecurity was assessed by Dickerson et al, (2020), to be common with people of the ethnic minority group, due to their association with loneliness and economic insecurity.

The concept of alienation further explains how the instruments such as the laws and other structures in a capitalist state by the ruling class, hinders the lower class from achieving health goals both physical and mental.

The explanations from this part of the section on the Marxist theory of alienation would help in the understanding of the representation of the ruling class of the UK in controlling the migrants from accessing the services of the NHS.

This section dealt with two aspects of sociology of health and they both are helpful in the assessment and analysing the data.

The historical analysis of the sociology of health will serve as a foundation for the understanding of how the British society functions sociological.

Bringing in Marx's theory of alienation at the second part of the section gives an understanding of the part played by the ruling class or capitalist through the instruments in controlling migration and access to health services in the UK.

Meeting point between the sociology of health of the UK and African concepts of Marxism and Socialism.

This section is a continuation of the concepts applicable to sociology of health, and how it helps integrate the African philosophical concepts of Marxism and socialism into the already discussed area of Marxism and sociology of health in capitalism.

Integrating these concepts of African origin, would help us understand the functioning of the African society which is the origin of the participants and to be able to interpret the data collected from these people.

Meeting point here I mean the understanding or the interpretation of the African concepts with regards to sociology of health or using the African concepts to interpret the functioning of the society as that of the sociology of health, and in so doing, that will help the research in the interpretation of the data from both the perspective of the west and Africa in order to give a concrete response to the research question.

Consciencism of Kwame Nkrumah.

Consciencism is one of the concepts of ''the African revolution'' from Kwame Nkrumah of Ghana. Africa being a land of multiple traditions and cultures, this concept sets out to bring together these traditions such as Christianity, Islam and the African tradition itself which to him were all considered as symbols of equality. The philosophy of

Consciencism according to Kwame Nkrumah draws its' inspiration from the African roots which is synonymous to people living in a society of freedom and equality.

In explaining the logic of Consciencism, Kwesi R, (2016) said this.

> ''Although Nkrumah's final chapter is rarely read and examined because of its use of symbols and logical notations which make it quite daunting to work through, it is, arguably, the most important chapter of his book, for at least two reasons: One, the chapter gives us an application, on the social and political plan of the central theses of philosophical consciencism; it brings together Nkrumah's ideas on liberation, materialism, dialectical moments, socialism, and positive action. The interrelation and interconnectedness of these ideas help us to appreciate the broader spectrum and applicability of Nkrumah's Consciencism''. Kwesi, (2016).

The first point of the above quotation is the smooth and equal functioning of the social and political plain. The society created out of consciencism is a classless society with no barriers for individuals to achieve their goals. The classlessness of the society will place all citizens to same platform in both financial, political and societal level and at such accessing health care facilities will not be a problem to others.

Looking at a society created out of consciencism and that created out of capitalism, that will help us understand the impacts of these two societies and to interpret the data and to answer the research question.

Ubuntu

''UBUNTU'' is peculiar to African Society and also known as the African Humanism. It means a person is a person through other people, for example, ''I am because we are''. The word UBUNTU is a word from the Zulu tribe of South Africa and cuts through all the Bantu speaking people of Southern Africa, Central Africa and East Africa. In Zimbabwe, it is known as Hunhu, which represents a traditional African philosophy thriving on the vision of a virtuous individual and a common ground of consciousness that all Bantu tribes of Africa share, (Sibanda, 2014).

It is based on the principle that the welfare of an individual human being is inextricably bound to the welfare of the community, (Caromba, 2015).

This concept like Marxism shapes the society for the benefit of everyone. The oneness philosophy of Ubuntu is the one aspect understanding of the interconnectedness of everyone.

Unlike a capitalist society, an Ubuntu society is that which is equality enshrined and free from all sorts of barriers and this will help understand and interpret the data from African who are originally from this region and based in the UK.

Ujamaa.

The next concept is that of 'Ujamaa' of Tanzania, put in place in the days of the father of African Socialism Julius Nyerere and based on the principle of Collectivisation projects that herded peasants and others into socialist groups, as explained in section two of this chapter.

The teachings of Ujamaa, are associated with socialist and Marxist tendencies and have been proven to be in existence even before the coming of the West or colonial masters into Africa during colonization, (Nyerere 1962).

The concept teaches collectiveness and equality in treating everyone in the African society.

The concepts of Ubuntu and Ujamaa are both characterised with equality and communality, making it concepts of a classless society as that of Nkrumah's Consciencism. And they will help the research in understanding the difference from a capitalist society and to interpret and analyse the data collected.

Meeting Point of these concepts and Marxism, for the understanding of social structure of the UK.

By meeting point here, this research is trying to bring out the contributions of the African concepts of Consciencism, Ubuntu and Ujamaa and that of Marxism that will give an understanding of the British society, and to answer to the research question.

The three cardinal principles of Marxism that are useful to this research as earlier explained are Dialectic Materialism, which will help the research understand the conflicts and difficulties migrants undergo during the processes of accessing health care in the UK, Historical materialism which will help in understanding processes of changes in migrants' health and access to health care, including the different ways the immigration laws affects migrants and what it would take for the situation to be

improved in the future. The Marxist economics permits the research to identify the role played by the ruling or political class of Britain in exploiting the labour force of the migrant working class, and the difficulty faced by the migrant in accessing the health care system.

The three African concepts of Consciencism, Ubuntu and Ujamaa portrays a classless society of equality free from barriers and gives an understanding of the individual and communal effect(s) of the immigration laws on the African population resident in England and Wales.

Conclusion.

An understanding of the principles of Karl Marx and the African concepts will give a better understanding of the British Capitalist society and the impacts it would have on the migrants when accessing health care.

It also gives the research the opportunity to understand how the application of the laws in the British society would affect the classes of people differently.

The theoretical foundation of the sociology of health outlined in this chapter will help in the understanding of the situation faced by migrants and other residents of the UK and to help in the interpretation of the applicable laws.

The key concepts of Neo-colonialism, Capitalism, imperialism and the law have been elaborately discussed in this chapter including their Marxist implications. This equips the research with necessary understanding of how capitalism works in Britain which is the lieu of the research.

The African concepts discussed in this chapter and their complementary aspects of Marxism in the interpretation of the data and identification of the situations faced by the migrants involved and to answer the research question.

The Marxist interpretation of the concepts of Neo-colonialism, Capitalism and imperialism will be helpful in the next chapter which is the context chapter in situating and explaining the reality of what applies in the UK.

Chapter 3 - Context.

This chapter will lay down the context in which certain concepts and principles related to the research are applicable in the UK.

The context provides the research with the reality of the concepts as applicable in the UK and specifically in England and Wales. This will help the research in its interpretation of the concepts in relation to the data to provide an answer to the research question.

The chapter is made up of eleven sections, with the first section dealing with social structure of the UK, the second section deals with the categories of migrants involved in the research, the third section talks of the health disparity amongst races in the UK. Section four elaborates on the history of British immigration control while section five throws light on the legal framework of immigration control in the UK. Section six gives an insight on the impacts of capitalism on the policies of the NHS and section seven brings out the implication of some repressive action of the British state towards migrants. Section eight brings out the housing effects on health, section nine talks of the typology of housing accorded to migrants in the UK. Section ten draws our concern to access to health care as a human right while section eleven makes a reflection on other determinants of health.

Social Structure of the UK.

Sociology of health as discussed in the previous chapter, helps in the understanding of how the society functions and with the experiences of sickness and diseases termed to be the outcome of the organisation of a society, or class stratification as per Marxism, (White, 2017). So, discussing the social structure in this chapter will give a better understanding of the sociology of health of the UK and how the migrant class are affected by the legislations under investigation.

In the Marxist analysis of class struggle within the British society, migrants, especially the refugees and asylum seekers can be understood as part of the international working class, (Vickers, 2012). In this relationship of class struggle, Marxism considers the law as an instrument used to keep the Bourgeois at the head of the proletariat, or the working class. According to Kautsky, (1888), the economic powers of the system or the struggle, uses the law to their desired results. In the present case, the immigration laws of the UK are considered an instrument of controlling or limiting the

rights of migrants. Gordon, (2005, 53), in a study of the political economy of law-and-order policies of capitalist states such as Britain, Canada and the USA, considers the law to have little or nothing to do with crime fighting, but aimed at the re-composition of the working class into cheaper and more flexible labour forces.

Elaborating on the social structure of the UK, in this section of the research would permit us to connect the migrant population to the larger British society for us to be able assess the impacts of the law as faced by this group of persons.

In sociology, a social structure would be the stable arrangement of institutions in a society whereby humans interact. In a capitalist society, it is stratified into classes with hierarchies of power. Scambler, (2007), relates it to the ‘’changing dynamic of class relations of the economy and command relations of the state and to the changeable distribution of asset flows’’ which is synonymous to Marxist class stratification.

In Marxism, classes are defined and structured by the relationship between labour and capital or the relationship between labour and ownership of property and the means of production. In a contemporary class structure, the capitalist stage of production consists of two main classes made up of the bourgeoisie and the proletariats, and the migrant population being researched here are classed under the proletariats or international working class as earlier referenced in Vickers, (2012). The bourgeoisie in this case determines and owns the means of productions while the proletariats provide the labour force for a salary or wages, (Przeworski et al, 1982).

In this process of class stratification, the dialectic and historical materialism will help in the understanding of the difficulties and the changes undergone by migrants within the class structure during the process of accessing health care in the UK.

History of British social classification.

The description of the social structure of the UK made in the earlier paragraphs will help the research in understanding the social stratification as well as the sociology of health of the UK. This will assist the researcher in his analysis and consideration of the pre-existence of these structures and their relationships with the migrant population and access to health.

Historically, the social structure of the United Kingdom could be traced through a study of its social class with a reflection on the pre 21st century and typical of its old traditional styled social class of the upper, middle and the working class that has been

the measuring tool for shaping the society. Significantly, there has been a shift in structure of social hierarchy to generate new forms in replacement of the initial class of solidarity which is associated with a total swing in social values to individual and private objectives, (Marshall et al, 1988). It is also a fact that like other European countries and before the industrial revolution, the British society was traditionally a hierarchy divided within a system involving hereditary transfer of occupation, politics and other aspects, (Weatherill, 2002), and ever since, the structure has been in constant revision as earlier discussed in this thesis.

The conventionally identified Weberian and Marxian theories of social classification which are derived from market processes and the sphere of production respectively could easily be understood through the analysis of the Registrar-General, John Goldthorpe and Erik Wright, (Marshall et all, 1988).

That of the Registrar-General which rest on the assumption of a graded hierarchical skill-based occupation that associates class in relation to the degree of expertise involved in carrying out functions. This class scheme categorises and allocates individuals and families into social classes and is widely used throughout Europe.

In this regard, the office of the population censuses and survey (OPCS) recognized five basic social classes of the 1921 to 1971 which where occupational classification and based on reputation in the society while in 1980 a swing to social class based on occupational skills was introduced, (Rose, 1995).

The John Goldthorpe sevenfold type social class draws its' inspiration from the Weberian concepts of market and work situation of identified occupations. Later, Goldthorpe redefined his scheme by subdividing three of his original classes to come out with eleven classes. According to Marshall et al, (1988), although Goldthorpe and colleagues were critical towards neo-Marxist ideologies of class structure and paying allegiance to the Weberian-inspired theories, their theories ended up being drawn from both Marx and Weber.

The last of these early classifications was that of the American Marxist scholar Wright, (2003), who modified Marxist's model of social class by carving out four main classes, the capitalist, the petty bourgeoisie, managers and the working class and he based his classification on the social relations of production.

Recently, Mike Savage of the London school of economics and a group of other British sociologists, who considered the old British model of social classification as outdated did a reclassification of the social class. On this reclassification, they embarked on a more extensive British survey findings from one hundred and sixty-one thousand (161000) people to arrive at a seven social class classification for Britain, (Savage et al, 2013).

The seven classes earmarked are the Elite class, Established middle class, Technical middle class, New affluent workers, Traditional working class, Emergent service workers and Precariat. The fix Elite class stays at the top while the Precariat at the bottom and the British immigration plays a big role in maintaining this structure, (Manacorda, 2012), (Shapira, 2010). Meyers, (2003) holds the position that an immigration policy shapes immigration pattern which in turn have a tremendous impact on the demography, culture, economic and politics of a state.

The role of the British immigration, as explained later in this chapter would be to would be to restrict, exploit and maintain the migrant in the working class.

Some of the theories presented earlier, treats class structure here as something that is unique only of the UK, and in that line writers such as Nkrumah, considers the different forms of colonialism in Africa to have generated different forms of class struggles and structures, (Mendy, 2006).

In his explanation, Nkrumah considered Neo-colonialism as a modern form of capitalism. He further explained that this concept gave the controlling countries the economic power over the countries which neo-colonialism is being applied. That it is based on the principles of breaking the countries subjected on to neo-colonialism into controllable portions and subjecting their citizens of these countries into same conditions. That neo-colonialism is an approach used by the British in the post-war period to create class segregation and to sponsor the welfare state, (Nkrumah, 1963). This segregation further create a situation where the migrants of the working class remain in a standstill, continuous exploitation by the ruling class through racial and discriminatory tendencies (such as institutional racism as would discussed in this thesis). This segregation and the neo-colonial control of the UK over its' colonies could be mirrored from the creation of the commonwealth organization and the commonwealth immigration acts.

This social structure elaborated in this section has thrown more light on where the migrant population belongs in the UK, and this will guide all the remaining part of the research in the assessment of the impacts they face from immigration control and specifically when accessing health care.

Categories of migrants involved in the research.

After the definition of migrants introduced in part one of this thesis, this section will identify or outlines the various categories of migrants involved in the research.

As introduced in chapter one, Migrants are foreign born nationals who have moved to the to a country and in our case, the UK for one reason or the other for a defined or undefined period, (Anderson et al, 2015).

In continuation of the definition of migrants in the first chapter, and for purposes of clarity, we would also want to say migration may also involves nationals returning back to their countries of origin after spending sometimes in a foreign country for resettlement, (Parutis, 2014), and can also be termed retro-migration or back-migration, (King, 2000), and this category of migrants do not need leave to remain or do not go through the process of scrutiny as other migrants of foreign origin. This definition is out to situate and cover those migrants of foreign origin who have had British nationality and who might have relocated to their countries of origin and decided afterwards to return back to the UK.

The two main categories of migrants we shall be looking at in this research shall be undocumented and documented migrants.

The undocumented migrants generally made up of refugees and Asylum seekers without status. In this category we have refugees and asylum seekers awaiting initial decision from the Home Office, Failed asylum seekers, Refugees and asylum seekers who have been refused leave to remain and their cases are pending appeal. Students and workers who entered the UK through the Tier4 and Tier1 Visas and have exhausted their stay in the UK or come to the expiration of their visas and those who have entered the UK without visa via trucks, seas, and land from the neighbouring borders such as France, Scotland and Ireland without authorisation and regulated by the Dublin Accord.

The second category would be the documented migrants such as Students who have come to the UK through the Tier-4 visas, refugees who have been granted refugee

status, persons of foreign origin who have acquired British citizenship either through naturalisation or by birth or by marriage, Migrants who came into the UK from other European countries after acquiring citizenship or indefinite leave to remain from these countries and were regulated by the Dublin accord or the European convention as it was then before Brexit. The definition and description of these migrants would be given later in this section.

This section would also emphasize the fact that this research is going to be dealing with migrants generally but specifically using a group of migrants from the English-speaking Cameroon and Nigeria who are believed to be historically linked to the UK through colonialism including the fact that they share certain cultural values.

This research would be talking mostly of migrants of foreign nationality who have decided to migrate to the UK or elect[5] residence in the UK. They[6] can either be with right to stay or work (Documented Migrants) or without the right to stay or work (Undocumented Migrants), (Krause, 2008). The migrants include those who have moved to the UK to earn more money and to learn English and to try life abroad. In doing this, they use different cultural capital such as skills, qualifications, and the environment to enhance their economic capital in the UK (Economic Migrants), (Parutis, 2014). Here, we are referring to situations where skilled foreign nationals use the skills acquired from their countries of original to exploit the available opportunities in the UK for financial gain and to equip themselves economically for future advancement.

In this category, we have students who came through the Tier4 visa. Tier4 is made of people from outside European Economic Area coming to the UK to study for further education, (Achinewhu-Nworgu et al, 2010). In this same category, we have students that have finished their studies and are either stuck in the UK for one reason or the other, such as myself[7], or those who have made decisions to exploit the better economic opportunities in the UK for their advancement in life after studies.

[5] Electing residence here we are referring to those migrants who were born of foreign parents in the UK and have decided to follow the procedure of being granted leave to stay in the UK. This is so because UK nationality is not acquired by birth.

[6] Here we are referring to non-national migrating to the UK and who are required to undergo a strict or legal verification process upon entry and acquiring leave to remain in the UK.

[7] Am a trained legal practitioner from the supreme court of Cameroon, I came into the UK via the Tier4 student visa but got stuck in the UK because of the ongoing political instability that involves myself as a lawyer and human rights activist.

We also have professionals who came in through the Tier1 and Tier2 work visas, for both high skilled and low skilled employees respectively needed in the British labour market.

Some of these persons are from marginalized communities that are becoming increasingly vulnerable due to sudden or long termed changes to these environments which as a result caused them to flee to the UK (environmental migrants), (Moriniere, 2009). While others are from war torn countries or other forms of instability. This may also be as a result of state policies or tradition or customs which discriminates and persecutes their person. (Kinshasa, 2002), and have migrated into the UK through the Mediterranean Sea and Sahara Desert, for example. The category of migrants in this paragraph are protected by the 1951 convention of the rights of refugees.

The individuals mentioned in the previous paragraph could either be seeking protection through the Asylum process, the UK Gateway Protection Programme or the Syrian Vulnerable Persons Protection Scheme.

In this category, we also have the failed Asylum seekers, known to be those who have made an application for protection under the above-mentioned convention and have been denied leave to remain in the UK up to the appeal processes, (Alexandria. J, 2014). This category of migrants is divided into two, the first category made up of those whose' appeal rights have been exhausted and are willing to take further steps and are still under the control and support of the government of the UK[8]. The second category is made up of those whose' case and appeal rights have been exhausted and have made the decision to stay undercover or without the knowledge of the state. Bloch, (2013) considers these categories of refugee as those whose' experience of the asylum system has led them to irregularity and that their living irregular is with constraint, fear and other negative social effects that follows.

Due to the inherent stigmatisation of these individuals from their countries of origin as explained earlier, which is the cause of their moving to the UK, Vickers, (2012) decided

[8] Immigration and Asylum Act 1999 as amended, Section 4(3) states that the Secretary of State may provide, or arrange for the provision of, facilities for the accommodation of a person if—
(a) he was (but is no longer) an asylum-seeker, and
(b) his claim for asylum was rejected.

to call them Refugees, as he considers them to have come to Britain to seek refuge, with backgrounds often including trauma, abuse and health problems.

Taking part in the research will bring out my insider-outsider positionality as an African migrant, (Carling et al 2014), and this will help in my everyday experience as a service user to gain access to research participants and other materials for the research and to improve the overall quality of the research, (Becker et al, 2010).

Health disparity and race in the UK.

After going through the social structure of the UK and the migrants involved in this research, this section is going to lay down the general principles of understanding the concept of ethnicity and race and using Marxism to get a further insight of how these terms affects health in the UK.

In so doing, the research would be giving an understanding of the role played by race in the social structure of the UK and the health consequences thereof.

Health disparity is a form of social determinant of health which is closely linked with social or economic disadvantaged group of persons, also known as preventable differences in burden of disease or opportunity to attain or achieve optimal health experienced by a people or a group of persons who are socially disadvantaged.

It negatively affects groups of people who have systematically experienced greater social or economic obstacles to health, (Braveman, 2006). In the UK, it is more and visibly faced by the marginalised people of colour or the black ethnic minority group, (Marmot et al, 2005, Keys et al, 2021). These groups of persons are most likely to suffer these disparities and inequalities while accessing healthcare facilities and other social opportunities such as education, (Mehra et al, 2020).

Understanding the role of race in health, will create the ability to situate the position of the ethnic minority population vis-à-vis the immigration control, as well as the impacts of the immigration control on health and access to health care in the UK.

In the general sense, ethnicity could be defined as a grouping of people who are identified on the basis of attributes such as language, traditions and other ways of life that keeps them different from others, while race of the other hand is a grouping of individual based on shared physical and social characters which are distinct to others. In differentiating both, Ethnicity has to do with culture while race has to do with biology

and genetics, (Gracia et al, 2018) and both could be associated with identification, (Moran, 2019). For more information on the concept of race, (Williams et al 1994), considered it to be an ‘’unscientific, societally constructed taxonomy that is based on an ideology that views some human population groups as inherently superior to others on the basis of external physical characteristics or geographic origin’’.

The definition of race and ethnicity earlier given could be better understood to satisfy the position of this thesis from a further insight through Marxism, which views ethnicity and race as a formation of privileged capitalist state to keep the less developed states and their populations and the working class within its’ country in a permanent inferior and less privileged state. Marx’s position holds that ‘’Ethnicity is an illusion ultimately in the interest of the capitalist class’’, a classical Marxist would hold that ethnicity is an objectification of the structural process and that it misrepresents the societal ownership despite the identity of the members of the society, (Mejer, 1987).

Furthermore, a Marxist also looks at race as an economic factor where there is an interplay within the ruling class at the detriment of the working class. This explains how in capitalism, the state is used as a site for the production of racially structured situations and to maintain these structures for economic purposes, (Solomos, 1995).

This position of Marx will clarify our understanding of the immigration control of the UK towards the Ethnic minority population beginning from the creation of the Commonwealth Organisation and its accompanying Immigration Acts**.**

Relating racial differences to health improvement, some scholars have arrived at the conclusion that the disparity between the black and other minority groups and white race to be quite disturbing. Byrd and Clayton (2002), in analysing the medical history of African Americans and the problem of race and their relationship with medicine and health care of the United States, held the position of Martin Luther King in a speech delivered on the 25 of March 1966 that racial inequality establishes class-based health disparity which affects the minority population while Nazroo, (1998), had earlier taken same position for the UK.

In the UK, the Black Asian Minority Ethnic (BAME) Groups are more likely to report ill health and experience ill health earlier than the white British people and from the understanding of Martin Luther King’s position of the previous paragraph, the health

care variations can be understood to have result of social inequalities, discrimination and poverty.

The current covid-19 pandemic has a disproportionate effect on the BAME group as compared to the White British population, as indicated in the Public Health England report, (June, 2020), which states that a range of people including those from the BAME group were disproportionately impacted by the pandemic. This same report indicated that the death rates involving covid-19 for people of black ethnic background was two times greater for males and 1.4 times greater for females as compared to whites. The disproportionate impacts put the non-white people at high risk of death than the white population, (Press Association 2021, 2020). Relating this to the ongoing Covid-19 pandemic, (Ali, 2020), on agreeing that this disproportionality puts the non-whites at high risk of death, added that Race and Ethnicity could be used as determinants of covid-19 outcomes.

Healthwatch (2020), also reports that the Black Asian Minority Ethnic Group (BAME) residents of the UK had a poorer experience of health and social care services than their white counterparts with many BAME people reporting longer waiting time to access healthcare. It also reports that people of the BAME group were more likely to be digitally excluded and that this may impact their experiences in accessing health and social care as well as other health related cases especially during this trying moment of the Covid-19 pandemic.

Health inequality is a domain where the influence of the UK government is visible. The UK government plays a huge role in encouraging health inequality through the creation of structures or institutions that are suppressive to other racial values to maintain an atmosphere of inequality, Vickers, (2019) considers this as structural discrimination.

The benefits of these structures to the capitalist classe in Britain are that it is used as a form of investments for financial gain, (Steier, 1995), and one of the financial gain is the restructuring of the NHS and levying the migrants to pay for health care services.

Putting in place these structures gives the capitalist Britain the ultimate powers in the control of the business and investment world as to what when, and how to invest, (Payne et al, 2009), same theory is applicable to the health sector as to what type of health services the migrant population gets and at what cost. The benefits of the capitalist class remain the main objective of the instrument of the state to rule over the

working class and most especially the migrants working class and their countries of origin.

Laying the foundation of the concept of race and ethnicity and their impacts on health care as applicable in the UK, paves the way to the understanding of the reality of what the participants are facing while accessing health care in the England and Wales of the UK, which will assist in the processes of analysing the data.

The role played by the British government through the structural capitalism and its' outcomes of inequality, will help the research interpret the role of the instrument of immigration control in affecting migrants' health and access to health care in the UK.

History and structure of British Immigration Control.

This section with be dealing with two aspects of the research. The first would be establishing the evolutionary presentation of the British immigration control and their relationship with the migrants from the 1905 0f the Alien Act to the time the research will cover up to 2020 and the second aspect would be establishing the UKs' immigration structure.

Discussing the structure and history of immigration control gives an understanding of the British system especially if it has to do with the legislation involved and to facilitate the application of the three Marxist concepts outlined in Chapter Two to answer the research question.

History and institutional arrangement of British Immigration control.

This research has its consideration of the history of immigration control to commence from 1905 to 2020. The history is blended with the contribution of multiple political approaches but with same trend of excluding, punishing and restricting migrants coming to the UK. While the institutional arrangements devolve from the Home Office that was created in 1782

For the purposes of consolidating the occurrences during the period carved out, the history will be focused on the period from 2007 to 2010 and from 2010 to 2020, which were under the control of different Political Parties, to establish the different ways in which migrants were being treated in Britain within this period with regards to accessing health care in the UK. As for the institutional arrangement, this research will focus its' attention on the lone institution of the UK which is the Home Office.

The research will be using Marxism to diagnose the imperialistic characteristics of the UK towards immigration control to bring out its implication(s) towards access to health care of migrants. This will be done by looking at the introduction and functioning of the point-based system and other aspects of immigration control and how these affects the migrants under investigation and their countries of origin which are former British colonies. The principles or processes of brain draining, and other forms of institutional capitalism and institutional racism would be taken into consideration while carrying out this assessment.

These processes will help in the understanding the foundation of the instruments involved to facilitate the application of the core Marxist principles and to identify issues faced by migrants during the processes of promulgation to application of the laws involved in immigration control.

As earlier indicated, the immigration control of the UK is structure to follow same pattern as of the Alien Act of 1905, and in addition to the laws instituting the granting of common status of British subjects upon specific ties with the dominion of the crown, (Karatani, 2002). This justifies the selective admission and control of the migrant population with outputs that favours the British ruling class as discussed in Chapter Two through Marxism. Upon looking at the political, legal, and administrative framework of the 1905 Act. Wray, (2006) and Bashford et al (2014) consider the Aliens act 1905 to be the major antecedent to Britain's enduring and legislative moves of the post 1905 periods to restrict and regulate the entry into and out of the British borders by the Foreign Nationals and Commonwealth Citizens in particular as would be discussed later in this section.

After the institution of the Aliens' Act, the next phase of the British immigration control was during the period marking the end of the first world war, between 1914 to 1918 where stricter immigration controls were instituted. During this period, the 1914 British Nationality and status of Alien's Act was put in place due to Germanophobia and to prevent the further entrance of immigrants during the World War One, and British citizens from escaping conscription into the armed forces, (Panayi, 2017). The goal of this phase remains within the context of immigration control of the 1905 Aliens Act but with more focus on Germany and its mercenaries.

A further phase of the British immigration control period was between the 20s and the 30s, with the alien order of 1920 was promulgated to strengthen the Alien Restriction Act after the first world war in 1919 when the extension of the Alien Act was put in place with principal aims at controlling the aliens widespread unemployment in the UK at that time. This Alien's Order 1920 was promulgated, requiring all alien seeking employment to register with the police, (Susheila et al, 2010).

The period between 1939 and 1945 marked another phase in the history of the British immigration control. During this period, new emergency focuses were to be dealt with and one of them was the wave of displaced people from the world war that needed taken care of such as refugees and other categories of people fleeing from the war-torn countries.

Between the 1945 and 1968, which is the major period of decolonization, marked another period in the history of the British immigration control. This period is sub divided into two with the first phase marking the Commonwealth immigration growth in the UK, beginning from 1945 to 1961. This influx came as a result of the fact that in 1948, the Nationality Act was promulgated for the extension of British nationality to people of different nationalities. This act gave the citizens of Commonwealth Countries, British citizenship and due to the shortage of labour force in Britain during this post WW2 period, their numbers into Britain was increased as mentioned in, The Cabinet Paper (n.d.). The second part of the post-colonial restriction period that began from the 1961 to 1968, was met with a continuous increase in the migration from the British former colonies. The migration rate into the UK was steadily increasing with West Indians and other nationalities of the ethnic minority group migrating into the UK, (Macrotrend, 2022).

This period represents the major antecedent to Britain's enduring and legislative moves to restrict and regulate the entry into the and out of their borders, and the Commonwealth and Immigration Act 1962, is one of the instruments where Citizens from the British formal colonies were strictly controlled upon entry into the UK. This Act allowed only citizens of Britain and their colonies who have British passports to enter the UK. In 1965, the government of the UK reinforced the control on commonwealth entrants and reduced the numbers entering the UK, and those who fall in that category lose their automatic right to remain in the UK and had to work and pay

tax in the UK for at least five years to gain the right to remain, (to be discussed further in the later paragraph).

The period between 1968 and 1978 coincided partly with the UK gaining membership with the European union and marked the creation of new laws on immigration. During this period, key events such as the independence of Kenya, Uganda and Tanzania which led to their minority Indian population to be chased out and some of them were led towards the UK for a safe heaven. About 30,000 Ugandan Indians migrated into the UK at this moment, (Rujani, 2012). The 1968 Commonwealth and Immigration Act and the Immigration Act 1971 were promulgated respectively at this moment to restrict and control the inflow of these Indian citizens.

The period between 1979 and 1989 marked another phase in the history of British immigration control. During this phase, the immigration rules were tightened with concerns centred on foreign spouses joining their UK partners. The British Nationality Act 1981 in its' section 2(1)(a), laid down conditions of British Nationality for persons born out of the UK before 1st January 1983.

The period between 1990 to 1998 was marked by an increase in in the immigration figures in the UK. In a special report on race issues by Carvel, (2001), it is suggested that the increase was politically motivated to increase the needed skills at that time and to blend the aging population of England and Wales of the UK with the young and vibrant population of the immigrants, confirming the role of the ruling class in exploiting the migrant class.

The period between 1998 and 2010 and from 2010 to 2020 are the period earlier announced in this chapter to elaborate on the immigration trends of the two main Political Parties of the UK, (The Conservative and the Labour Parties). The research will also compare their different agendas and actions on migration and how the agendas indirectly or directly affect the migrant population in accessing health care. The Labour Party was the party in government between 1998 to 2010 and the coalition government of the Conservative and the Liberal Democrats that lasted from 2010 till 2015 then the Conservative government continued till 2020.

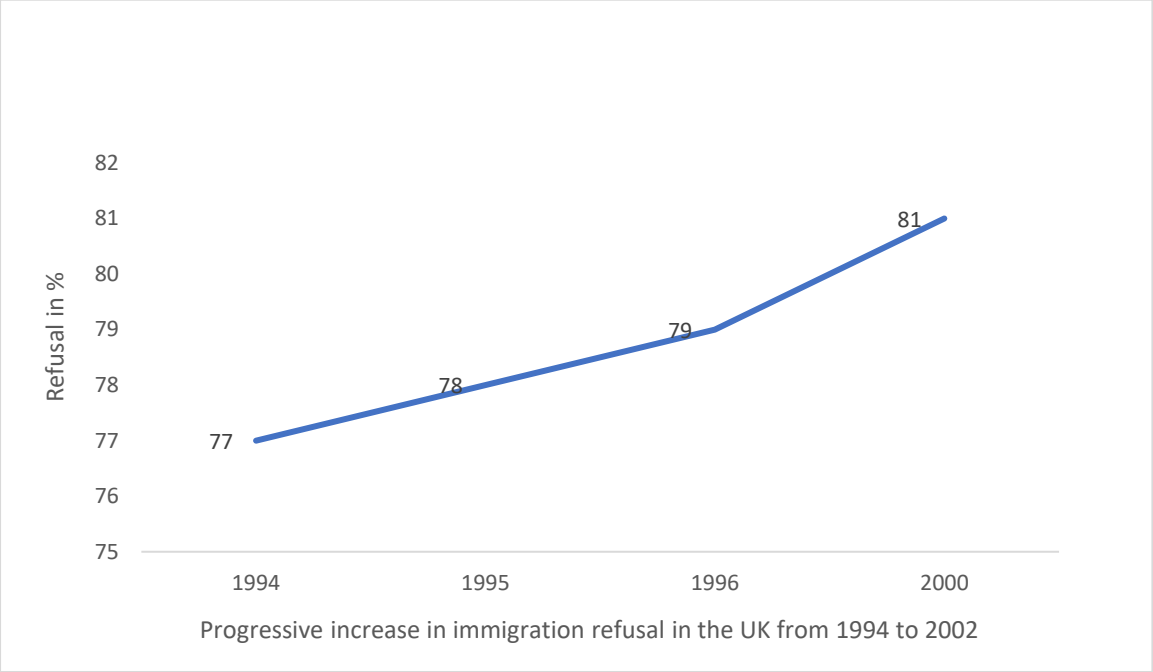
From 1998 to 2010 marks the era in the history of British immigration control during which the one-stop appeal system requiring all grounds of appeal to be in an asylum application and no further appeal was allowed. This was done through the revision of

the 1996 asylum and immigration act to get the 1999 Asylum and Immigration Act. It is also during this period that the 2002 Nationality, Immigration and Asylum, the 2004, Asylum and Immigration (Treatment of Claimant etc) Acts, were promulgated to remove the right of appeal against a refusal of a protection or human rights claim, the implication of this will prevent claimants raising new claims at last minutes, with new grounds of arrest of migrants instituted and specifically to those considered illegal, (Section 1). The one stop appeal system gave the asylum seeker no second chance to remedy or introduce an application of their claim, though it was later revoked by the Asylum and Immigration Tribunal (Procedure) rules 2005.

Within this period, was the introduction of the Immigration and Nationality Directorate (IND) casework programme meant to fasten or fast track cases of asylum seekers and ease their deportation. This programme was initiated in 1995 and intended to go through by 1998 though met by crisis. In the year 2000, the IND crisis coincided with a 76040 increase in asylum claims and a home affairs committee was created in parliament to carry out an inquiry on that, which triggered an increased in application refusals both at the borders of entry and other agencies.

Data from Control of Immigration statistics, (2002), as presented in F 3.1, demonstrates the execution of the 1993 asylum and Immigration Act, the 1996 Immigration and Asylum Act and the Immigration and Asylum Act 1999.

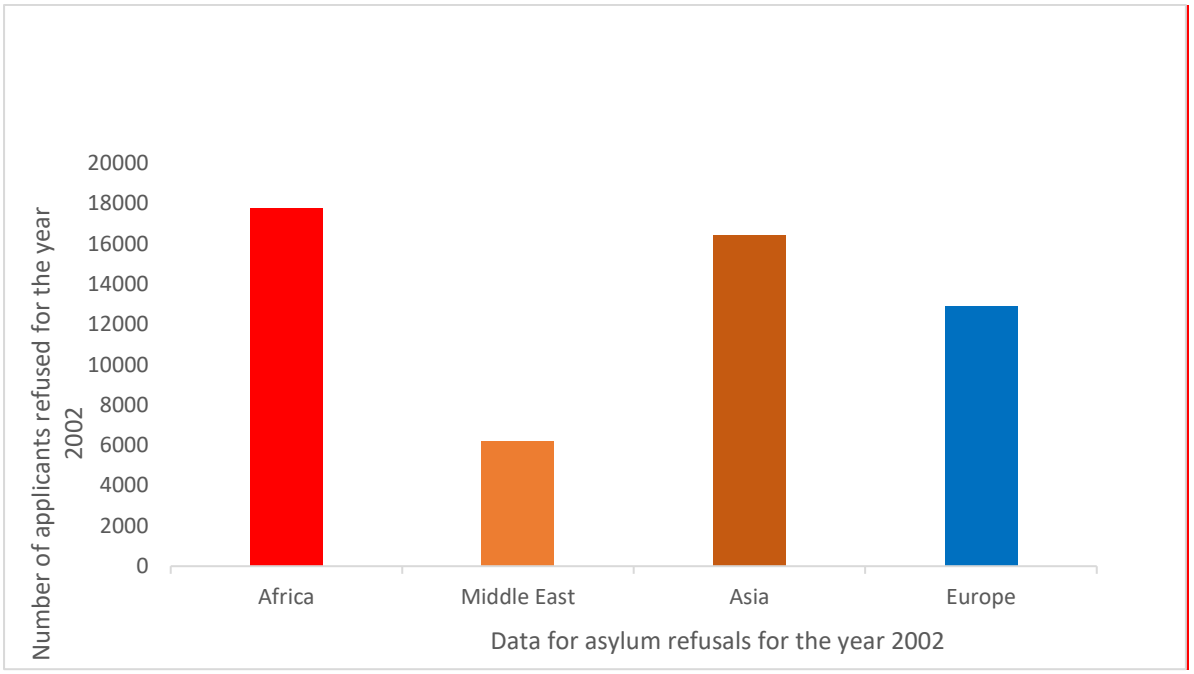
Fig:3.1: Graph demonstrating an increased in immigration refusal in the UK from 1994 to 2002.



The graph shows a high gradient demonstrating an increase in the number of applications refused in the UK during this period aimed at reducing Asylum seekers in the country, and this demonstration represent the achievements of the British immigration control between 1994 through 2002 with a high number of refusals in both the border of entry and other agencies. The increased as mentioned on the graph rosed from 70% to about 81% and above. The statistics demonstrates a progressive increased in the number of asylum refusal in the United Kingdom from 1993. The progressiveness of this approach could be seen from the relative increased in refusal based on the number of applications. For example, 1994 had 32830 applicants and 16500 were refused, in 1995, 43965 applicants and 21300 refusals, in 1998, 46015 applicants and 22315 refusals in the year 2000, 80315 applicants and 75680 refusals and in the year 2002, 84130 applicants with 55130 refusals.

Focused on the data for 2002, it demonstrates that asylum seekers of ethnic minority countries such as Africa and Asia faced the highest numbers of refusal in the UK as compared to their counterparts of Europe and America when they apply for asylum or any form of protection, with Africa recording 17745 refusals, Middle East recording 6216, Asia recording 16415 and Europe recording 12 890, as demonstrated in Fig 3.2

Fig:3.2; Data of asylum refusal for the year 2002, demonstrating applicants from the ethnic minority countries such as Africa and Asia facing the highest numbers of refusal in the UK as compared to their counterparts of Europe and America.



In 2006, the Immigration and Nationality Act was also promulgated. This act instituted the recognition of migrants in Immigration Detention Centres as ineligible to national minimum wage(s) for work done within these centres. This, act subjects the migrants in these centres to unpaid or underpaid labour. The creation of the Border and immigration agencies were between 2007 and 2009, and this came as a result of the 2006 crisis pointing at some systemic failure in both prisons and immigration, (HM Inspectorate of Prisons, 2007). In this crisis, some foreign nationals had been released from prison without consideration of whether they should be deported and were further assumed to be deportable. Foreign nationals who had been in open conditions, or were on licence in the community, were returned to closed prisons, even if their behaviour had been exemplary. The crisis prompted the rebranding and turning the IND into an executive agency that was created in 2007. As per this research these changes had no major significance than justifying the act of the British government against migrants and this further explains the role of the law in capitalist Britain in immigration control.

In 2008, the immigration rules introduced the first points-based system permitting migrants to be admitted into the UK based on their qualification under the labour government, (Donald, 2016). This system prioritises skills and talents over where the migrant is coming from and made up of different tiers. And prior to BREXIT, and because Britain was a member of the European Union, the point-based system or rule was only applied to migrants outside the EEA. The first tier (Tier 1) of this point-based system consists of high valued migrants with exceptional talents and skills and those with high net worth to invest in the UK. The second Tier (Tier 2) was for migrants with skills of jobs that can't be fulfilled by UK or EEA workers. Tier4 was meant for students while Tier 5 was meant for temporary migrants, (Rasquinet, 2018). Tier 3 on its part was meant to be made up of migrants in-between skilled and unskilled workers, which was later on stopped by the UK, (Donald, 2016).

Looking at the trend of immigration control between the period 1997 to 2010 under the government of the Labour Party, immigration control was more focused on refugees and asylum to the extent that these group of persons were being seen from a negative perspective with emphasis on considering them as deviant and dangerous to the growth of the British society, (Mulvey, 2011).

After the Labour Party, came the coalition government between the Conservative and Liberal Democrats from 2010 to 2015. From 2010 to present date, with the continuation of the concept of the Hostile environment in the UK. This was done specifically with the main aim of making life unbearably difficult in the UK for those who cannot show the right paperwork or those whom they considered illegal in the UK, as intimated by the then Premier, Theresa May. Or, as she said in her words at the time; “The aim is to create, here in Britain, a really hostile environment for illegal immigrants”, (Joint Council for the Welfare of Immigrants, 2021). This was all done and portrayed to be protecting legal or regular migrants.

Methven, (2019) holds that the Hostile Environment started about 70 years in the post-war periods in the reign of Winston Churchill who took to promoting post-war racist policies that helped formed the Tory Party Hostile Environment behind the Windrush scandal. Wardle et al, (2019), considers the recent Windrush scandal to be an extension of the longer history of colonial relations between Britain and the Caribbean and as a further reason to demand reparations for slavery. The Tory Party, decided to go by the reigniting this concept, and it had a huge impact on the lives of migrants in the UK, (Sheona, 2018). The Windrush Scandal is a British political scandal that began in 2018 and concerning Caribbean people who were wrongly detained and denied their legal rights and threatened with deportation with at least 83 of the cases wrongly deported to the Caribbean by the Home Office.

It deters migrants from going to the hospitals and also from reporting crimes and unsafe working conditions. The policy approach of charging and exposing the data of this vulnerable group of persons creates an atmosphere of fear and leaves them with increased risk of contracting disease and withdrawal from attending health centres, (Weller et al, 2019).

With regards to housing, it reduces the options of the undocumented migrants from renting a home and pushes people into poor quality or even dangerous accommodation, at the mercy of their landlord. During the Covid-19 period, the policies towards housing have also restricted the ability of this group of persons from adhering to public health guidelines during this period and increasing their chances of contracting these diseases, (Dona, 2021)

Hostile Environment policies also converts doctors, landlords, teachers, and other public and private sector workers into immigration workers. The checks in hospitals, by landlords and other sectors offering services to migrants converts these sectors to immigration checks centres, (Griffiths et al, 2021)

The 2014 and 2016 Immigration Acts are some of the acts promulgated during this period with main aim of instituting the hostile environment by controlling and or limiting migrants' access to health care and other services in the UK, which the government considers as justification for effective immigration control. In 2017, the government signed a Memorandum of Understanding with the NHS and the Home Office for data sharing of patients and considered it effective immigration enforcement whereas it is in the context of creating a Hostile Environment for migrants through racial profiling, (Hiam et al, 2018).

The Tory Party's immigration control reflects as an extract of the 2013, Immigration Bill Factsheet overview of the 2014 Immigration Act where the Immigration Minister, Mark Harper MP said:

> "The United Kingdom has a long and proud history of immigration. Our immigrant communities are a fundamental part of who we are and we are a richer and stronger society because of them''.
>
> "But the public expects and deserves an immigration system that is fair to British citizens and legitimate immigrants and tough on those who abuse the system and flout the law''.
>
> "The Immigration Bill will stop migrants abusing public services to which they are not entitled, reduce the pull factors which draw illegal immigrants to the UK and make it easier to remove people who should not be here''.
>
> "We will continue to welcome the brightest and best migrants who want to contribute to our economy and society and play by the rules. But the law must be on the side of people who respect it, not those who break it'', (Immigration Bill Factsheet overview of the bill, 2013).

Digesting from the minister's quote, he expressed the need of the British government to protect genuine migrants. He also gave the need to protect the immigration system by fishing out those they believed are abusing the immigration system of the UK for the benefit of those they consider regular or legitimate.

From the perspective of the universal right to health as enshrined in CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), the immigration act does not only punish the irregular migrants as intimated by the immigration minister Mark Harper, MP, it creates a hostile environment for these

migrants and facilitate the extraction of huge money from them into the system, deprives them of their fundamental human rights to health, housing and other services such as the right to work. This could be seen through the immigration detention system where a new form of labour market is created through the immigration removal centres and prisons acting as cheap labour centres to some private and public companies in the UK where detainees are picked to work for lesser pay rates, (Burnett et al 2010).

Looking at the trend of immigration control during this period, (Between 2010 to 2020), Hiam, (2018) suggest that the immigration control is considered to be for effective immigration control and protecting the regular migrants of the UK by discouraging those they considered irregular. In practice, the immigration procedure creates uncertainty and causing a huge negative effect on all migrants.

These legislations are intended to create an atmosphere of extracting money from these group of persons. The hostile environment creates an environment of fear for these vulnerable population subjecting them to Labour exploitation and other forms of financial exploitations, (Lewis et al, 2015).

After going through the history of immigration control of the UK and taking note of some key points with focus on the attack towards migrants, a further insight was visible demonstrating the consistent priority or trends placed to back the political agenda and to the interest of the British ruling classes above the interest of the refugees and other migrants in the UK.

The trends of the immigration control from the inception of the 1905 Alien's act have always been to control, limit and punish migrants in the UK. The limitation and controls emerge through instruments like the Commonwealth Acts of 1948, 1962, and 1968. Other aspects of these rules could be seen from the implementation of the 2016 Immigration Acts which introduces new methods of application to the regulations and punishes landlords and employers for dealing with those migrants considered as irregular.

As for the institutional arrangement of immigration control, some aspects of UK border structures and control could be visible prior and after the inception of the 1905 Aliens Act which was one of the pioneer Acts of immigration control in the UK then followed by the Commonwealth Immigration Act (1948, 1962, 1968, ect) that controlled restrict the entry of Commonwealth citizens into and out of Britain.

Generally, the UKs' institutional arrangement for immigration control devolves from the Home Office that was established in in 1782. The structure starts from the UK immigration service or the Aliens Branch from 1905 to 1933 or the Immigration Branch of the Home Office from 1933 to 1973 which were responsible for the day to day operations of the UK Border controls at 57 designated ports (airports, seaports, the UK land borders with Ireland and the channel tunnel) (Hansard 2007) and as part of this responsibility the detection and removal of immigration offenders such as undocumented immigrants, illegal workers and over stayers and to prosecute related offences.

These Immigration Branches or services were functional till their disbandment in 2007 with the creation of an executive Branch of the British Home Office Known as the UK Border and Immigration Agency, specifically on the 1st of April and replaced by the UK Border Agency (UKBA), that was a merger of the Border and Immigration Agency, (BIA) , the UK Visa and the Port Customs Function of HM Revenue and Customs . The UKBA that was part of the Home Office was replaced by the Immigration, Border force and immigration enforcement of 2013, all under the Home Office to carry on the same functions as the UK Immigration Branches enumerated earlier.

The policy direction of immigration towards asylum seekers and refugees who are a particular and vulnerable group of persons indicated in the previous paragraphs, shows how impacting they could be on the group of persons and their lives in general. In a study carried by Bloch, (2000), on the direction of the social policies in the UK towards refugees and asylum seekers demonstrate how impacting these policies are to the participation of these asylum seekers and refugees in the communities. The case study for this research was that of 180 refugees and asylum seekers from Somalian, Tamil and the Congolese community in the London Borough of Newham. In examining the direction of social policies towards refugees, asylum seekers and other forms of migrants as well as the impacts it causes on their participation in activities in Britain, the research came out with the following findings.

On examining the participants' interaction of social and economic participation with immigration status by Bloch, the research findings demonstrates that there is insecurity that asylum- seekers experience while waiting for their cases to be determined and that this impacts every aspect of their lives.

As part of the findings, pertinent points such as their exclusion from economic life and in some cases from welfare benefits to create an impossible atmosphere for them to participate in the country of asylum.

This case study of Bloch is so important to this research because it deals with the impact of directing policies towards asylum seekers which is similar to the direction of policies towards the control of access to health care of migrants in the UK. The findings arrived at by Bloch, (2000) would go a long way to assist this research in getting the impacts of hostile environment and other aspects of immigration control on the health and access to health care of migrants in the UK.

Legal framework of immigration control relating to Migrants' health and access to health care in the UK, as applicable in England and Wales.

The previous section discussed the history of the immigration control and the structure of the UK immigration laws, which elaborates on the origin and nature of the laws, this section will be specifically dealing with the aspects of the laws that controls immigration including the institutional, political, social and economic aspects of enforcing the laws in England and Wales.

The discussion here will be done in two parts with first part establishing the legal framework of British immigration control with consequences on migrants' health and access to health in England and Wales.

The second elaborates on aspect of comparing the application of these legislation in both England and Wales, in this section, I shall be bringing out the similarities and differences applicable in both countries.

Establishing the legal framework as introduced will permit the research to be specific in the selected areas to answer the research question and in line with the data collected.

The section also demarcates the assessment of the impacts of the immigration act of the UK between the period of 2010 and the end of December 2020 just before the implementation of the Brexit rules. Some aspects of applying the laws would be considered from the period prior to 2010, for the purpose of establishing the trend and continuity in the objectives of the British Immigration control since the inception of the 1905 Aliens' Act.

Conducting the research within this period (Periods beginning 2010 and December 2020) will permit participant who have experiences prior to this period and those with experiences within this period to provide data that will help establish the continuity of the British immigration control and the consistency of their actions towards migrants in the UK from the inception of immigration control.

Legal Framework of migrants' access to health care in England and Wales.

This section lays down the foundation of the application of the rules of accessing healthcare facilities by migrants in both England and Wales.

This section will also explain the laws relating to the different services offered in both countries and how they treat the various categories of migrants in the process of accessing health care and in the course of doing, the aspects of comparison would be put in place.

As per the legal dispensation of the UK, all those considered as ordinary residents are entitled to free primary health care in all walk-in centres, free registration with the General Practices, (GP), free care at all accident and emergency care, and free diagnosis and treatment of all infectious diseases, (Doctors of the World, 2015).

For the purposes of controlling access the National Health Services (NHS), the 2014 Immigration Act defined an ordinary residence as reference in the NHS charging regulations as persons not ordinarily resident in Great Britain or persons not ordinarily resident in Northern Ireland includes,

(a) persons who require leave to enter or remain in the United Kingdom but do not have it,

and

(b) persons who have leave to enter or remain in the United Kingdom for a limited period.

And it is on the basis of these that the 2014 immigration act as amended are applicable on access to health for migrants in the UK.

Prior to this legislations, (2014 and 2016 Immigration Acts), the 1971 immigration act (section 1), and the British Nationality act 1982 (section 1), stated that ‘’a person is settled in the UK if they are ordinarily resident in the UK without being subject to

immigration time restrictions''. And furthermore that ''a child born in the UK will be a British citizen if either parent is settled in the UK at the time of the birth''.

In the prominent case of R v Barnet LBC ex-parte, Shah [1983], 1AER, 226, the House of Lords defined the concept of ordinary residence to imply having a particular mode of life for a considerable time as stated bellow;

> ''ordinary residence is established if there is a regular habitual mode of life in a particular place for the time being, whether of short or long duration, the continuity of which has persisted apart from temporary or occasional absences, residence must be both, voluntary and adopted for a settled purpose. And that a person can be ordinarily resident in more than one country at the same time, distinguishing it from domiciled. And that an ordinary residence is proven more by objective evidence than evidence of an individual's state of mind at a point in time''

This judgments' position for ordinary residence was reliant on the decision of the party who decides to make a particular place their home. In this decision, the party (Migrant or resident of the UK) has a right of choice of whether to be an ordinary resident or not, the Immigration Acts are used as an instrument to deprive these individuals or to take away that right from them. This is an example demonstrating the role of the law as an instrument of oppression.

This example will help in the analysis of the data to determine whether the role of the laws is to suppress or protect the migrant population. The outcome with help in determining the impacts of the laws on health and access to health of the migrants.

In looking at the legal dispensations for England and Wales in this section, I shall be differentiating the Acts which are national status or Legislations from the Regulations which are the instruments or directives for the implementation of these Acts.

In addition to the fact that the thesis is looking at the impacts of the immigration rules on health and access to health care of a group of persons indicated within the period of 2010 to the period of November 2020, this section will also be out to show the continuity of the Acts and other instruments promulgated prior to this period and how consistent they have been in the sustenance of the culture of the British Immigration control since the 1905 Aliens' Acts.

Prior to the 2010 period, this research traces the British immigration control to the 1905 Aliens' regulations and to the post war period beginning from 1945. The post-war period, characterised by an influx of migrants from other parts of the world including the commonwealth countries that triggered the reinforcement of border control, (Marshall, 2021).

The main groundworks were put in place between 1945 and 1960s, as discussed in the previous section. As for the Regulations prior to the 2010 period to oversee the implementation of the statutes and with regards to health care, the main statutory regulation is the National Health Service (Charges to overseas visitors) Regulation 1989, statutory instrument No 1989/306 for England and Wales and amended as follows,

The National Health Service (Charges to overseas visitors) Regulation 1991 (SI No 1991/438), introducing exceptions for family planning services for England and Wales,

The National Health Service (Charges to overseas visitors) Regulation 1994, (SI No 1994/1535), removing dental and optical emergency departments from the services exempt from charges and amended the list of diseases for which no charge shall be made for England and Wales,

The National Health Service (Charges to overseas visitors) (Amendment) Regulation, Wales (SI No 2004/1433), to tighten loopholes and modernise the charging regime.

Specifically and for England, the National Health Services (charge to overseas Visitors), (amendment) Regulations, 2004. In this regulation, there have been multiple changes to the health policy to regulate migrants' access to health, one of which restricted migrants to aspects of health that were to be accessed for free.

The National Health Service (Charges to overseas visitors) (Amendment) Regulation, Wales 2008 (SI No 2008/2364) introduced a new category of exemption for health services for victims of Human Trafficking.

The National Health Service (Charges to overseas visitors) (Amendment) Regulation, Wales 2009, (SI No 2009/1512) to introduced amendments to failed asylum seekers, Missionaries, and spouse, civil partner, and children.

The National Health Services (charges) (Amendment Regulation Relating to the Pandemic Influenza Wales (SI No 2009/1175) which adds pandemic influenza to the list of diseases that are treated for free.

Immigration statutes post 2010.

The post 2010, immigration statutes for the UK are;

The 2014 Immigration Act, which makes provisions for health charges to be instituted on migrants and foreign visitors into the UK. It also introduces the definition to an ordinary resident of the UK. It also makes provisions preventing landlords from renting houses to some migrants,

The 2016 immigration Acts which introduces sanctions on illegal working and further stricter measures on the application of immigration rules in the UK.

Regulations.

The enforcing regulations that came in during the period beginning from 2010 onwards in England and Wales were.

The NHS (Charges to Overseas Visitors) (Amendment) Regulation, England 2015. It came into force on 6 April 2015 and apply to all courses of treatment commenced on or after that date.

The NHS (Charges to Overseas Visitors) Amendment Regulations, England 2017. which had the effect of: (i) mandating upfront charging of overseas visitors for treatment that is not “urgent”; (ii) requiring NHS trusts to flag on their record whether an overseas visitors is chargeable; and (iii) extended charging to all secondary services funded by the NHS, regardless of whether those services are provided by NHS or other providers; or whether they are provided at a hospital or in a community setting.

The National Health Service (Charges to overseas visitors) (Amendment) Regulation, Wales 2020 (SI No/113). Which adds Coronavirus to the list of diseases listed in Schedule.

The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2020, The National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) (EU Exit) Regulations 2020.

Comparing the implementation of the rules between England and Wales.

From establishing the legal framework of the application of health care services to migrants in both England and Wales, the next stage will be comparing how the application is in both countries to assist in answering the research question in that direction.

Comparing the application of the legislation in both countries will provide the opportunity for the reader to understand how migrants treated in the different parts of the UK with regards to accessing health care.

Differences.

The implementation of this instrument in England and Wales differ in the following ways.

The guiding regulation for Wales (Implementing the Overseas Visitors Charging Regulations, Wales) deals with cases of overseas persons that need the NHS trust services only in Wales. Special situations such as general practices (GP), dental and optical practices are governed by the WHC 1999/032 while that of England (Guidance on implementing the Overseas Visitors Charging Regulations, England), deals with cases of overseas persons that need the NHS foundation trusts, NHS trust services only in England. Relevant services in England are those provided or arranged under the 2006 NHS Act except for, primary medical services provided under part 4 of that Act, primary dental services provided under part 5 of that Act, primary ophthalmic services provided part 6 of that Act; and equivalent services provided under that Act, all governed by the HSC1999/018.

In Wales, the trust organizations are bound by these rules to inform the Welsh Assembly via OVIS form (Overseas Visitors Forms) if the services are offered to non-residents in the UK from countries with whom the UK have a bilateral health agreement to assist the government at its national level in maintaining or striking a fair balance between its citizens and foreign patients. While in England the trust organizations are bound by these rules to inform the department of health via an IGA (Information Governance Alliance) form if the services are offered to non-residents in the UK from countries with whom the UK have a bilateral health agreement with to assist the government at its national level in maintaining or striking a fair balance between its citizens and foreign patients.

In Wales, the rules states and directs that the trusts and the public must seek advice from the Welsh Assembly by contacting the Policy Officer about any aspect of guidance that needs clarification and lastly that the guidance rules supersede and replaces all previous guidance in Wales while that of England is done by informing the Department of Health.

There is an existing linguistic and cultural differences between Wales and England which affects the manner in which the immigration instruments are applied in both countries. In Wales, the Welsh language is common in all environments including hospitals with an increase in demand for the language to be introduced in all sectors of the Welsh health care to serve those who use it as first language, (Murray, 2001) while in England, it is predominantly English.

The participants of this research are from countries with English as their first language which means they may find it difficult to participate in an environment where they are no familial with the language. Language barrier can affect both the provision of effective and necessary health care services as well as accessing the services, (Ali et al, 2018)

SIMILARITIES.

In both Wales and England, the immigration Acts (2014 Immigration Act, for example) requires the NHS to provides health care only to those who live in the UK and not to those outside the UK regardless of whether they have a UK passport or they worked and made tax contribution in the UK before.

Secondly, the guidance rules place an obligation on all NHS trusts in both Wales and England to sort out all those who are not UK citizens and that are requiring their services for payments to be made.

The elaborations made on the application immigration legislation in both England and Wales gives the research a broad base to assess their impacts on migrant's access to health care and this will also help lay the foundation of the role of capitalism on the NHS and its rules in the next section.

NHS Social Policies and capitalism.

After establishing the social structure and legal framework of immigration control of the UK in the previous sections, this section outlines the role the NHS plays in British Imperialism and capitalism to affect the right to health of migrants.

The policy approach of controlling access to the NHS by the British system and specifically that of England and Wales is considered to be the tools of executing imperialism and capitalism and this will also be analysed in this section for an understanding of their influence on the service users.

The research being focused on the NHS, which is the main health provider of the UK and by getting a knowledge of the role this institution plays in Capitalism and imperialism, would help in establishing the impacts of the British state and laws on the health and access to health of migrants.

Since the creation of the NHS in 1948, the organisation has become a symbol of British Welfare Capitalism with the generated ideology of Racism affecting the careers and lives of some physicians of the Black Asian Minority Group, (Vermon, 2021).

The treatment of 'overseas health workers' within the NHS in Britain is drawn on a complex interplay between racism and nationalism underpinned by the historical construction of the welfare state through internal and external immigration controls introduced with the aim of regulating migration and migrant labour through strict visa control and work limitation in some cases. This treatment in total keeps some of the migrants aspiring to get into the medical core at threat and this at times induces them into considering the unfair treatments within the NHS to be normal, (Kyriakides et al, 2003).

Racism within the NHS could be explained from the fact that Physicians from ethnic minorities account for 35% of hospital-based doctors in the UK, but comprise only 20% of consultant specialists, (Spooner, 2003). This creates a serious problem of marginalisation on the part of the BAME group within the NHS as asserted by Dangerfield, (2012) that around 1% of NHS chief executives are of black and minority ethnic (BME) origin, health service figures show.

In confirmation of the problem of institutional racism or racial inequality within the NHS that affects acceding positions of hierarchy within the NHS, Yvonne Coghill, who is national programme leader for equality in the health service, said "I believe it is an

issue that there are not enough BAME executives,**"** she said further that "If you are working at that level and aspiring to be a senior leader and you look up and you don't see anybody like yourself up there, it's automatically going to demotivate you.", (Dangerfield, 2012). This explains the impact of the existing reality within the NHS that discourages existing BAME staff of the NHS from working to get to administrative post within the NHS.

This discriminatory phenomenon against the Black Asian and Minority Ethnic (BAME) staff has been existing and manifested to present date in the NHS employment history even with the introduction of some regulatory instruments such as the Race and Amendment Act of 2000 inclusive of other policies made to encourage equality within the NHS, (Kline 2013).

The assertion of institutional discrimination of the BAME group within key institutions of the UK is contained in the MacPherson report of 1999 where he investigated the failure of the police in properly investigating the murder of a teenager, Sir William Macpherson Stephen Lawrence and came out with the concept of institutional racism in the UK, which he defined as ‘’The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, religion, belief or ethnic origin’’, (Lawrence report, 1999). To buttress this point, the (BMA, 2021) highlighted the existence of structural race inequality within the NHS and attributed same to the legacy of historic discriminatory processes and policies in existence within the NHS.

In a survey of the Bradford Teaching Hospital Foundation Trust (BTHFT), NHS Bradford and Airedale (NHSBA) and (Bradford District Care Trust (BDCT), 2010), some points were outlined on how the inequality within the NHS has affected the BAME group and these points were as follows.

That national patient surveys show lower levels of satisfaction amongst BME patients.

Young black men are six times more likely than young white men to be sectioned for compulsory treatment under the Mental Health Act.

The prevalence of stroke among African Caribbean and South Asian men is 40% to 70% higher than for the general population.

South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population.

In the UK, men of Black African and Black Caribbean descent are three times more likely to develop prostate cancer than white men of the same age.

The above points confirm the existence of institutional racism in this part of the country and the impacts it has on the Ethnic Minority population and specifically those from black background. Though the third, fourth and fifth points listed here earlier are genetic to the BAME group, the impacts of further factors such as racism and other racial discrimination and segregation causes them to impact migrants from accessing health care in the UK.

While confirming the establishment that people from BAME groups experience poorer health than the 'ethnic majority in a Briefing Paper of the A Race Equality Foundation, presented by Karlsen, (2007), the points below were raised, and confirmed later by Phelan et al, (2015), Razai et al, (2021),

That People from minority ethnic groups do experience poor treatment due to the negative attitudes of others regarding their character or abilities. This occurs in their day-to-day interactions with other people as well as in their access to and interactions with services. Racist attitudes have been shown to affect health in a variety of ways. Understanding these processes is important for the development of effective policies to reduce the health disadvantage experienced by people from minority ethnic groups in the UK''

That people respond to racist experiences in different ways and that this makes evidence of victimisation difficult to establish. In addition, the particular form it takes and victims' responses to it have an important influence on the health impact of victimisation''

That Healthcare services have an important role to play, as a domain for racist experiences and as a source of support for victims and in this case, we are referring to the NHS services. There is evidence that the responses of services to victimisation can influence health, in both good and bad ways.

NHS used as a tool by the ruling class.

Of recent, the capitalist and discriminatory approach is what the UK Tory governments have been using the NHS to maintain their control over the ethnic minority population, (Wright 2010). It is also evidenced that the NHS has been in coexistence with racism in both structure and administration, and this approach has been consistent with other governments of the UK, (Eversley, 2010). One of the main approaches by which the NHS is being used to attain these objectives is the multiple political interventions through legislative reforms. The labour government came up with the 2004 Immigration Act that has as objective to limit the role of the court in immigration appeals by introducing single-tier Asylum and Immigration Tribunal and The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004 for NHS trust hospitals in England and Wales, This regulations were meant to amend the National Health Services (Charges to overseas visitors) Regulations of 1989 which provides for making recovery of charges for health services provided to certain persons who are not ordinarily residents of the United Kingdom.

The introductory chapter of this regulation (Guidance for NHS trust hospitals in Wales of the 31st of May 2004) states as follows.

> ‘’The National Health Service provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived and paid National Insurance contributions and taxes in this country in the past’’.
>
> ‘’This guidance is concerned with what should happen when people who do not normally live in the UK need treatment provided by a NHS trust in Wales. Treatment for overseas visitors from a general practitioner (GP), dentist or optician is dealt with in WHC 1999/032. Separate Regulations govern the charging arrangements in England and Scotland. There are at present no charging arrangements in Northern Ireland’’.
>
> ‘’The charging Regulations place a legal obligation on NHS trusts, in Wales to establish if people to whom they are providing NHS hospital services are not normally resident in the UK. If they are not, then charges may be applicable

for the NHS services provided. When that is the case the trust must charge the person liable (usually the patient) for the costs of the NHS services''.

The 2014 Immigration Act was promulgated to implement Charges to overseas visitors. In 2015, a consultation on the extension of charging overseas visitors and migrants using the NHS in England was tabled and meant to go through at the parliament without deliberation and implemented for 2017.

All these acts have as goals to charge overseas visitors for NHS health care services being accessed for free, and to put an end to overseas visitors outside the EEA benefiting from the free prescriptions of dental and optical services. The approach in its entirety thwarts the credibility of an organization that is meant to serve humanity such as the NHS which should be aimed at providing best and free health services to all at the point of delivery.

Established on the 5th of July 1948, the NHS was aimed as part of the Welfare state of the UK to provide free medical services to all British residents regardless of their financial situations or origin, so applying this approach by the minister would be defeating the purposes of its creation, (Routledge, 2012, Wathen, 2019).

Charging overseas visitors for services provided by the NHS could go a long way in breaching the moral obligation or the duty of care of medical practitioners to their patients as well as the obligations of advocates in upholding the right to health or human rights of the mases (Smith et al, 2018).

Scott, (2014) argued that the NHS has no better future with capitalism and suggested a socialist form of administration, or one that devolves entirely from the peoplew to get the NHS to its' deserved position. He tendered his dissatisfaction with privatisation of the NHS and other related companies, as this would not get to the objectives of the organisation. He advised that moving away from profit making tendencies such as charges on prescription and other services would lead the NHS to its' desired height.

Explaining the role of NHS in British capitalism would permit us get an understanding of the stages of analysis of the data collection and to come out with the answers to the research questions.

Effects of institutional racism in the UK during a period of health crisis.

During period of health crisis such as the covid-19, pandemic institutional racism has a very huge and negative impact on the BAME group of England and Wales, (Public Health England, 2020, ONS, 2021). Consultant Sinha, (2020) held the position that white supremacy within the NHS had a huge negative impact on the BAME group especially when they stand up to request for equality in treatment during this period.

Institutional racism is increasingly higher during periods of health crisis as earlier explained in this section for the ongoing Covid-19 pandemic. While confirming the alarming and disproportional impact of the Covid-19 on the BAME group, Farah, (2020), blamed the government for failing to take their responsibility of curbing racial inequality with the health sector of the UK.

The report of the ONS, (2021), holds that due to racism within the NHS during the Covid-19 pandemic, people of the ethnic minority group were more exposed to the consequences of the pandemic. Same report suggests that people from the ethnic minority background in both England and Wales are more likely than those of white background to live in areas where deprivation has worsened since 2011 and that the mortality is more in areas of deprivation.

The Commission on Race and Ethnic Disparities, (2021), also holds that the institutional racism within the NHS is the cause of disparities in infection and deaths between the white race and those of the Ethnic minority. That people from the Ethnic minority are faced by an increase in risk of infection and deaths than those from the White race during this period.

Migrants Housing in the UK and their health impacts.

This section is a continuation of the previous section which deals with the housing effects on health.

After listing the health effects of housing in the previous section, it is time to bring out the type of housing accorded to migrants in the UK to be able to relate this to their health effects. Housing being considered as a determinant of health; this section will permit the research to come out with the impacts of health and access to health care.

Housing in this research is one of the fundamental human rights enshrined in the international instruments discussed in the next section and ratified by the UK.

Depriving migrants of the best attainable values of this right would be breaching their rights as mentioned in the next section.

Knowing the health impacts of housing in the previous section, and now the type of housing accorded to migrants in the UK would situate our focus of the research on the research topic, and while applying Marxism, provides us with a deeper understanding of the laws applicable in immigration control.

The research would be considering two categories of housing for migrants, and this would be in relation to undocumented and documented migrants as earlier discussed in this chapter.

The housing or accommodation journey for migrants in the UK could be seen in two categories, with the first category made up of housing provided by the government through the Home Office and related charities based on certain conditions, guided by the provisions of the Asylum and Immigration Act 1999, (section 4, 95 and 96 are the commonly used article) to those who prove destitution, (Smart, 2009), (Section 95(1)(b)). In this category, we have the migrants with unsecure immigration status such as asylum seekers, failed asylum seekers, refugees and overstayers.

The second category is that of houses provided to migrants who are legally authorised to enter a housing contract either with the council or private landlords and may also be assessed on the basis of possessing the financial capability to secure accommodation for themselves or to support their family members and relatives. In this category, we have migrants with secure immigration status such as those with definite and indefinite leave to remain, those with status from other European states and who have migrated to the UK through the routes of the European Union or treaties, and their dependants.

Housing for those with insecure immigration status.

Initial or temporary housing support.

The support is on temporary basis through section 98 of the immigration and asylum act 1999, pending the provision of the housing support of section 95[9] of same law.

According to this section, the Home Office offer support' in the form of temporary full board short term accommodation, if an asylum seeker is likely to become destitute, pending the section 95 application for longer term support is being considered. They get eligible refugees and asylum seekers into an initial accommodation which is a hostel-styled accommodation for a short period of time (About three to four weeks, renewable) before their various accommodation and financial applications are made.

Dispersal

The dispersal phase is when the government through the home office and other organizations places migrants to accommodations throughout the country in a way or fashion, they so desire. The Charities on their part can also act by carrying on same process of scrutiny and either lodging the refugees and asylum seekers in their various accommodations pending confirmations from the home office or carry on a referral process to the home office for further action. At this stage of the state assistance, the provision of accommodation is governed by the Asylum and Immigration Act 1999 and mostly section 9.

As mentioned in the previous paragraph, housing of section 98 is meant only for temporal basis which is the initial accommodation offered by the home office as it is deemed insufficient to cater for the needs of the destitute, but that is not the case in practice. Section 98 have been in constant use to provide both short termed and long termed support for asylum seekers during the pandemic and that has been affecting them seriously as evidenced in the case of JM and the Secretary of State for Home Department ref-[2021]EWHC2514(Admin). It was held in this case that using the section 98 support during the period of Covid-19 crisis was illegal, and insufficient to support the applicants in their situation.

[9] Section 98(2); Support may be provided under this section only until the Secretary of State is able to determine whether support may be provided under section 95.

Similar controversy occurred with the Napier Barrack in Kent and the Penally Barracks in Pembrokeshire which were meant to be used as initial accommodation or section 98 for short term, but people were being kept there in unhygienic conditions for more than the time required. This caused some healthcare professionals to raise concern on these barracks that housing refugees in military barracks do provoke flash back to some refugees fleeing from war thorn areas and getting them into more mentally instability. That the barracks do look abandoned and lacks adequate medical and other care facilities with over crowdedness and far from the needed healthcare facilities during the covid-19 period, (Grierson, 2020).

Still on the application of section 98 accommodation rules, a high court ordered the rehousing of an asylum seeker from the Napier Barrack as his lawyers argued that he was forced to sleep on overcrowded, unsanitary, and unsuitable army barrack and that he has been subjected to prisonlike conditions, (Grierson, 2021).

Long-Term immigration Housing.

The next form of immigration housing in the UK is the long-term housing support from the Home Office, guided by section 4, 95, and 96 of the Immigration and Asylum Act 1999.

Section 4 of the Asylum and Immigration Act 1999 and the Asylum (Provision of Accommodation to Failed Asylum Seekers), applicable in line with The Immigration and Asylum (Provision of Accommodation to Failed Asylum-Seekers) Regulations 2005 in providing support for those whose asylum claim has been refused, who appear to be destitute and who are taking all reasonable steps to leave or cannot leave the UK.

The provisions of section 95 make a distinction of the persons entitled to the support and the criteria through which they are selected for the award[10].

[10] Section 95, (1) The Secretary of State may provide, or arrange for the provision of, support for—
(a) asylum-seekers, or
(b) dependants of asylum-seekers, who appear to the Secretary of State to be destitute or to be likely to become destitute within such period as may be prescribed.
(2) In prescribed circumstances, a person who would otherwise fall within subsection (1) is excluded.
(3) For the purposes of this section, a person is destitute if—
(a) he does not have adequate accommodation or any means of obtaining it
(Whether or not his other essential living needs are met); or.
(b) he has adequate accommodation or the means of obtaining it but cannot meet his other essential living needs.

Section 95 provides that an individual and his or her dependants who are seeking asylum in the UK and who are or likely to become, destitute are eligible to this support.

Claiming asylum here could either be at the airport, seaport or visiting the declaration centres for same purpose. Those coming in through the seaports and airports could be given initial accommodation or section 98[11] accommodation pending the application of the section 95 accommodation.

The support can either be in financial terms or through lodging as the case maybe but needs to be able to care for the person under destitution as prescribed in the section and the houses are offered on a no-choice basis in any location in the UK. According to Cheung et al, (2014), the approach of providing housing to migrants on a no-choice basis instituted by the 1999 Asylum and Immigration Act (Revising the 1996 Asylum and Immigration Act) mentioned above, has no positive effects on the migrants. A qualitative study conducted in Leeds UK by Dwyer et al, (2008) considered issues relating to forceful housing dispersal of migrants on a no choice basis to variety of locations in the UK under the requirements of the 1999 Immigration and Asylum Act and concluded that the tiering of housing entitlement existing in a particular and selected population (especially migrants of ethnic minority group) is as a result of a special legal status accorded them by the statutes and which in turns renders them susceptible to homelessness. They added that the provisions made by the law in question failed to meet the basic housing needs of many of the migrants and do request that the law be revisited. The dispersal of this group of individuals (Migrants) into various parts of the UK on a no choice basis, renders them vulnerable.

Detention centres.

As the name implies, it is used for detention and removal of immigrants from the UK. The UK holds a record as one of the highest criticised immigration detention systems due to the poor facilities involved and termed the largest users of detention centres for migrants in Europe, (Gill, 2016, Silverman et al, 2021). Some migrants are being kept in these centres during the process of the determination of their applications. Migrants are believed to faced series of issues ranging from loss of their rights to being stigmatised, (Kellezi et al, 2019), which may lead to suicidal thoughts and other life-

[11] Section 98, (2), Support may be provided under this section only until the Secretary of State is able to determine whether support may be provided under section 95.

threatening thoughts, (Kellezi et al 2016), that may also result to low quality life resulting from the distress and other forms of inhuman treatments they received therein, Bosworth et al, (2012).

We have Immigration Removal Centres (IRC), Prisons and Short-Term Holding Facilities (STHFs) which are predominantly used as detention centres.

Despite the health difficulties noticed in housing during previous health crisis, the UK during the Covid-19 pandemic still priorities detention centres with about 19,000 people placed under detention during this period, despite the outcry from the population of the UK for the lack of facilities during the first covid-19 lockdown, (Morphy-Morris, 2020).

Immigration Removal Centres.

These are centres holding foreign nationals awaiting decisions on their asylum application or awaiting deportation following an unsuccessful application and or other circumstances. There are seven IRC in the UK with the Harmondsworth removal centre being always the highest detention centre with high number of persons in detention, (Guild, 2016).

Formerly known as the immigration detention centres but changed to the Immigration Removal centres by the 2002 National Immigration and Asylum act to reflect the part it plays in removal of asylum seekers and other forms of migrants from the country and run under the detention rules 2001 with 615 bedspace capacities.

Human rights abuse and other inhuman practices are believed to be recurrent and rampant in most of these centres with the Harmondsworth Detention Centre noted for poor housing conditions for the detainees that results to deteriorate their health, (Athwal, 2016). Inhuman treatments such as Coerced exploitation and captivity of the detainees with no labour protection such as low or no wages for work done do exist in this detention centre, (Bales et al, 2018).

Short-Term Holding Facilities.

These centres are governed by the short-term facilities rules of the 27th of March 2018 and came into force on the 2nd of July 2018. These facilities are mostly attached to reporting centres and airports where people are being held under detention for up to 24 hours and not more than seven days.

Our assessment of the short-term holding facilities of the UK would be reliant on the Report of the National Inspection of the short-term holding facilities in the UK managed by the Border Force UK, (HM Chief Inspector of Prisons, 2020). This report outlines the deteriorating nature of these centres as well as their effects on the users who are mostly migrants. Some of these facilities are Aberdeen Airport, Bristol Airport, Cardiff Airport, East Midlands Airport, Felixstowe, Harwich International port, Immingham Docks and Killingholme Port. From this report, the chief of prison recommended urgent improvement. He noted the housing facilities were very and unfit to accommodate detainees, and also noted the poor administrative conditions that needs reshaped to suit the provision of the law.

Immigration detention in prison is when non-British nationals who have served their prison sentences and are held in Prison custody under the immigration powers awaiting deportation.

Housing for the migrants who are legally allowed to sign a house contract.

Having looked at the housing of migrants during their various applications for protection before the home office or as the case maybe, I shall be looking at the other form of housing which is usually after the determination of an asylum claim. During this period the individuals are asked to quit the section 95 or whatever accommodation offered them through the home office within a period of 28 days. For those Asylum seekers whose' cases have been decided with a negative outcome and appeal rights exhausted, the Home Office quit notice may lead to them becoming homeless or if they decide to go to their countries of origin, then the section 4 of the Asylum and Immigration Act 1999 support earlier discussed would be accorded to them.

This eviction process treats most of the asylum seekers renders most of them homeless and desperate and exposed to danger during pandemics, International Observatory Human Rights, (13th November 2020). Due to the harshness of the immigration system towards applicants, some of them decide to go homeless after eviction or undercover, (Djajic, 1997).

The concept of homelessness is explained in section 175 of part VII of the 1996 housing regulation as being related to the availability and other related natural occurrences[12].

Homelessness is presented by this Act as if people go homeless because of the unavailability of housing facilities and other natural factors while this research holds that homelessness experienced by some of the refuges and asylum seekers is a punitive approach exhibited by the hostile environment on the migrants and to be migrants from coming to the UK.

The research also holds that above concepts of homelessness apply to everyone who has not got the legal right to occupy any accommodation in the UK as is the case with Asylum seekers and Refugees, failed asylum seekers and other undocumented migrants. Francesca in a BBC interview, said this to Nagesh, (2018):

> ''In the UK, a person is considered homeless if they don't have a legal right to occupy any accommodation or if the accommodation, they are currently occupying is unsuitable to live in. So, I needed to prove to the council that staying on my Mum's sofa with my daughter was officially unsuitable to me''.

[12] Section 175, (1)- A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he-
(a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,
(b) has an express or implied licence to occupy, or
(c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.
(2) A person is also homeless if he has accommodation but—
(a) he cannot secure entry to it, or
(b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.
(3)- A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy.
(4) A person is threatened with homelessness if it is likely that he will become homeless within 56 days.
(5) A person is also threatened with homelessness if—
(a) a valid notice has been given to the person under section 21 of the Housing Act 1988 (orders for possession on expiry or termination of assured shorthold tenancy) in respect of the only accommodation the person has that is available for the person's occupation, and
(b) that notice will expire within 56 days.
The sense of someone threatened with homelessness as mentioned in section 175(4) could be explained in the provisions of the Homelessness reduction regulation 2017 as:
Section 1
(5) A person is also threatened with homelessness if—
(a) a valid notice has been given to the person under section 21 of the Housing Act 1988 (orders for possession on expiry or termination of assured shorthold tenancy) in respect of the only accommodation the person has that is available for the person's occupation, and
(b) that notice will expire within 56 days."

This quote from Francesca practically demonstrates the concept of homelessness in the UK as expressed by the Housing Acts 1988 and 1996 and the Homelessness Reduction act 2017. This explanation also demonstrates the reality on the migrants, most particularly the asylum seekers the asylum seekers who got to be given the accommodation of section 4, 95, 98 of the Asylum and Immigration Acts on a no-choice basis, migrants from the EEA and A8 countries who need to pass through the criteria and waiting time to be able to access council accommodations.

For refugees with leave to remain in the UK, the transition period between which they are granted leave to remain and securing accommodation for themselves is frequently that of tough time characterised by homelessness and all sorts of tortures, (Rowley et al, 2020). These refugees are given 28 days to secure accommodation for themselves after being granted leave to remain and this has frequently been an impossibility for these migrants to secure housing based on the financial and documentary criteria attached to the housing processes.

It is during this period they are expected to secure a job to be able to cater for their needs. Employers do request proof of address, employment history and other residential requirements for them to be able to secure the job.

It is during this period they are expected to get themselves a personal and secure bank account for financial transactions. Opening a bank account in the UK requires proof of address to be able to secure one.

It is during this period that they are expected to secure housing for themselves. While few are opportune to secure council houses of which each council in the UK have its own rules as to how to secure a house, and the council decides who to get the house based on point banding system. After the application, you are then placed on the waiting list till when you are offered one by the council. Of the other hand, the difficulty involved in securing a council house pushes a majority of migrants and others in need of housing to end up renting from private landlords and paying huge sums of money, (Perry, 2012, Power, 2021).

Similar rules for housing apply to the private landlords and estate agencies who would require applicants to provide prove of address and tenancy agreements from previous accommodation and financial deposit from migrants who have just been granted leave to remain for them to be able to rent a house.

I for one have been in a similar situation like Francesca from 2017 to 2020. I came to the UK through the Tier4 study Visa in January 2015 and in 2017, I was bound to seek for protection through asylum from the government of Britain due to my political involvement in Cameroon. On requesting for the section 95 accommodation, I was asked to prove myself destitute and I was not able to provide the documents needed and I was bound to stay in a friends' house and sleeping on his couch till 2018 March that my Leave was granted. Still, from March 2018 I couldn't rent a house of my own because the landlords needed a proof of address from a previous landlord. I managed to live in a friend's living room and sleeping on his couch for another one year just like Francesca did then my friend gave me a note that I took to one agent to secure my first apartment in January 2020.

Migrant Housing has been one of the main topics of debates in the UK with series of deliberations for solutions. Ranging from house shortage to the difficulties migrants encountered in accessing. In line with some of the reasons for BREXIT as well as the way forward, such as the future housing market, quality of houses as well as the recovery of the economy prior and after covid outbreak, (National Housing Federation, 2019).

Council Housing and private tenancy.

The next form of migrant housing we are to discuss here is the council housing. In this housing type, there are some criteria for which individuals need to attain to be eligible.

Refugees and Asylum seekers are only eligible for this housing when they have been granted leave to remain and or right to work in the UK. Workers from the EEA countries including those work have been temporary disrupted by health conditions or unemployment are also eligible for the council housing. Workers from the A8 countries are also eligible for the council housing. It is in this category of housing that the migrant participants of Cameroon and Nigerian origin with residence permits from other European countries do belong. We also have housing provided by the council to those who have or are suffering from domestic abuse, which is accorded after they have passed the Local Connection criteria.

The Report of the Chartered Institute of Housing (2007), points at very limited use of council houses in the UK. Same report indicates that very limited number of migrants are being accepted by the local authorities as homeless in the UK.

Migrants in UK council housing are facing the most difficult situations during the Covid-19 pandemic especially with the outdated nature of houses being used to house them. Because of this, council housing in the UK is rated the worst in the whole of Europe due to the deplorable conditions in which they are, (Hewitt, 2021).

Generally, migrant housing in the UK is in such a deplorable situation and analysed as the system using the housing situation to prey on the asylum seekers, (Wallace et al, 2022). Despite the glaring evidence of the poor housing, the system still pushes to the world that it is being taken advantage of by the vulnerable migrant population, this could be deduced from the government considering this as ''being generous'' and from utterances made by top political figures like Nigel Farage by calling these accommodation ''four stars accommodation'', (Hall et al, 2021).

As for the category of migrants made up of students and other form of migrants with short stay leave to remain, their housing arrangements are included in their application for visas and that secures their stay here in the UK as far as housing is concern. Their housing situation is dependent on the financial commitments presented at the time of their visa application and if upon entry into the UK, they have a change of situation, then they may risk being homeless as earlier explained.

This information and other literature on housing conditions of migrants in the UK including other sources will provide a first-hand information of the situations faced by migrants and gives the opportunity for the research to properly analyse the data collected to answer the research question.

Housing effects on health.

Since housing is one of the main social determinants of health, this section will be discussing its' effects on health. In discussing the health impacts of housing in this section, will permit the research get the consequences of migrant housing in the UK of the next section.

Housing being one of the social determinants affecting the health of migrants indicated at the beginning of the research, it implies that understanding the housing effects on health would mean understanding effects of the laws on housing on migrants and equally the effects of these laws on migrants' health and access to health care as required by this research question.

The asylum and immigration act 1999 primarily regulates accommodation for refugees and asylum seekers in the UK, it therefore means that the health impacts of migrant housing are influenced by this legislation.

The social structure of the UK discussed earlier in this chapter lays the foundation the health-related issues with migrants such as inequality is associated with quality of housing. Egan et al, (2015), in a study carried out in areas based on proportionality of investments in housing in some parts of the UK came out with the conclusion that; areas with high investments have improved health scores as compared to those with less investments. Implying that residents of areas with high investments would certainly have a quality health than those in areas with less investments. Hamoudi et al, (2013), in a quasi-experiment meant to examine the impact of the dramatic increase in housing prices in the United State in the 1990s and early 2000s on physical health outcomes among a representative sample of middle aged and older Americans, came out with the results that 'Respondents living in communities in which home values appreciated more rapidly had fewer functional limitations, performed better on interviewer-administered physical tasks and had smaller waist circumference''.

The nature of housing and environment determines the health outcome of individuals residing in the area. In the same line, children living in crowded environments, are more likely to be affected mentally through stress and anxiety, (Maller et al, 2006, Environmental Health, 2013). People in precarious housing area have worse health condition than those in adequate housing area and the more the elements of precariousness the more the health impacts as opined by Curl et al. (2015), in a study on housing improvement and health conditions in Glasgow UK through a conclusion that health gains are achieved more in areas where housing improvements are targeted and less in areas where it is not. During period of health crisis such as the Covid-19, the nature of housing which includes lack of basic infrastructures affects mostly people with informal settlement such as the refugees and asylum seekers and this prevents them from respecting the rules put in place during this period and thereby making them vulnerable to diseases. Nyashanu et al (2020), argued that this principle applies to all settings both low and high income and mostly with people with informal settings such as refugees.

Affordability is one of the aspects of housing that determines the wellbeing of the individuals. To an extent, the quality of housing acquired is determined by the financial

strength of the individuals and this goes to determine their health. The more quality and affordable houses are made available to the people the better their health. Atalay et al, (2017), in a survey on the effects of house price variation using samples of 19,000 individuals from households, income and labour dynamics in Australia (HILDA) for 2001-20015, and after examining the relationship between house price fluctuation and individual health by exploiting large exogenous change in house prices, came out with results that Increase in local house prices is associated with positive effects on the physical health of the owners and negative effects on the physical and mental health of the renters.

Homelessness is one of the housing situations that has a health impact on individuals. Desjarlais-de Klerk and K., A. (2016), in utilizing the homelessness management information system (HMIS) from Calgary Canada to examine the difference in physical and mental health between homeless individuals living in shelters and formerly homeless individuals living in government assisted housing, concluded that there were no significant differences in mental health between these two groups. However, and regardless of the housed status, they found out that past stress exposure, of homelessness negatively affected their mental and physical health though those housed are less affected than those not. Specifically, homelessness could also be seen to openly affect children with long-lasting conditions that could entail a long process for healing, (Augustin 1990). Pregnant women could also have a significant mental and physical health effect from homelessness as it could lead to their physical health being affected by the poor conditions of where they stay or pass their time. Mentally, being homeless is in itself a challenging thing to think so if a pregnant woman is found in that condition, it could affect their mental health from the stress, anxiety and exhaustion they experience, loss of control, loss of self-worth and isolation which may further impact her ability to take care of her physical health in pregnancy, (NSPCC 20016). Clark et al (2019) established in their investigation that unstable housing is a huge contributor to complications during pregnancy.

Considering that the area or location of housing can affect the health of individual, the research submits that when migrants are in one way or the other allocated housing in areas that are not healthy, there is all possibility that their health would be affected. One of the conditions considered by the research is that of environment which are highly contagious and overcrowded. Boomsma et al, (2017), on their part submitted

on the point that migrants are being forced to live in slum houses which are associated to disease transmission with less support and placing them in the position of less affordability thereby subjecting and relating them to poor health and wellbeing. Curtis et al, 2010, carried a study and found out that ‘’poor child health increases the likelihood of both overcrowding and homelessness and that it may also increase the likelihood of having inadequate utilities and general poor housing quality’’. In a research carried out by Lisa, (2006). She found out that children living in crowded areas are more likely to be affected by depression, anxiousness, stress, and other forms of abnormalities if not well taken into consideration.

The next section is discussing the housing accorded to migrants in the UK and this section has already put in place a foundation on the effects of housing on health. This would facilitate the association of the housing for migrants to the health outcomes and consequently the impacts of the immigration legislation.

Other determinants of health in the UK.

Having talked of housing as a principal independent health determinant, we have got to throw more light by discussing other social determinants to health which could affect or impact the health of individuals including migrants. Elaborate on the social determinants of health in this section will help this research in analysing the data of the participants especially in line with the impacts they faced in accessing health care and coming out with the recommendations. Gibson et al, (2012), held that the study of the social determinants of health by the policy makers, provides a proper analysis of the safety of the patients. They argued that the understanding of social determinants of health is a key need of policy makers and thus enables a deeper analysis of both patient safety issues such access to medicine.

These determinants could be, neighbourhoods in which people are born and lived, education, social status, employment, racism, discrimination, job opportunity, income, access to nutritious meals, access to health, access to clean air and water.

These determinants will be discussed in relation to the migrants to assess their impacts on the health and access to health care in the UK.

These determinants could be understood from the nature of how they affect the population at global and local levels. In other words, these factors are also listed as

the most powerful determinants of the populations' health including that of the migrants that we are investigating.

These factors are considered social determinants of health because they can be translated into action through policy processes to resolve issues of health such as inequalities in health between races, countries and region, Marmot et al, (2005). This is in line with the position of Exworthy, (2008), that policy and policy makers do impact the social determinants to shape the society and, in this regard, the research will find it pivotal to consider the social determinants as one of the core determinant of health and access to health care.

The legislations under study are directly related to these determinants by their involvement in the day-to-day wellbeing of the migrants. For example, the day-to-day wellbeing of the migrants in the UK are shaped by the following laws, the Asylum and Immigration Act 1999, the 2014 Immigration Act and the 2016 Immigration Act, relating to accessing certain services by migrants such housing, banking and the right to work and as earlier discussed, restricting them of these services impacts their health.

Considering these additional determinants of health, will serve as a complement to the other determinants previously discussed, this research will emphasise that the better social determinants of a society, the better the health outcomes and the reverse is true.

Marmot, (2005), in his study confirms that Health follows social gradient, which means the higher the social status the better the health and vice, Employment conditions, access to job, access to nutritious meal, racism and a host of other factors are pertinent in the shaping of people's social position as well as their health conditions.

In further exploring these factors, we shall be looking at the relationship between some of the social determinants and their effects on physical and mental health.

Beginning with social exclusion as a social determinant of health, it is fundamental determinant of health as it consists of dynamic multi-dimensional processes driven by unequal power relationships interacting across four main dimensions (economical, political, social and cultural) and in different levels including individuals, household, groups, community, and country. The social exclusion knowledge network examined the rational processes that lead to the exclusion of particular group of people from engaging fully in community life and activities. The nature and operation of such

processes and their association with populations' health status and health inequalities were analysed in a diversity of country contexts, chosen to reflect the impact of differing structural constraints, (Shaw et al, 2005).

In the UK, social exclusion maybe referred to in relation to racial discrimination with effects are mostly noticed on the Black Asian Minority Ethnic Group, (Somerville et al, 2002).

In relation to health, those who are socially excluded from the social activity are prone to more health problems than those not excluded and would face higher death rates than those who are not, and the Black Ethnic Minority and the disabled community in the UK are those faced with social exclusion more and are more affected than the other community, (Shaw et al, 2005). Noel, (2020) held that the high impact of the Covid-19 on the Minority Ethnic Groups in most of the countries of the world, including the UK was as a result of the existing social exclusion.

Gender inequality is another damaging and determining factor to both physical and mental health of some individuals in the world. Gender based inequality is a noted violation of human rights which is prevalent in the world and UK inclusive, with health effects on the victims, (Keyhani, 2013). Gender-based violence could also be termed a form of marginalisation, (Vaittinen et al, 2019), which could get worst or evolve into other situations during health crisis. Burki, (2020) concluded in his research that women are of the group that faces gender inequality during periods of health crisis and that the covid-19 exacerbated gender inequality and disparity faced by women and introduced and introduced further and new challenges. The United Nations Women, (2020), recently conducted a study and came out with a finding that the current covid-19, more women will be living in poverty than men, due to social exclusion.

Racism and discrimination are also a form of health determinant in a society. These happens by affecting the health and economic opportunities of marginalized racial group of persons instilling racial inequality and reinforcing negative stereotypes which may result to health inequality, (Yearby, 2020). In the UK, racial and related social factors do underpin patients' access to health care. The present pandemic has exposed the existing systemic racial discrimination that has been targeting and

affecting the black ethnic minority population of the UK through the NHS, (Danso, 2021).

Unemployment, Job quality and financial status are also part of the social determinants of health. These three factors could all be classified as one because they are the determining factor to the ones' financial strength. Poor mental and physical health could be associated to job loss or joblessness, underemployment, or poor income. Suicide attempts and occurrences are likely to be associated to job lose while mental illnesses and drug addiction are associated unemployment. The health outcome of these determinants would be associated to the amount of enhancement accorded to employment status, (Hergenrather et al, 2011).

The Covid-19 pandemic came with job insecurity with underemployment and unemployment highly noticed within the ethnic minority group than other groups in the UK and this has accompanying health effect on this group of persons, (Iob et al 2020, O'Connor et al, 2021). Earlier before the Covid-19 pandemic, Korzeniewska et al (1995), had suggested that unemployment could affect both the mental and physical health of its' victims, who may be facing fear or frustration which could leads to more serious disorders such as neuroses, depression and so forth. It can be also responsible for suicidal attempts.

The impacts of the determinants of health listed in the previous paragraphs are directly connected to the health consequences of the immigration control in the UK and this will help in establishing the reality of occurrence and in the process of interpreting the data collected from participants.

The Right to Health and The International Conventions as Ratified By UK.

The research topic deals with an aspect of human rights which is the right to health as a principle and the practice involved or caried by the British states. In that regard, this section will be aimed at establishing this right as an obligation of the British State as enshrined in both national and international instruments with emphasis on the constitution of the NHS which in its principle 1 and 2 cautions on the provision of health needs as requested UK residents but not on their ability to pay. And this is realised by viewing some aspects of the human right instruments through a brief insight of some of the sections or articles involved.

Note should be taken that the research approach of Marxism considers the Law as an instrument of class suppression used by imperialist against the less developed countries, therefore the research will be looking at the obligation of the British state from the content of the instruments while the second part of the section will be looking at the intentions behind the creation of the acts or instruments. This will be done through the interpretation of the Human Rights Acts and their application, using the ''White Man's Burden''.

Marxism in this case will help in establishing the reality of Human Rights as advocated for and its' application in capitalist and imperialist states such as the UK. The reality will be assessed from the obligation of state parties to the instruments to provides access to good quality health care and other related services including housing to the residents. In considering these instruments, migrants, including Refuges and asylum seekers would be seen as are part of the population, (for our case, it is that of England and Wales of the UK) and most importantly as they are a particular, and vulnerable part of the population that deserves special protection, (Equality and Human Rights Commission (EHRC), 2018a, 2018b, 2018c).

Considering that the Right to Health is a fundamental right and seen to be one of the focal points of the research, this approach will help at the stage of interpreting the data collected to establish if the practice in the UK, (with focus on England and Wales) affects migrants and access to health care.

In so doing, this section will be presenting some national and international instruments known to the UK[13], including their obligation to uphold these rights, and while doing this, we shall also be elaborating on the Marxist interpretation of the concept of human rights to be able to explain the practice in the UK and its' implication on the migrant population.

The International instruments to which the UK's responsibility in protecting human rights in general is founded on are the Universal Declaration on Human Rights, (UDHR), adopted by the United Nation's General Assembly (UNGA) with the rights and freedoms beings enshrined in it and accepted under resolution 217 during its' third session on the 10th of December 1948 at the palais de Chailot Paris France and considered to be the basis of most international Human Rights treaties and to have

[13] Those instruments that are promulgated by the UK or conventions that are ratified by the UK.

influenced the UK's 1998 Human Rights Act with the right to health, right to life, fair trial and freedom of expression. The obligation of the UK to institute the rights are enshrined in the preamble, articles 1 and 25. The International Covenant on Economic, Social and Cultural Rights (ICESCR) where the UK ratified by adhering to their obligations under article 2(1)(2), article 3 and article 4 of the covenant. This Covenant was adopted and opened for signature, ratification and accession by the general assembly of the UN under resolution 2200A(XXI) of the 16th of August 1966, entry into force in the UK was on the 3rd of January 1976. Another international instrument that the right to health is enshrined in is the 1951 Refugee Convention and its 1967 Protocol. The Convention was drafted and signed by the United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, held at Geneva from 2 to 25 July 1951. The Conference was convened pursuant to General Assembly resolution 429 (V) of 14 December 1950. The Convention was adopted on 28 July 1951; in accordance with Article 43, it entered into force on 22 April 1954. The Protocol was adopted on 31 January 1967; it entered into force on 4 October 1967 in accordance with its article VIII.

The convention was ratified by the United Kingdom of Great Britain and Northern Ireland on the 11th of March 1954.

The Protocol to the 1951 refugees' convention was enacted to remove the refugee convention's temporal restrictions to give way for a universal application and taken note of with approval by the Economic and Social Council in resolution 1186 (XLI) of 18 November 1966 and was taken note of by the General Assembly in resolution 2198 (XXI) of 16 December 1966. In the same resolution the General Assembly requested the Secretary-General to transmit the text of the Protocol to the States mentioned in article V thereof, with a view to enabling them to accede to the Protocol. It was ratified by the United Kingdom of Great Britain and Northern Ireland on the 4th of September 1968 and by ratifying both the convention and protocol make binding on the member states.

While the national instruments on Human Rights regulation to which the UK submits to are, The Human Rights Act 1998, that received royal assent on the 9th of November 1998 and came into force on the 2nd of October 2000 and aimed at incorporating into the UK laws the rights contained in the European convention on Human Rights and other international conventions ratified by the UK, Article 1. The Equality act 2010, that

came into force on the 1st of October 2010 to replace the former anti-discrimination laws and to legally protects people from discrimination in the workplace and in a wider society, as would be elaborated in the following paragraphs.

These instruments are founded on two principal objectives with the first one outlining the various aspects of the Human Rights to health attributed and the obligation of the state parties involved.

Outlining the various right and their importance attributed by the instruments are seen in the following phrases,

The importance of life and need for protection.

Point 1 of the ICESCR General comment Number 14 describes health as a fundamental human right indispensable of other rights[14], which reiterates on the importance of right to health to all without exception.

Article 2(1) of the 1998 Human Rights Acts prioritises everyone's right to life of which the right to health is inclusive to be the main objective of the laws in place[15].

As for the inalienable and equal nature of the right to health, the preamble of the UDHR attaches these rights to every being of a family and calls for its respect by all the necessary institutions. The preamble and the first article lay down the basis which these rights have to be respected and goes further to entreat all the member states to embark on their obligations with the convention[16].

[14] ''Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable''

[15] ''Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law''

[16]''Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,
Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,
Article 1, UDHR,

Article 25 on its' part lays the foundation on the various rights deserved by every person.

The second attribute of these instruments is the obligation of the state party to ensure the protection of these rights and are elaborated in the following paragraph.

The states' obligation to protect the right.

In part one of the Equality act 2010, we have the following dispositions on the obligation of the state to make strategic decisions to cut down inequalities resulting from socio-economic disadvantage''[17]. As earlier discussed in this thesis, these inequalities have a huge health impact on the service users and most especially individuals from the ethnic minority population.

The dispositions of the 1998 Human Rights Act and the Equality Act 2010 places the obligations on the UK government to ensure the application and protection of everyone residing in the UK without exception and the right to health is a fundamental right enshrined in these legislations. Article 1 of The Human Rights Act 1998 integrates and oblige the application of all international conventions ratified by the UK as national laws.

Articles 2, 3 and 4 of the Covenant lay down the obligation of state parties to ensure the rights enshrined in the covenant are respected[18]. The above is read in line with the

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All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
Article 25, UDHR,
Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

[17] (1) ''An authority to which this section applies must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage''.
(2) ''In deciding how to fulfil a duty to which it is subject under subsection (1), an authority must take into account any guidance issued by a Minister of the Crown''

[18] Article 2 of ICESCR, (1). Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
(2). The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

ICESCR general comment number 14 adopted at the twenty-second session of the committee on economic social and cultural rights on the 11th of August 2000 and contained in document E/C.12/200/4 to elaborate on the provisions of article 12 of the ICESCR.

This articles also outlines the obligations of state parties in acceding and ratifying the covenants and binds them to seeing into the execution of these obligations in favour of the persons concerned[19].

The explanations given in the previous paragraphs have to do with the content of the acts, while the next paragraphs will be dealing with Marxist interpretation or the context to which these laws are promulgated.

Marxist interpretation of the context of Human Rights Practice through the poem ‘’White Man’s Burden’’

After presenting the content of the conventional standpoint human rights instruments in the preceding paragraphs, I shall seize the opportunity in a few paragraphs to give a Marxist insight of the context or interpretation of this concept from the poem, ‘’white man’s burden’ of Rudyard Kipling (1865-1936).

This interpretation will help in further understanding the role of the Human Rights instruments including other legal instruments in the control of migrants by the UK and other imperialist states and their effects on the health of these migrants.

This poem originally published in 1899 was written by an English writer Rudyard Kipling to encourage the American to have strong and firm control over Philippines, to represent one of the territorial prizes of the Spanish-American war and which to Rudyard, characterised the British rulership over India, (Brantlinger, 2007). This poem was meant to praise colonialism and imperialism by projecting the white race as that which will bring salvation to other non-white races. Reflecting this to the British State,

[19] Article 12, (1) ICESCR, s The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.
(b) The improvement of all aspects of environmental and industrial hygiene.
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.
(d) ‘’The creation of conditions which would assure to all medical service and medical attention in the event of sickness’’.

Kipling had in other write-ups also shared the ‘divine mission’ of the English or the white race to conquer, rule and civilize all other inferior races of the world, (Brantlinger, 2011). Mutua, (2002), on his part holds that initiating and being in control of the Human Right Institutions, the imperialists would always use the carrot-and-stick approach to implement certain policies through their recipients and that human rights is mostly used to achieve this aim, while Ruggie, (1983), opinion on Human Rights is that it represents a system reproducing itself within a new domain than be transformed. Signifying that the end result of the international human rights laws would only reflect the interest of the initiators or the imperialist.

African Marxist such as Amilcar Cabral of Guinea Bissau, Kwame Nkrumah of Ghana, Senghor of Senegal, Nyerere of Tanzania hold the position the law including other Human Rights Instruments are instrument of colonial rule as explained in chapter two of this work, and from the above teachings of the white man’s burden, we could deduce that Human Rights is a form of justification by the British state and other imperialist power to uphold imperialism and other forms of modern slavery on the less developed countries as was the case of Nigeria, (Ibhawoh, 2008).

As for the human rights protection of non-citizens such as refugees and asylum seekers in the UK, Weissbrodt, (2008) and Gibney, (2011), affirms the existence of prescribed rights and the reality in practice as shaped by street level bureaucrats and other social factors which tends to have a huge impact on the migrants.

The analysis of the previous paragraphs comes to throw more light on the reality of human rights practices and this will help in interpreting and analysing the data and in determining UK’s practice of Human Right.

Conclusion.

The context of practice relating to immigration control in the UK is seen in this chapter to directly or indirectly affects migrant health and or access to health care. This chapter analysed this from the structures and tradition put in place by the respective British governments of England and Wales. The assessment is carried on by looking at the social structure, the history of British immigration control as well as other determinants of health.

In so doing, the chapter has laid the foundations relating to the origin and implementation of immigration legislations, the human rights rules and other aspects

relating to the research topic, to facilitate the collection and analysis of the data in the previous chapters.

Most of the concepts applicable to the UK including that of human rights are given a reflective understanding through the application of Marxism to keep the research in track with the method and for this concept to reflect in the research.

Chapter 4.

Methodology and the perspective of the research.

The previous three chapters have mapped the theoretical journey necessary for locating the methodology of this thesis. In their individual contents and context, chapter one makes a general introduction to the thesis, Chapter Two presents literature which shows the foundation of the sociology of health in the UK as well as the origin and strength of the British immigration system with some pointers to the likelihood of health inequality and perceived discrimination faced by migrant groups. Chapter Three deals with the context of applying concept of health and access to health care and other related principles in the UK.

In this chapter, I shall be discussing the methods employed in the realisation of the empirical part of this research.

The chapter is made up of two sections, with the first section introducing and giving the perspective of the research. Section two talks of the methods used in conducting the research and the following aspects will be discussed herein: The study design, sampling and recruitment of participants, the data collection, procedure, ethical requirements and participants' wellbeing.

The design of this chapter will help in directing the data collection process and equally facilitate the next stages of the data analysis as well as the recommendation and conclusion stages of the research.

Introduction and the perspectives of the research.

This research takes a committed approach, from the perspective of the PhD researcher as a migrant who has made a conscious decision to stand in solidarity with other migrants who are either facing or are at risk of facing similar problems to what he went through during his stay in the UK as a migrant.

The research is informed by an ontological understanding that researchers are necessarily entangled in struggles and conflicts and will inevitably identify more with the perspective and interests of some sections of society than others (Colvard, 1967).

Considering the researcher as a person subject to the legislation under discussion, this research offers a unique 'insider-outsider' perspective that is further concretized by drawing attention to seldom-heard perspectives of migrants of his society or that

which is similar to his. The research will contribute to a fuller understanding of the operation of the British Immigration Acts, as applied in Birmingham and Cardiff of England and Wales, aiming for a ‘strong objectivity’ combined with a ‘strong flexibility’ and a ‘strong method’ (Hirsh et al, 1995). Triangulation between multiple sources of data will enable internal validation and a reflexive approach will support the reader’s critical engagement with the researcher’s perspective.

Perspectives of the methodology.

In coming out with the methods for this research, I was driven to look at both objective position which is partly inspired by my experience as an asylum seeker in the UK and subjective position of others who have had similar experience as me to be able to concretize my position and views of the legislations under investigation.

Objective positions are those taken out of impersonal perspective or positions that connotates neutrality, (Bernard, 1919). The objective position considered here represents the convictions I have got for my views of the subject matter which is the impact of immigration control on health and access to health care in the UK.

As an insider-outsider researcher and taking into consideration the fact that the research places migrants like myself at the centre, the subjective position, is seen to help develop the research and accord more credibility and authority, to my research, (Carling et al 2014). The subjective positions of the participants would go a long way to elaborate the impact(s) of the British immigration legislations on health and access to health care, which is the main aim of the research and for a better understanding of my objective position of the research question.

For Descartes, subjectivity emerged when he doubted the veracity of his knowledge by considering it as an inherited myth, (Cho, 2007). Marx took a different position to that of Descartes in considering Subjectivity during his critics for competitive capitalism as class consciousness, (Hall, 2004). The Marxist subjectivity of class consciousness builds a framework structure of experience(s) of the environment and how these structures are determined. This will allow us to understand the processes involved in immigration control and how these processes affect migrant’s health and access to health care.

From Marxist perspective, the concept of class-consciousness is a historical phenomenon born out of collective struggle, which is a self-understanding of members of a particular class or group of persons of a society, (Miller et al, 1981). This concept will further give understanding of the difficulties undergone by the group of persons on which this research is conducted on and to interpret the role played by the immigration control.

It is also a subjective awareness held by members of a particular class regarding the need for collective action to bring about changes in the society, (Halfin, 2000). The class consciousness would help understand the practical contribution of the various class of persons (The migrant working class and the capitalist Bourgeoisies) concern in this research topic, (Lukacs, 2014).

As a refugee and someone who has gone through the stages of asylum seeking here in the UK, I have personally experienced most of the occurrences with regards to the impact of the legislations and the British immigration control in general on health and access to health care. On that note, am inspired to conduct this qualitative research with the research question reflecting an objective ontology that would require a subjective view of other participants to better understand the objective reality of my thought for the research question. This will also create an opportunity for me to demonstrate my reflexivity by identifying those areas of immigration control impact on health and access to health care that do not feature in my personal experience.

According to, (Andrews, 2012), the social construction of knowledge for the better understanding of the existing reality would require both the objective and subjective reality because the society is seen to be existing both as objective and subjective realities, In the present research, the subjective and objective reality of the research question would be better understood from the application of the positions of the participants collected during the data collection process that would be analysed

As per, (Kuhn et al, 2000), the coordination of both the objective and subjective realities results to the attainment and understanding of the existing reality. Bernard, (1919) stated that objective stance is definite and measurable while subjective stance are indefinite and unmeasurable and suitable standards for measuring social processes and relationships such as

the research we are conducting. To further confirm the role of the subjective stance in the understanding of the research question, I shall be taking same position as with the German philosopher Theodor Adorno, as referenced in McHugh (1989, page 91), who stated that, ‘’subjective reflections have something sentimental and anachronistic about it. Nevertheless, in an individualistic society, the general not only realizes itself through the interplay of particulars but society is essentially the substance of the individual’’.

This idea of Theodore will help to jointly understanding the standpoint of participants in the research and interpreting same to respond to the research question.

The choice of the methods for this research emerged from the ontological position that multiple representations and subjectivities do exist in the UK with regards to the difficulties existing in accessing health care especially with the Ethnic Minority group. This position is appropriate for the subject we are embarking on especially dealing with my personal perspective as an insider and that of other migrants going through the UK system as myself[20] as well as the perspective of professionals of law, health and social works who are believed to be in direct contact with the migrants.

African perspective of subjectivity.

As earlier mentioned, the research questioned would be better understood from the subjective stance or contribution of participants. It is important I present the understanding of subjectivity from an African side of the coin since the research is dealing with a group of persons coming from Africa and who are of African heritage.

In equating the subjective views in a socialist society from an African perspective, I shall be referring to the famous African philosophical concept of Ujamaa as introduced by one of African fathers of Socialism Julius Nyerere. In his quest for rural development, ‘'the Villagization’’ was introduced as a concept in Ujamaa.

[20] They have either gone through the British immigration system of asylum, the section 94 and 95 of the asylum housing, the council housing and assistance offered to migrants in the UK and the NHS health system.

This concept is built on African Values and entails the shifting from an individual workforce to that of an Ujamaa Village where people cooperate directly in small groups for the joint interest of the community, as referenced in Wakota, (2018).

Julius Nyerere in his speech at the UN on the 14th of December 1961 when Tanzania, (Then Tanganyika) was being admitted into the UN, reiterated on his commitment of incorporating the Universal declaration of Human Rights as internal and external policies of the Ujamaa (Nyerere, 1966, 146). This to him includes amongst others the right of the views of everyone to be taken into consideration. Meaning the logical views of individuals involved in the Ujamaa village would be taken into consideration.

Another aspect of subjective view is projected in the African concept of socialism known as UBUNTU. The UBUNTU is described as an African philosophical concept that places emphasis on being self through others, (Jacob et al, 2013). It is also considered to have emanated from a context of leadership practices beneficial to the African Socio-Cultural and institutional environment.

Ubuntu like Ujamaa previously mentioned is also premised on the collective endeavour and people-oriented preferences, (Ebot Eyong, 2019).

Subjectivity as considered by the Marxist to be a phenomenon born out of collective struggle could be seen as part of the UBUNTU practices as Nussbaum, (2003 page 21), considers it to be ‘’a capacity in African culture that expresses compassion, reciprocity, dignity, harmony and humanity in the interest of building and maintaining a community with justice and mutual caring’’.

The famous and celebrated Archbishop Desmond Tutu of South Africa and his priest Michael Battle, in a publication situated the indigenous African people and their way of life to the UBUNTU. they held the position that indigenous African people are in a set of delicate networks of interdependence among themselves and other creations. This interdependence is what he termed UBUNTU which is about wholeness and

compassion for life and everything that has to do with life, (Battle, 2009) In his words Battle said this,

‘’Ubuntu is an African concept of personhood in which the identity of the self is understood to be formed interdependently through community’’ Battle, (2009, page 1 to 2)

To the prelates, the indigenous people of Africa have a view or perspectives that needs taken into consideration. This view comes with a sense of belonging to the African community which could be equated to the Marxist self-understanding of a group of persons of a social class[21] of subjectivity.

As earlier mentioned, the subjective approach from an African perspective would assist in the method of data collection and for proper understanding of the views of the individuals concern in the research and for the concretisation of themes to be analysed.

The perspectives elaborated on in this section would help the research from the process of data collection to the process of analysing the data to arrive at the required answer to the research question.

Methodology of the research.

Research design.

The research design provides the researcher with guideline on how to carry out the research, (Gaber et al, 2012). It is one of the most important components of a research methodology, (DeForge, 2010, page 1252), as it lays down the structure and path of the research.

The research methodology places migrants at the centre, in order to assess the impact of immigration control on their wellbeing as a group. Lawson, (2000), suggests that migrant stories and experiences can be effectively captured through in-depth and narrative interviews. The in-depth study of the research topic will be realised in this case if the research relies and focuses on the selected group of migrants.

[21] As referenced earlier in Miller et al (1981).

In general, and in view to point out the impact of the acts or immigration control on health and access to health care, the research initiates an inductive approach which looks at the various factors affecting health, and access to health care from the perspective of migrants and practitioners. This approach of analysing the data will expose or bring out the experiences of participants and presents a bigger picture of what is happening in the UK with regards to access to health care and related services.

Some aspects of participatory methodology is applied in the research at both the data collection and analysing stage drawing on the researcher's insider-outsider positionality as an African migrant (Carling et al 2014). Becker et al (2010) suggest that in social policy research, the involvement of a service user as researcher helps to ground the research in the everyday experience of the user, helps in its relevance, helps the researcher gain access to research participants and can improve the overall quality of the research. The legal background of the researcher assists in the practical applications of the research topic.

A comparative approach of the application of the immigration acts through the data collected is put in place by considering the similarities and differences in the application of the legislation in Wales and England. Consideration was also taken to the difference in culture between the two countries, and this helped enhance the analysis of the data collected from these two zones.

The case studies of Cardiff and Birmingham enabled attention to specific local characteristics of cities that have experienced significant levels of migration in recent years. This takes into consideration the Welsh government's argument that they need more of a say in immigration to Wales (Shipton 2014), and local contexts that include discussions by the Conservative and Labour leaders of Birmingham City Council about the city offering home to refugees from war-torn countries (Elkes, 2016).

Two focus groups made up of six members from both England and Wales were created for an in-depth open-ended discussion on the research topic and the discussions carried out for not less than one hour to get a blend of

data collected from both countries. Robinson, (1999) suggested that focus group are used to provide the Healthcare Sector with concrete feedback from a face-to-face contact of those using the services or those presumed to be using the services. That through the focus group, the public attitude, illness and health behaviours as well as the peoples' experiences of diseases and healthcare services are made known, as referenced in (Robinson, 1999).

In applying the ideas of Robinson mentioned above, a focus group with migrants and health related professionals, would give the migrants who are mostly the users of the services provided by the health sector the courage to bring out their worries for channelling to the appropriate quarters. The migrants who are considered vulnerable and being able to voice out their worries in a gathering with British nationals gives it credibility and the necessity for a solution.

Since migrants or participants of this research are the service users of the UK healthcare services, their participation here will provide tangible information to assist in the recommendation for future restructuring of the healthcare system.

The design explained in this section gives a framework of what is to be done in this research and this gives us a proper foundation of how the data is to be collected and analysed.

Sampling and Recruitment.

It is from this stage that the process of identifying, and selection of participants is made and in line with the requirements of the research question.

It is also at this stage that the structure as to the number of participants and the size of data required for the research is carved out.

The recruitment process was aimed at interviewing 30 migrants participants including myself, six professionals and two focus groups of six members each from Birmingham and Cardiff with each group consisting of a professional in health or human rights. Due to data saturation, I was able to interview twenty-eight migrants instead of the 30 previewed, while the six

professionals and the members of the focus groups made their attendance as requested.

A sample of 28 migrants including myself was drawn from residents of Cardiff and Birmingham. A purposive sampling strategy is used in the research with the aim of including migrants from African countries specifically from English-Speaking Cameroon and Nigeria who have British stay and those who do not have leave to remain in the UK and or citizenship.

In addition to the data collected from migrants, data was gathered from experts of both white and black ethnic background with specialties in the fields of law, health and social services to draw on their working knowledge through contacts with clients and to provide an opportunity for triangulation with data gathered from other participants.

This diversity will enable exploration of the relationship between formal immigration categories, countries of origin and ethnicity, following Vickers et al, (2013) suggestion, that ethnicity makes a difference to experiences of care.

In recruiting for the research, I was aiming at exploring experiences among the targeted population which is the migrant community of England and Wales and specifically those based in Birmingham and Cardiff and to meet the target of the research and focusing on this targeted population will make way for a positive outcome for the research, (Hulley et al, 2001).

In recruiting, variety of initial contact points were made and taking into consideration with more emphasis on the different categories of migrants and other qualities mentioned in the previous paragraph to better answer the research question.

These contacts were initiated in Birmingham where I live and Cardiff through friends and organisation leaders with whom I was involved during my asylum process between 2016 to 2018.

Key informants from different organisations and locals who are migrants and who showed interest in my field of work were contacted by drawing on my own local knowledge during the campaign against human rights abuse against migrants in Wolverhampton, Birmingham in England and Bangor in

Wales as well as my professional knowledge as a legal practitioner from Cameroon. During this contact process, it was made clear to the interested participants that their taking part in the research was without compensation.

Of the migrants recruited and who actually took part in the interview, were refugees, asylum seekers, failed asylum seekers, students who came into the UK on the strength of a study visa, student who came into the UK on the strength of a study visa, (some of whom had exhausted their leave to remain on this basis), migrants who got into the UK through the borders of France, Ireland, and Scotland and finally migrants with UK citizenship or citizenship of another EU country.

The migrants recruited must have stayed in the UK between one to ten years and are at the time of the interview resident in England or Wales. This is to ensure that they have experienced the impact of the Immigration Act for a reasonable period that is worth assessed and that they have stayed in the UK within the 2010 to December 2020 timeframe.

In order to put in place the participants' welfare discussed in the last section of this chapter, the research categorised the recruits into two, with the first group made up of mostly vulnerable citizens fleeing from the unstable political crisis in Cameroon that started in the late parts of the 20th century through the 21st century from the long-termed political leadership of the French-Speaking Paul Biya that has ignited a call for political liberation and ethno-regional identification of the two English-Speaking regions of the country, (Konings et al, 2003) that has resulted into an arm conflict and causing the people from these regions to be victims of targeted perpetration of inhuman acts, (Koning et al, 1997). These citizens are considered vulnerable because they are at risk of continuous victimisation here in the UK because of their immigration status. Those coming from Nigeria are mostly those fleeing from instability caused by religious/political conflicts that has been existing since the 80s and keeps growing with the continues insurgencies of the Boko Haram, (Falola, 1998).

The second group of migrants are those migrants who left their countries either for study purpose, to better their life in the UK due to the limited

opportunities of their countries of origin and those who left their country of origin to other European countries then moved to the UK after securing their permanent stay in those countries under the EU laws.

Another factor taken into consideration is the ability of these migrants to understand the purpose of taking part in the research and the will to be part of the project.

Having a mastery and understanding of the spoken English was a prerequisite for recruitment. Despite this linguistic requirement, some participants had in their expression phrases in pidgin English, a language commonly used in Cameroon and Nigeria. This issue was resolved as explained in the procedure section of this chapter.

I recruited professionals in the fields of law, health and social works of the UK, for the purpose of getting their subjective views as those directly involved in life of migrants vis-à-vis access to health in the UK and for triangulation of the data collected.

The selection criteria for the professionals was on the basis that they were in direct contact with the migrants in their fields of works to increase the sources of data and approaches for the enhancement of its credibility. And these professionals were also recruited on the basis of the areas in which they carry on their practices or exercise their functions and not where they are resident. For example, the solicitors contacted are based in London but carry on their practices in both England and Wales and they were able to give me their experiences in both England and Wales as required.

Some of the participants in the focus groups are also individuals who have taken part in the research in the interviews individually with their personal opinions and bringing them in the focus group would be testing some of the responses earlier collected from them as individuals as they would be answering same questions in a group with people who have different experiences from theirs.

The focus group added to the research two types of data, one of which is collected communally from same participants who gave their individual participations at some point in the research and the second data collected

from these individuals is data which was individually provided at some point of the research but is now verified, scrutinized or debated upon by other participants.

The section has also made available the structure of the data to be collected at the next stage and in preparation of the stage of analysis in response to the research question.

Recruitment procedure

All participants were provided information about the purposes and aims of the research before they were recruited, and it was also made clear that participation is voluntary and that participants may withdraw their participation from the research for up to a reasonable period before the research is completed.

Before the commencement of each interview, participants were given the consent form to read and sign and for those who were not able to be met face to face or via social media to read and sign the form, same was read and explained to them before the commencement of each interview. Since the research would be made available for public consumption, the consent of the participants is necessary and appropriate, Cheap et al, (2018). Seeking the consent of all the participants before the research data is collected would entail upholding the ethical values of the research, Lee, (2018) and as suggested in the research proposal.

One important aspect of this research is the fact that it stretches through the recent Covid-19 health pandemic (The research started in October 2018 through 2020 to 2022), during the data collection stage where the initial procedures were altered as would be discussed in the next section of data collection.

Sign postings were made to organization with expertise and responsibility to handle migrants with distress resulting from and relating to discussing past or present predicaments such as City of Sanctuary Birmingham and Cardiff respectively to handle any eventuality.

During the process of data collection. common expression in pidgin English were introduced during a deep conversation while carrying on the interview.

Also, the accent of participants was another issue to be considered during the data collection process as people from Cameroon and Nigeria have a similar way of speaking and communicating. This issue(s) was resolved by my ability to understand the participants since I was born and raised up in that area and got a good mastery of the pidgin English as well as the accent used, and I was able to get an interpretation and understanding for each of the slangs.

The procedures outline the stages in recruiting participants into the research and this prepares the research for the next stage which is that of data collection.

Data collection.

The section is that which puts or lays down the procedures and condition of data collection and it is a continuation of the previous section of the research procedure.

The questions meant for the interview are listed in the research questionnaire and further questions are arrived at from the response provided by the participants.

One thing special with this research is the fact that it is conducted through the period of a health pandemic, (The Covid-19 pandemic) which requires special conditions to be put in place for the data collection.

Due to the restrictions instituted during the covid-19 period for social distancing, the supervision team and I agreed on reducing the number of face-to-face meetings between myself and the supervision team as well as the participants of the research by using skype, zoom and Microsoft teams as the main and secure means of collecting the data and other meetings in line with the rules in place.

The skype and teams' calls were booked in advance on an agreed date and the consent was either sent before the meeting or read on the day of the meeting.

During the meeting for the data collection, the participants were informed of the procedure which includes recording of the call using an external device to be transcribed later.

This method enables inclusion of people such as the vulnerable migrants who might otherwise be excluded from research, for reasons such as geographical distance, incompatible time frames and most specially the huge effects of the Covid-19 pandemic and its restriction measures, Cook, (2011).

The measures taken during the covid-19 restriction period appeared to have helped me in the research as it ended up facilitating my job and contributing more to the research completion than I expected. For example, at the end of the third year, I realised that the number of meetings I had organised via social media platforms outnumbered those I had programmed through face-to-face meetings with both my supervision team and other participants of the research, and I covered a good portion of work as required by the thesis.

There were a few face-to-face meetings organised during this period and these were done in compliance with the social distancing measures put in place by the UK government. A three metres space was provided between each participant during the data collection and mask and disinfectants were provided to each participant at all times during the process.

Of those face-to-face meetings, three interviews were collected from members of my household who have been living with me for more than 15 months. The last of the face-to-face meeting was conducted in Cardiff with two migrants who refused to give interviews via social media for fear of the unknown at separate instances and in respect to the three metres space social distances and putting on face covers in respect of the Covid-19 social distance rules.

An issue of insecurity came up as a result of the restrictions that resulted to the usage of social media for data collection causing most participants expressing insecurity about giving out their information via this means (Social media). This was common with those having unsecured immigration status. They thought using the social media to provide the information I

needed could result to them being exposed to some form of danger to the immigration system of the UK. Constant education and assurance was the main approach used to bring them to the understanding that they are secured.

Semi-structured Interviews were arranged and conducted with 22 participants from Birmingham and Cardiff via skype, Teams and zoom and recorded from 60 to 120 minutes after the questions have been presented to the participants and a consent form for signature. Six other interviews were conducted on a face-to-face basis in strict compliance of the social distance rules as explained earlier in this section making a total of 27 interviews in total. The interviews were then transcribed to be analysed.

Two of the data from medical professionals and two collected from the legal experts were collected through correspondence in words document where the questions were forwarded to the persons consent and they reply through same words document and further correspondences carried on in same manner. One of the data was collected from a social worker via skype and transcribed accordingly.

I also encountered issues with collecting data from some professionals such as those of the legal fields. I came to understand that it is difficult to take time out of a lawyers' schedule for pro-bono services in the UK. Though that was not the case with my days back in Cameroon as a practicing lawyer, I tried to fit myself in their schedule by constant notifying the lawyers I recruited, and I finally got them provide me with the information required. Finally, I got more than two legal practitioner who provided me with data and I had to choose from these number the two that gave me more materials to use for my research.

Interviews for the two focus groups were conducted at two different instances and in different ways. That of the first focus group was conducted via zoom on Tuesday the 4th of August 2020 and recorded in the presence of 6 members, with 4 of them from Cardiff and 2 of them including myself from Birmingham to top the number of participants to 28. Of the four members from Cardiff, one of them is a Cameroonian asylum seeker the second is a

Cameroonian with European citizenship and the third is a Nigerian failed asylum seeker and the fourth is a British citizen and worker with the City of Sanctuary Cardiff, those from Birmingham we had myself a refugee and another Cameroonian who is also a refugee. Three of the six members of the focus group were initially and individually interviewed on their experiences of accessing health and healthcare facilities in the UK.

For the first focus group meeting, each party was allowed at least 5 minutes to talk on the topic of their experiences on access to health and related services in the UK. Time of 2 minutes per participant was allocated for questions or answers pertaining to each presentation. questions or responses to any presentation and I acted as the moderator and contributor to the group meeting. Each party was allowed to start a presentation with an introduction to help identify the speaker during transcribing. The meeting that lasted for about 125 minutes was introduced and closed by me.

The second focus group meeting was held at an amusement park in Birmingham on the Sunday the 8th of November 2020 in the early periods of the day as I went to the park for sports with five other members, three Cameroonian refugees including myself, two Nigerian (One refugee and one with British citizenship) and a non-migrant who is a British national and worker attached to one of the organisations looking after migrants in the UK. The focus group meeting was done respecting the two metres between each person and another to respect the social distance requirements. While the conversations were ongoing on the topic of access to health by migrants in the UK, I recorded on my phone using the app otter for transcribing.

All the interviews were conducted in English and transcribed for utilisation during analysis. Although the English language was the main and only language meant to carry out the interview. In addition to other factors, I was equipped with the necessary requirements to better understand and liaise with the participants since I am a migrant with same experience and from same cultural background and because I am of same status as most of the participants or have gone through similar experience as they have. To mitigate the effect that may arise from the interview process, contacts of two organisations (City of Sanctuary Birmingham and Cardiff) were made

available to each participant to call for assistance in case they feel depressed or affected by the interview. As for the accent of the participants, there was no problem because I fall within that category of migrant and of the communication skills of that area where they come from. Two of the members of this focus group were initially and individually interviewed on their experiences of health and access to healthcare facilities in the UK.

I also encountered issues with gathering information for the writing of my thesis, during the lockdown, because most of the libraries where not open for face-to-face meeting, and very few of them operated via social media.

The university school library of Nottingham Trent University was not open for public use and as a result, some information that were not accessible online were not reachable and this was because the library was not open at those moments. In most cases, I would contact the library to provide me with the needed information via post and or provide me with alternative source for access. In most instances, I got to go for alternative source which would lead me to further reading and additional materials for the research.

The process of data collection including the precautions taken to put in place the covid-19 rules, would guide in the analysis that follows this stage.

This process will also help and guide in the conclusion and recommendations that would reflects data collected.

Ethical Requirements.

The requirement in this stage of the research elaborates on the conduct of the research and participants as well as the tools to be used in carrying out any aspect of the research.

Conducting the research at the Nottingham Trent University, the ethical requirements of Nottingham Trent University and those of the British Sociological Association are those taken into consideration during this research process.

Nottingham Trent University has a procedure for research ethics which requires the ethical implications of a study to be fully considered before full approval to start a project. This was applied for and granted between June

and July 2019. Banks et al (2013) suggest that when research is closely related to people's everyday lives, ethical considerations are paramount.

Putting these requirements in place protects the participants, free of defaults and directs the research to its logical conclusion.

Participants' wellbeing.

In this section of the research, measures are put in place to prevent migrants from being affected by any of the aspects of the research. This measure has to be put in place by the researcher because the participants haven't got the ability to protect themselves, (Schwenzer, 2008), or they are not aware of what is to be done.

Because the research is also dealing with people with insecure immigration status, symbols and pseudonyms were used to represent or identify these individuals. All necessary measures were put in place to prevent them being exposed to undue risk of harm, including emphasising that they only need to discuss topics they wish to, and to avoid those that would affect them in one way or the other, (Hugman et al, 2011).

Participants were also asked to indicate immediately when they feel distress for the interview to be halted or stopped and this is to avoid them being further affected by the research process. Duvell et al (2010) define irregular migration as an elusive phenomenon as it takes place in violation of the laws and at the margins of the society and therefore, considering particular issues of ethical consideration in carrying out such research is of great importance. This approach mitigates the risk of participants being negatively affected during the process of data collection.

These measures will keep the research in track with the ethics with the participants providing their best to answer the research question.

Conclusion.

As understood from Ketchen et al, (2006), a research methodology helps in strategizing and managing research, this chapter has laid down the approach involved in carrying on the research and most especially that of data collection to analysis. This was done by putting in place mechanisms to

facilitate a smooth research as well as those to minimise the difficulties encountered during the research process

As part of the mechanism, this chapter lays down the foundation on how participants are recruited, and how the data is collected as well as the research design in its entirety. The themes of the research are reflected upon, derived and grouped in this chapter during the data collection stage for analysis in the next chapter.

In the next chapter, the concept of access to health would be applied through the analysis of the data and in line with the research design and for the purposes of coming out with the required recommendation.

Chapter 5- Empirical research.

The previous chapter lays the foundation on the method used in the research where the importance of the perspective of both the researcher who is also a participant and that of other participants was introduced, while this chapter will be relating the participants' inputs to the precedents set out by the literature outlined in chapters 2 and 3 and analysed in line with the research questions. The foundation laid in the previous chapter will help in developing and structuring the analytic steps required in this chapter.

The chapter is made up of three sections to lay the framework of the analysis. The first section lays down the perspectives of the participants, the second section is that of the approach taken, which lays down the basis upon which the data is analysed, and the third section is that of deriving and analysing the themes from the data collected, (this explains how the themes are derived from the data then analysed).

In this chapter the concept of access to health care and the impacts of the legislations under investigation is applied with the interviews regrouped and coded to form themes as outlined in this chapter and in line with the literature reviewed in Chapter 2 and 3, to respond to the research question.

In using the approach indicated, a representation of impacts of the legislations and immigration control on health and access to health care will be presented as experienced by the participants.

The narrative obtained from the interviews are going to facilitate a better understanding of the objective narrative of the researcher who is an insider-outsider.

The data collected provides some empirical support to the concept of health inequality as a consequence of the application of the Immigration Acts under investigation. Social and economic factors affecting health and access to health care of migrants in the UK have been discussed in the literature in chapter three to affect the health care of migrants and this argument is explored using the data gathered. The data collected will be linked to the literature in chapter two and three which suggests the importance of historizing the problem faced by migrants through the Marxist dialectical

materialism, and this would help us get a better understanding and response to the research question.

In analysing the data, the research will place the migrant at the centre through the inductive approach as elaborated in the previous chapter. This approach will permit the collaboration of the researcher with other participants to identify and interpret patterns within the data collected and to understand the participants from the perspective of the difficulties they face in accessing health care in the UK to be able to get the reality of what is going on, (Braun et al, 2021).

In relying on the three concepts of Marxism earlier explained in the first chapter to get the impacts of the British immigration Acts or Immigration control, on the health and access to health care of migrants, this will permit the research to look at the history of the events that led to the creation of the British Immigration control and legislations to be able to contextualise the narratives and interpretation of these instruments and provide readers with a necessary knowledge and background of the legislations. This also goes in line with the Marxist materialistic views of history which relates or situates every phenomenon of social life within a particular historical framework in terms of the process of its' origin, development, and causal determination, (Petrova-Averkieva, 1980).

Analytic perspectives.

This section gives the general perspectives to be taken in the analysis as well as the importance of this approach to the analysis and the research in general.

In order to determine or be specific in the relationship between the views of other participants of this research and that of the researcher (myself) on the research question, and to situate our various position of immigration control or the Immigration Acts, the data is analysed using the theoretical thematic analysis and the ontological position of realism and relativism as applied in Braun & Clarke, (2013). This triggers the utilisation of a multi-perspective analysis requiring the sampling of the ontological and Marxist position of the researcher who holds the position that the reality of the impacts of the British

Immigration control or Immigration Acts on the health and access to health care of migrants does exist and that this reality will be better understood through the relative interpretation of the data.

The explanations of the above paragraphs could be better understood using the ‘’Ontology through the looking glass’’ given in Braun & Clarke, (2013, page 27-28), which explains my views of the impacts of the Immigration Legislations as an insider-outsider and that of the different migrants and participants in the research. **In so doing, it will enable me to explore the complex convergence and divergence of the participants from different perspectives to generate a richer understanding of the experiences than my single ontological position, (Kendall et al,** 2009).

The section is so instrumental to the next section in providing the perspective of the participants of the research and the approach to be used in the ethical representation of the research processes.

The perspective arrived at in this section gives a grasp of the topic which will also help in the process of coding the themes derived in the next section.

Approach.

From the foundation laid in the previous section, it will permit this section to assess the basis upon which interviews are analysed and how in some chapters particular interviews were selected for in-depth study and understanding of the research question.

After a careful reading of the transcripts collected, all data were coded and placed in relationship with the research question. Data for participants with unprotected or unstable immigration status such as asylum seekers, failed asylum and students with limited leave to remain in the UK were coded with a ‘’v’’ after their initials and those of professionals and other participants with stable status were coded with a ‘’ok’’ at the end of their initials. Considering the gender and place of resident of the participants, the codes M, F, B and C, were added to the codes earlier mentioned, with M representing male, F for female, B for Birmingham and C for Cardiff. For example if a female asylum seeker who is a participant is resident in Cardiff, the code will be ‘’VFC’’ and so on.

The coding and creation of the research themes was aimed at capturing and understanding the research question and during this process, particular attention was paid to participants own personal experience(s) with regards to access to health care and related services in the UK and most especially the areas where they are resident in the UK (Either Birmingham or Cardiff) for the purposes of comparing as requested by the research question. Similar emphasis was laid on the experience(s) of the researcher who is considered as insider-outsider of the research and that of the professionals for the purposes of triangulation of the research data.

During the formulation of the research themes, data and codes addressing similar issues were assembled and categorised to form possible themes. All codes were derived from the data collected.

The themes realized were later regrouped to form larger themes with sub-themes for a better understanding. The codes were arrived at before the themes and the themes arrived at before the grouping and all these were based on the research question. For example, the themes that have to do with ''Housing as a factor affecting good health'', ''Right to work and financial empowerment as factors affecting access to health'', ''Discrimination'' and that of ''Education as a factor affecting health'' were assembled to the theme ''Social factors affecting health and access to health. While those that have to do with ''Identification checks'', Mistrust of health professionals'', ''Political atmosphere'', Negative results of other application'' and ''Human Rights'' have all been put together and called ''Political interference and impacts of street level bureaucrats impacting health and access to health care''

In going through the theme phrases as mentioned earlier, I reread the transcripts to make sure the themes reflect the pattern in the data collected, the themes were identified based on the data collected and in relation to the research question.

Also, as a participant and part of the research, I took special consideration of going through the data collected to check on situations where some participants disagreed with points widely agreed on by most participants and to see if it fits the themes arrived at, Guest et al, (2011).

In defining the thematic structure of the research, I aimed that each theme be unique, coherent, and accurate, meaning it provided a unique answer to the research question, fitted well with other themes and were a good representation of the analysed data and

this was all achieved by identifying the essence of each theme and visiting all the data code of each theme.

The processes of coding and arriving at the themes of thesis have been laid down in this section, the next section is out to put in place the themes as coded for analysis.

Deriving and analysing the themes.

This section presents the themes that were carefully arrived at from the data collected and as coded to represent the presentation of the participants in the research.

The results of the information collected in the field for this research were coded in line with the research question as explained in the previous section and grouped in two main themes which are ‘’The social, economic and legal factors affecting health and access to health care, (Theme 1) and Political factors and acts of Street Level Bureaucrats impacting health and access to health care, (Theme 2) as would be discussed subsequently.

The themes would be analysed in the coded and grouped formats in the following paragraphs.

Theme 1: Social, Legal and Economic factors affecting access to health.

The themes arrived at in this part of the research were all assembled under the social, economic and legal facts and would be analysed in relation to the research question.

During the data collection process, the contributions of the participants indicated that, housing, right to work and financial empowerment, discrimination, and education were the social factors that affects health and access to health care in the UK, and the effects of these factors were presented differently (some participants experienced positive outcomes from the factors while others did not) by the participants as to whether they benefited or not from these factors as will be seen next.

Housing as a factor to good health:

On carrying out the interviews of this research, twelve of the twenty-eight participants and one medical practitioner expressly raised concerns pertaining to migrant housing in the UK being an impacting factor to health and access to health care while others did impliedly.

The concerns raised by these participants where in two folds with some seeing migrant housing in the UK as an impediment to health and access to health care while others did not find any negative impact of the migrant housing to the migrants.

The first part of the analysis on housing affecting health and access to health care will be that of the professionals in health. Then later that of other participants, before my personal experience in housing.

Worries pertaining to the nature of housing, location of housing, proximity of such housing to health and other social facilities, negligence on the part of the government and racism pertaining to housing were raised as impacting health and access to health.

> ‘’As a nurse and a community practitioner, I would say the nature and location of housing affects the upbringing of children that much. The housing pattern and location meant for migrants in the UK puts their offspring at a disadvantage to other children. …, there is a link between poor housing, poor education and mental health problems. …, lots of refugees (both adults and children) in mental health hospital that I have worked in have a trace to their background or from where they were brought up. It is either poor background or poor upbringing which relates to the housing or where you were located in their youths, and this is common in most areas I have done community work in the UK. …,.
>
> …, am referring to the housing that are in most of the migrant settlements I have come across. They look like a camp with constant security monitoring system. In most of those areas of predominantly migrant family, there is always a security patrol or checks moving around which to me is not supposed to be so because it gives an impression of the residence of that area especially the kids. (UchB, a Nigerian and community nurse resident in Birmingham)’’.

This participant is a Nigerian and practising nurse in the UK, who also doubles as a migrant. She expressed her experience in the field with the location and nature of houses and the house quality accorded to migrants as the main impact to the health and access to health of the migrants. As a community nurse in the UK, she recounts how she has had the opportunity to work with in some areas of the Birmingham municipality where she witnessed and experienced this. Her explanation was to the

fact that there are certain communities or areas carved out purposely for migrants and these communities have a history and stereotypes that affects the inhabitants therein.

From her explanations, the nature of housing here is related to the hygiene of the houses while the location is related to the situation of the houses in the areas with facilities and the proximity refers to the distance of these houses to the needed facilities.

Remoteness of a house, Lack of basic facilities, Negligence and conspiracy between the government and Landlords was raised as a factor affecting migrants.

> ‘’…, as a leader to the Cameroonian community in the UK, I realised that the houses provided to immigrants of my country who are seeking asylum are not always the best. …, the houses provided to them are either in remote areas or do not have good heating facilities and this affects them both physically and mentally. …, some of them are seen thrown into the street after being granted the refugees status with no houses. …, Some of the houses are not meant to be used by human’’.
>
> I noticed that asylum seekers are being given houses that are out of the markets and the landlords use their connections with the local authorities to channel these people to their outdated property. These gentlemen told me they have no choice at that moment than to take whatever house they gave me. At times, the local authorities take these people to villages with cheaper houses, with high concentration of Britons and history of racial attacks and as a result, these migrants are subjected racial attacks by natives. (NiC, a Cameroonian with British nationality resident in Cardiff Wales)’’.

This participant is a Cameroonian with the UK citizenship and leader of the Cameroonian Community in Cardiff Wales. He believes that good housing goes with equipping same with the necessities required. He tendered his dissatisfaction on the nature of housing accorded to a migrant friend which to him hadn’t the necessary heating facilities and that this affected the health of the migrant negatively who was constantly in ill health. He is expressly noted in the interview that the government after granting refugee status to some individuals, the government tend to get rid of the

section 95 housing accorded to the migrants without giving them new habitable houses and this affects their health adversely.

The participant expressed further dissatisfaction on negligence as well as the deliberate acts on the part of some local authorities in allocating migrant housing in Cardiff. To him, these local authorities work in collaboration with some landlords for profit making at the expense of the physical and mental health of the migrant using the section 94, 95 and 96 of the 1999 Asylum and Immigration Act housing support projects. Negligence comes as a result of the fact that some local authorities do not consider some social aspects such as areas with history of racial attack on migrants, that are of adverse outcome to migrant's health before allocating houses to migrant, of which these factors are the barriers faced by these migrants in these areas and this affects the migrant's health wise. To him placing migrants in areas with history of racial attacks and a high concentration of Britons exposes these migrants to racial attacks.

In addition to the nature and condition of housing, issues pertaining to choices of houses was raised to be a factor affecting access to health and health care, and it was regarded by some participants as a sort of punishment by the state of Britain.

> ''From my previous house, I was surprisingly asked one evening to get ready to move to another house …, then I was brought into this house that same fateful evening …, and I met a lady with her seven-year-old son who told me she has been in this house for seven years …,
>
> ''…, putting me in this type of house is destroying my health and that of my child. I can't make a better health while here not to talk of my poor child who needs a healthy environment to play like her mates …, this house has all sorts of parasites and harmful insects coming out from the floors and walls dangerous for my toddler, maybe they don't want me in this country (in tears)'' (AdeB, Cameroonian Asylum seeker in Birmingham who came to the UK in 2019).

This participant is a Cameroonian refugee/asylum seeker whose claim for the leave to remain has been refused up to the appeal stage and she is still benefiting from the section 95 of the 1999 Asylum and immigration act housing support. She is also a nursing mother of a ten-month-old baby at the time of the interview.

In responding to our questions made us to understand that her section 95 of the 1999 Asylum and Immigration Act accommodation assistance was imposed on her with no opportunity for her to choose what she desired.

She described the house as being a harbouring place for pests and other parasites that are harmful to the health of her toddler and herself and that she had no opportunity to either object or make a suitable choice for herself.

She also made us to understand that the accommodation serves as a parking place for other vulnerable migrants like herself as she explained her meeting with another mother who has been in same house for seven years.

While in tears and explaining how bad the house is for her mental and physical health and that of her ten months old daughter, she also let us know that she believes her present condition could be some sort of punishment for her seeking refuge in the UK from her country of origin[22]. That as a nursing mother, she could not anticipate a good future for her child from this environment as compared to other children with good standing in the UK.

The participants who did not see anything negative in the migrants housing, presented to have come to the UK with the financial capability to afford good housing for themselves or had the luck of being with someone who has the means of affording a good house.

> ''As for me personally, I have never had a problem with housing for more than 20 years now in the UK maybe it is because I came here when things were not that bad. But I have heard of people facing serious housing issues ranging from poor accommodation to homelessness'' (CoB, a Nigerian with UK nationality and has been in the UK for more than 20 years).

This participant from every indication has a good foundation in the UK as compared to other participants. She came to the UK way back earlier than those who are facing things worst and may have built a good foundation for herself in the domain of housing. Notwithstanding, she still expresses concerns for some persons to her knowledge who are facing difficulties in housing in the UK.

[22] In pidgin English she said, ''ar sure say dem di only punish me for here say ar come their contry'' meaning ''am sure they are only punishing me for coming to their country'' and ''they'' here is being referred to the Home Office.

> ‘’For me, I haven’t had any issue with housing because since I came to the UK, I am staying with my uncle who is a British and Businessman and his house is good and ok for me. Personally, I don’t have any problem with leaving home to school and back, his house is a perfect paradise’’ (VicB, a tier4 student who came to the UK on a Tier4 Visa in 2019).

This participant has no issues with the housing situation for migrants in the UK and this is because he is being lodged by his uncle who has been living in the UK for more than twenty years. His situation could be understood as someone who has no need for the UK housing.

My experience on housing in the UK is different from that of the other participants in the sense that I was not given any form of housing though I applied for one I claimed asylum as a refugee in December 2017. After I had made my claim to the Home Office sometimes in the month of September 2017, I contacted the Home Office for accommodation through Migrant Help Birmingham. Then I was living with a friend who had helped me in his one-bedroom house for about six months and he had given me a two months’ notice to quit his house.

From October 2017 I was placed in for more than two months and the friend with whom I was living sent me packing and I became homeless. I slept in the street for three days under the cold and was offered accommodation by another friend who saw my health deteriorating. He met me when I was shivering and in high temperature, then he took me to his house.

The main problem I had at the Migrant Help Birmingham was that of reference. They asked me to get a letter from the person who was lodging me before they could do something and the person whom I was staying with was a Cameroonian student under the Tier4 Visa who was sceptical of the request and refused to respond.

That is how I found myself in the street of Birmingham for more than two weeks because I was not able to break the controls put in place by the home office to get a house and secondly because I could not afford the means for a house. That is how I lived under depression for more than seven months and sleeping on the floor of this good Samaritan.

Effect of housing during the Covid-19 Pandemic.

During the covid-19 pandemic, the housing situation for some asylum seekers was very degrading in the UK especially the housing facilities accorded to asylum seekers and refugees under section 95 of the asylum and immigration act 1999.

Covid rules, housing condition and choice of food for migrants was an issue,

> ‘’At the hotel that I stayed in Birmingham for more than a year beginning from November 2019 to January 2021 under deplorable conditions and nothing was being done even when I called migrant help to seek assistance …,
>
> …, room with no measures taken to secure our health from the Covid-19 virus. …, we had two small beds in a small room and a table at the centre of the room that we both used …, we all go for our meals imposed on us at the same place every morning with no social distance and control measures put in place, …, in the hotel and at the heart of the pandemic in March 2020, an additional person was brought to share my room with no checks effected on him’’
>
> ‘’I left everything to God in prayers and if I realised any symptoms of the covid-19 while doing my personal hygiene and first aid, (KabB, a refugee who came to the UK in 2019 with case pending at the level of appeal appeal)’’.

Still in responding to the question of the housing condition put in place by the government to the migrants in the UK during the covid-19 pandemic, KabB, a Cameroonian refugee expressed his general dissatisfactions with the measures taken by the government of UK during the lockdown period. He based his worries on the fact that during period of the covid-19 pandemic, he was housed in Birmingham alongside other asylum seekers under deplorable and dangerous condition from the periods of November 2019 to the January 2020 in the heart of the covid-19 pandemic. He also raised worries on how he was being overcrowded in a room during the pandemic raised the possibility of his contacting the pandemic. And that he made a complaint that wasn’t given any attention by the government. He also made us to understand that he had no choice of food of his own and was bound to take whatever food that was offered him in the placement even if the food was not going well with his system and that as an asylum seeker he had no funds to get food of his choice, and this tormented him emotionally.

He raised concerns on the surveillance system put in place to monitor them during this period which he considered to have restricted them from carrying out their personal activities, and that if he happened to have been a victim of the Covid-19 pandemic, he would have left his health at God's mercy by carrying on self-treatment even though he had no formal training.

Housing condition and other Covid-19 rules were also a point of concern.

> …, I was Housed a hotel in London in June 2019 then moved to Cardiff where I was still housed in a hostel with other migrants the conditions in both places were horrible with a small bedroom of two beds with two persons per room and the heating systems were not good. …, I was housed with an elderly man who looked sick in the same room, I had no choice though the condition of the house …, and unhabitable and it was during the covid-19 pandemic. The walls of the house were full of moulds, the heating not in good order and with a central control and the beds looked very old. I made complaints, but nothing was done about it. …, (MauC, a Cameroonian Refugee from Cardiff).

The second participant who also got the section 95 of the 1999 Asylum and immigration housing support, on answering the question on housing during the covid-19 pandemic, recounted a similar story but this time it was from Cardiff Wales. He complained of being housed in a house with deplorable condition, with more than one person to share a room in an old house with poor heating system, and that the situation even worsen during the pandemic and that this placed him at high risk.

His experience was both in England and Wales where he said the housing treatment, he received in both places were similar.

He also recounts of haven complained, but no measures put in place and that this affected him emotionally.

Notwithstanding, all the difficulties encountered by the participants during this period, I still registered an individual to be quoted in the next paragraph, (BertC) who appreciated the effort of the Welsh immigration service during the pandemic. This demonstrates the fact that though the laws believed to be structured to the detriment of the migrants, some actions of street level Bureaucrats work in favour of the migrants.

In some areas, the Covid-19 rules put in place by the government were respected as noted here.

> ‘’Our housing situations in Cardiff during the covid-19 period was under control as I can say because in our hostel or lodging, all the social distancing rules were being respected. I had my room and did my things separate from others and due the concerns I had bout my health, I was vigilant in all my undertakings.
>
> I also noticed that the administrators of the lodging were very vigilant and made sure anyone who had signs of covid-19 was being treated or taken out of the accommodation immediately’’, (BertC, a Cameroonian asylum seeker based in Cardiff)

This participant is a Cameroonian refugee who was lodged in Cardiff Wales during the pandemic. He seems not to have experience anything negative with respect to housing during this period as compared to others in England. His experience as expressed in the data was good as he did not go through any difficulty or threats with regards to housing during the pandemic.

He happened to be one of the fortunate one from our list who had a positive treatment from the immigration department of the UK in terms of housing during the Covid-19 pandemic.

Financial stability impacts health and access to health care in the UK.

> ‘’I haven’t had any issue with housing because since I came to the UK, I am staying with my uncle who is a British and Businessman and his house is good and ok for me. Personally, I don’t have any problem with leaving home to school and back, his house is a perfect paradise.
>
> But lately I have been to a younger friends’ place, and he has been having issues with housing because he cannot afford a good house for himself. His housing situation is deplorable and not good for habitation. He is undocumented asylum seeker and was sent to a house that is outdated with no good heating and light facilities. Staying in his room is like staying outside’’ and this is not good for the health, (VicB, a tier4 student who came to the UK in 2019 through the Tier4 Visa).

This participant is a Nigerian student who came to the UK through the Tier4 visa. His view of housing could be understood from two angles, first, he is comfortable because he came through someone who has all the means it takes to get a good accommodation in the UK, and secondly the experience he witnessed from his friend who was not able to afford the means for a better housing and who was accorded housing in a deplorable situation.

Right to work and financial empowerment.

From the data collected, I found out from 14 of the participants who are migrants and one medical practitioner that financial strength is as an aspect empowering health and access to health care as some participants opined that the right to work is more instrumental in a persons' life and that all migrants be accorded this right in the UK.

Of the remaining 14 migrant participants and 5 professionals, no direct comment was made attributing the right to work as an impediment to accessing healthcare in the UK. Even though these migrant participants did not raise this aspect of the right to work directly as being a barrier to them accessing health facilities in the UK, some presented aspects of poverty and other related responses which connotates and represents the fact that financial empowerment is vital in health and accessing health care facilities.

Financial empowerment of migrants can facilitate health and access to health care issues.

> ''Yes, I think empowering the refugees and asylum seekers financially through the right to work and …, would mean giving them the power to heal themselves from stress and other external factors. For them to be able to work their own money is to be able to work and pay for their mental and physical health. At the end of the day, …, giving them little amount of money such as £37 weekly for their upkeep to me would not be helping them. Empowering them through giving them the right to work would go a long way helping their state of minds'' (UchB, a Nigerian and nurse).

This participant is the Nigerian community nurse working directly with the people in the field. In this data, she discourages the aspect of offering a meagre weekly allowance of £37 to asylum seekers and prefers these individuals be allowed to work to determine by themselves the amount they may need for their wellbeing. This aspect of them being able to work to earn their own money has an important and positive part

to play in their mental and physical health than being given whatever the government feels they may need. From her explanation, the financial empowerment plays a huge role in them affording their health needs at the appropriate time.

The inability to provide financial needs affect the relationship between parents and their children.

> ‘’I also know for a fact that some parents with children under care are financially unstable because of their immigration status. They don’t have the right to work and make money to provide some basic needs for their children and this affects their relationships with their kids and their mental health as well’’, (ShepC, Social worker Wales).

This participant is a social worker of the NHS Wales and resident in Cardiff and at the time of the interview he considered financial strength to be paramount in the health of everyone. He affirmed that financial stability produces a positive effect on both the health and social relation of the migrants’ concern and their children and crave for the need of according the migrants with the rights to work to improve the strength and ability of those individuals.

Of the 14 participants who raised financial capability as a factor impacting their health and access to health care, affordability with regards to access to medication and food supplements was their main worries. To them, the decision of the government on what to give the migrants for weekly and/or monthly upkeep was not sufficient to solve their health worries.

Lack of money to buy medication and little or no assistance from government was raised as an impediment to access health care.

> ‘’Most of the time if you do not have the NHS card and number showing your status, you have to buy medication and I don’t have. …,even a letter from the gp showing that I have to get free medication, I have never had that.
>
> ‘’I beg from friends and churches to be able to eat and afford for basic medications. If I could work, that wouldn’t have been a problem because I would have been able to pay for my bills and this situation made me feel incapable and abnormal’’.

> If I were to advise the government, I would say let them allow the migrants to work and care for themselves because the little weekly allowance given is no way enough to help one. The £37 weekly given to Asylum seekers can't go anywhere to help someone who is suffering from fever and needs paracetamol. It can't even feed a grownup like me for two days. Only those who have gone through what I am saying can tell'' (AloC, a Nigerian with failed asylum status)

This participant is a failed asylum seeker whose participation in the research outlined the impact of restricting him to work and access to public funds which as a result weakens his financial status and leaves him unable to afford the necessary medical needs. Some of these basic needs are those that one needs to get them immediately their needs arise (such as getting medications from pharmacies and other food stuffs) at any time and would require immediate reactions based on financial strength. Such situations could be over the counter medications and food stuff for a healthy being which could only be gotten with money.

He further holds that because of the restriction om the right to work for asylum seekers and failed asylum seekers, he has resolved in begging from individuals and charity to be able to have basic medical needs and this keeps them in a state of mind of disability.

He further reveals that the weekly £37 given to some migrants including himself while he was still under the section 95 support can't go far to solve their problem (provision of First Aid) in time of health crisis. That the £37 weekly can't be enough to provide feeding to a grown up thereby leaving them malnourished.

Refusal and restriction of working hours on student migrants affects their ability to access health care.

> ''It would have been difficult for me if I did not have the money to buy drugs and this is because am allowed to work only 20 hours a week which leaves me with little or nothing after tax'', (VicB, a tier4 student based in Birmingham).

This data was collected from a Tier4 student who in the course of the interview complaint of the restricted hours (Tier4 Visa student are allowed to work only 20 hours a week) of work accorded by his visa type. The data resulted from a question as to

whether he would be able to pay his hospital bills when need arises and he replied that the job restriction on him as a Tier4 student affects his financial capability.

Applying the Health Surcharge affects migrants' health and access to health care. It also acts as double taxing migrant workers and undermines the legitimacy of some application.

> ''The Immigration Health Surcharge (IHS) is effectively a double tax. Migrant workers such as students who are working are paying towards the NHS but also pay the IHS charge. This is primarily about undermining people's ability to live comfortably in the UK. …,I know of at least one case where a woman who had given birth to her child in the UK subsequently made an application to stay because of the child, but the Home Office contacted the NHS Trust and arranged for them to issue an invoice for the maternity care…, the Home Office refused the application (of mother and child) on the grounds that there was an unpaid NHS debt (a general ground for refusal in the immigration rules). This shows that the charges are not about protecting the NHS but about undermining an otherwise legitimate application to stay in the UK'', (AsB, a legal practitioner who doubles as an activist for the rights of migrants in the UK).

This participant holds the position that the Immigration Health Surcharge applied to migrants who come to the UK and especially those with right to work is double taxing, as these individuals would be expected to pay tax during working. When the tax is considered used to fuel the NHS activities including the health care provision. As a legal practitioner, she recounts how failure to pay the Immigration Health Surcharge is being used as grounds for the refusal of a legitimate asylum application thereby refusing the applicant their rights to health in the UK.

My personal experience with regards to this theme was during the period of me experiencing homelessness as explained in the previous theme. I was not able to afford money to buy paracetamol for fever because I had no means and right to work. I was not even awarded the usual weekly £37 that was awarded to others because I was not considered eligible for the section 95 support without a letter of confirmation from the person lodging me at that time.

That alone kept me hopeless as I knew nothing good could come from me without money to take on my responsibilities. There was a time during my homelessness days when a friend asked me to pay him £150 monthly rent to occupy the storage of his house basement, but I couldn't afford the money because I was jobless and that destroyed my mental state.

Effects of financial capability during the Covid-19 pandemic.

During the period the Covid-19 pandemic, it has been the responsibility of most states of the world to raise the status of their citizens to avoid the handicap of inability to meet needs of all citizens. The UK on its part during this period have some migrants carved out from this assistance (Migrants without recourse to public funds such as asylum seekers and students with Tier4 visa).

> Yea, when I came to the UK during the Covid-19 period and we were taken to a hotel in Coventry. The hotel was not in good shape, and we had no means to keep ourselves better and no option to complain.
>
> We were given tasteless food and we had no means to get ours or complain. We had no laundry machine to get our cloths washed and we were given £5 a week for our upkeeps. To me this was not enough to look after myself during this period, (KabB, Birmingham)

This status exposes exposed most of the migrants to many unforeseen circumstances, though some of these migrants are seen to be working and contributing to the economy as other citizens of the UK but aren't able to benefit from the system in which they contribute to.

> I had my personal experience in August 2020 in my household. I have three Cameroonian asylum seekers in my household who are not beneficiaries to this scheme.
>
> I had to work hard to feed myself including the three Cameroonian. In September 2020, the four of us got infected by the virus and we had to isolate ourselves for fourteen days and then I had no money to feed the four of us.
>
> Personally, I was not able to get any of these aids to carry us for the fourteen days of isolation and as a result we spent the days in pain.

Discrimination as a barrier to accessing health care.

> ‘’The fact that I am at a hospital reception with others who are whites, and they are constantly being asked and looked after by the staff while am in the same position and state, means a lot. It means that my being there doesn’t matter to them. Even when you try to talk to them, they give you looks and attitude that are not welcoming. All this gives me a feeling of not being wanted in that environment’’. (AloC, a Nigerian failed asylum seeker based in Cardiff)

This participant explains his ordeal at a medical facility in the UK and precisely Cardiff which made him feel discriminated and felt as to withdraw from further attending medical facilities for attendance.

In addition to this participant,10 of the participants in the research mentioned discrimination as an aspect that prevents them from accessing healthcare facilities in the UK. The participants who are most asylum seekers revealed that discriminatory and racist behaviours towards them could go a long way to cause them to withdraw from accessing health care facilities. It makes them feel not wanted in such environment (In the case of hospitals they feel not wanted in the premises) and consequent in withdrawal.

The acts of some street level bureaucrats result to discrimination and not healthy for the service users.

> ‘’I was at a hospital reception with others who were whites who were constantly being asked by the receptionist and looked after while I was being ignored and this meant a lot to me. It means that my being there doesn’t matter to the receptionist who I had my file presented to. Even when I tried to talk to them, they gave me looks that are not welcoming. I felt it was because of my immigration status as a refugee that made them treat me that way and all this gives me a feeling of not being accepted in that environment’’. (AloC, a Nigerian failed asylum seeker).

This participant as earlier explained in this chapter, is a failed asylum who lost trust in the asylum system of the UK and went underground. He recounted his experience in a medical institution where he believed the white race were being prioritised for treatment over him. This treatment gave him the feeling that he is being discriminated for being black and that he is not being accepted by the community.

> My personal experience to racism was in the year 2016 while studying in Bangor Wales, I fell sick and went to consult at my GP. While at the GP practice and queuing up to be attended to, an elderly white woman in her 70s called me a ‘’black bastard’’ and asked me to leave her side. Though the staff at the GP practice intervened and asked me to be calm, I wasn’t myself anymore. I made the decision to leave the practice without being attended to.

Education as a factor that can affect health and access to healthcare.

The factor of education was only raised by two health practitioners and none of the twenty-seven migrants who took part in the research expressly made mention of education as a factor that affects health or access to health. Of the two healthcare practitioners, I had a nurse with the UK healthcare provider and a migrant from Nigeria.

Education is described here to affect health and access to health care in the sense that migrants who are not equipped with the necessary knowledge and awareness on the health services available to them.

Education, awareness and knowledge affect health and access to health.

> …, it is one thing to be able to access the healthcare facilities and it is another to be able to have knowledge of how to access them. …, I have had a situation where these individuals don’t even know how to go about this. They don’t know that these services are available to them. …,. Some whom are from war torn countries are still faced by some mental health situations that follows them all through. From my experience, it could be that they are not exposed, obviously they have come from very enclaved countries and faced very difficult circumstances …, So, I feel from a health care provider perspective that something need be done to educate these persons to their right to those services’’, …, these people need to be educated from the day they enter the UK as to the type of facilities they are privy to and those they are not. Just in educating, would give an opportunity for them to ask more question as to the problems they are facing and this would make them able to access those facilities. …, (UchB, a Nigerian and nurse).

This participant is a Nigerian community nurse working and based in the UK. She has been working in the healthcare sector of the UK for more than 5 years and she doubles as an educator also in the healthcare sector. From her experience in the field, she

found out that there is an issue of educating the population on what type of health facility available to them for them to be able to go for. Educating people on what service is available to them is encouraging them to have those services she implied. She further gave the importance of education especially if it has to do with migrants who are strangers in the UK and mostly victims from their countries of origin. It is also outlined in the data the need of education or empowerment to counter the possibility of the migrants suffering in silence for fear of being victimised with deportation.

Education is the responsibility of the government and organs concern to assist or promote access to health care.

> ‘’The organisations which process their journey (The asylum process of refugees) have the responsibility to explain the way to access health care and have the opportunity and to make sure they understand. Charities also provide written support in several languages outlining access to health, however in the end, those who hold the budgets are responsible for communication’’ (Ma, Retired NHS worker).

This participant is a seasoned and retired health officer of the NHS and also doubles as an activist for the rights of refugees in the UK attached to the City of Sanctuary. She raised the need for education in an opinion that it is the responsibility of organisations looking after migrants during their application process to educate them of their rights to health or access to health care. She concluded by saying it is the responsibility of the state to make available the means for these migrants to be educated and that if this is not made available by the government, it is a way of denying them of their rights to health.

Despite the fact that the 26 participants did not mention education as a serious fact affecting their access to health care, there were some responses to questions that made me understood the need for education to at least access to some health care services.

In instances where they are asked a question pertaining to accessing healthcare and they appear to have no idea, this gives the impression that they have not been told or have no idea of the existence of those services.

Education can affect people from accessing health care.

> ‘’I knew nothing and did not know how to go about anything since this is not my country, (AdeB, a Cameroonian refugee who came to the UK in 2018)’’.

This participant is a refugee who newly came to the UK in 2018 fleeing from the political instability from Cameroon, and when asked of her knowledge on going to seek healthcare upon arrival in the UK she said she knew nothing in that regard. This implies she lacked knowledge and awareness in the aspects of accessing healthcare facilities.

> I personally had an experience while in Birmingham in November 2018, I met a guy in the street who looked homeless and on inquiring, he was a Cameroonian in a dilapidating health condition. When I did further inquiries, I found out he had come into the UK through the borders of France. I requested he goes to the A&E for emergency treatment, but he refused saying he would not be accepted at the hospital. I had to educate him on his right to accessing healthcare facilities in the UK. I then took him to the A&E Birmingham.
>
> At that time, if I didn’t tell him what he is entitled to in terms of accessing healthcare facilities, maybe the worst would have happened.

Theme 2- Political interference and impacts of street level bureaucrats impacting health and access to healthcare.

This sub-section discuses factors affecting health and access to health care emanating from the action of street level bureaucrats and other forms of political interference that came up during the data collection process.

The data revealed that, Identification checks, Mistrust of health professionals, Political atmosphere, the negative outcomes of other immigration application, Personal and Professional values of street level bureaucrats and Human Rights could go a long way to affect migrants’ health and access to healthcare facilities in the UK.

Identification checks, as deterrent factor for some migrants accessing health care:

Considering identification checks of migrants as a factor affecting their health and access from healthcare and related services in the UK, all 28 participants held the position that unscrupulous identification processes imposed on them and most especially the migrants with unsecure immigration status during the process of accessing healthcare facilities affects them from accessing healthcare facilities in their various communities.

Most of the participants who raised this concerns of identification reiterated that the approach of identification checks looks like a sort of entrapment put in place by the system to monitor their moves and that this obstructs them accessing those facilities.

> …, what I noticed is that you may leave your home to the hospital for a problem and due to external factors, you end up encountering another problem. …, you go to seek medical redress and you end up being questioned and policed on things that are not necessary. I mean asking for identification instead of seeking to treat people of their illnesses., (AjB, a Cameroonian student who came to the UK through the Tier4 visa for studies and presently seeking asylum).

As for this participant, one of his worries was that the identification process may lead to further scrutiny which may further lead to further implicating the migrant and as a result, it scares migrants from accessing health care services.

Identification was also reported to be used as means to restrict access to free drugs.

> …, the staff I met focused her attention on my identification than the problem I had. I felt like I was being treated different and that I would not have had any attention if I had not presented any form of identification. …, the pharmacist refused to give me drugs that were meant to be free just because I hadn't a waiver from my GP specifying my status''. (AjB a Cameroonian student who came to the UK through the Tier4 visa for studies and presently seeking asylum).

In further response to the interview question, this participant expressed the feelings that the identification process is used to prevent access to medication by the system.

The documents requirement from refugees at GP surgeries is almost an impossible requirement to provide and this renders the migrants more vulnerable.

> …, It may lead to you being question on your leave to enter the UK which may necessitate the intervention of the police. This would cause any undocumented individual to think twice before going to seek health care. Most asylum seekers tend to hide themselves because of these aspects of documentation. If not that I was courageous, I wouldn't have gone to the hospital in the UK after being scrutinized on my first appointment. …, it may end up aggravating your medical situation or causing you another health situation, (AjB, a Cameroonian student who came to the UK through the Tier4 visa for studies and presently seeking asylum).
>
> …, In the UK, I had to show prove of payment of health insurance (Surcharge), this is not readily available to the ordinary migrant from Cameroon and causing them to withdraw at times…, (AsB, a Chevening Scholar 2017 and legal practitioner of the Cameroon Bar Association).

The data explains how the identifications requested from migrants is difficult and almost not existing as migrant are not allowed by the law to rent or open a bank account to be able to produce proofs of address.

Compared to where participants are coming from, the identification process before GP Practices in the UK with example of England and Wales, makes access to health care more difficult to migrant service users.

> ''In Cameroon, you can access any health facility of your choice at almost any time of the day. …, with the UK where you must show proof of an address and other qualifications criteria in order to be able to consult with a GP. This can be challenging for asylum seekers whose applications sometimes takes years to go through. In Cameroon, you just need to be human being and you are attended to. …, this is a big barrier to these vulnerable individuals''. (AsB, a Chevening Scholar 2017 and legal practitioner of the Cameroon Bar Association)

In continuation of his response to the interview, ASB who is a legal practitioner in Cameroon, considered the process of identification of migrants before access to health

facilities in the UK as challenging to asylum seekers and those migrants whose' cases are facing delay. He identified the proof of address required by some GPs for the purpose of registration by undocumented migrants as one of the main challenges faced by migrants as a result of the fact that they are not required by the law to secure a rented property talk less of having an address for the GP registration. All these barriers to him are big hinderance to the migrants from accessing healthcare facilities.

Identification and longer periods of appointments schedules made by the GP Surgeries makes things more difficult for failed asylum seekers.

> ''It is not easy for people like us failed asylum seekers especially those of us who are not in the system. …, and it is not also easy to go back to the GP because of the fright of the unknown. …, you need to start explaining yourself to them and it is not easy. At times you gather the courage to call them, but you are given appointment for four to five months which makes me more careful'' (AloC, a failed Nigerian asylum seeker).

This participant is a failed asylum seekers from Nigeria who for one reason or the other decided to go underground[23] explained that he gets frightened with the identification process because he considers it unsafe to his status. This participant came to the UK in 2018 and had his case decided upon with a negative outcome holds the position that questioning on his immigration status each time he gets to a GP practice keeps him frightened for fear of the unknown and because of his experience with the system. He explained that having had to start explaining himself to any GP was the difficult and most frightful part of the procedure and this discourages him from further going for health treatments.

Further questioning at a GP surgery on issues that are not health related keeps migrants frightened and scared.

> ''…, I feel insecure because each time am before any authority here including the health authorities, they keep on digging into my background during the identification process …, this may cause one to say things that are not in his favour and that to me looks frightful and makes me feel unsafe to go before them subsequently (MauC, a Cameroonian with refugee status from Cardiff).

[23] This occurred to him because of the bad experience(s) he had with the asylum system, leading to him being irregular implying living as an irregular migrant with some constraints. (Bloch, 2014).

This participant is a Cameroonian refugee based in Cardiff at the time of the interview and who explained how identifying himself before any health facility during health seeking process kept him in fright and insecure. He recounts how the approach used in the identification process could be termed racial profiling from the nature of questions asked. That this identification approach caused him to feel reluctant going to healthcare facilities for help.

> My personal experience with identification checks was at the incident I explained earlier of me being homeless and sick in the street of Birmingham. During that period, (between 2016 to 2018), I had digested the concept of ''Hostile environment'' to mean, undocumented migrants, which I interpreted as including Refugees and asylum seekers are not wanted in the UK. I knew deep in me that if am caught by the law enforcement officers, it would be difficult for me and that alone caused me to avoid going to any public or state-owned institution such as hospital for fear of being checked.

After looking at the positions of the participants on the approach and effects of the identification processes in health facilities and taking into consideration my personal experience, this research would draw a conclusion by taking into consideration other factors such as racism and education to hold that immigration checks during the process of accessing healthcare could affect migrants and most especially those with insecure immigration status such as asylum seekers, refugees and failed asylum seekers.

Mistrust to medical professionals.

By Mistrust here, the research is referring to the relationship between the healthcare officials, immigration officials and the migrants under investigation during access to healthcare in the UK. This relationship from this theme has a role to play in migrants' access to health care and the data collected shows that it has not been working in the interest of the service users who are the migrants.

In carrying out the interviews, about 4 of the participants, all asylum seekers and failed asylum seekers gave testimonies on how inhuman treatments towards them from some health officials gave them reasons to lost trust in the system.

Relating to other participants in relation to this point, the research holds that trust issues between the parties (health providers and service users) has a role to play in

migrants' access to healthcare in the UK. The research further holds that the relationship between a service user and the service provider has a lot to play, and it is on this ground that the research considers a deteriorated relationship to affect the service user.

The relationship between migrants and service providers of the UK healthcare system were assessed in the data collected to have emanated from the discriminatory and racist treatments accorded to migrants' service users.

Racist and discriminatory utterances from Health professionals causes service users to lost trust in them.

> ''Nurses in Morton Hall detention centre sometimes openly say to us while we go to complain our health problems that ''we have had all of these in the past'' (meaning whatever complaint we the migrants make are normal to them), they sometimes do not take our complaints serious no matter the circumstance(s) …, This had a huge impact on our mental health especially while in the detention centre and even when we got released back into the community because it makes me to doubt whatever is in the health sector says, …,. I for example and while at the centre did not feel comfortable going to see a doctor in that centre because of these utterances and that same feeling comes up now that am out of detention, …,'', (KinB, a Cameroonian refugee, former Morton Hall detainee who came to the UK since 2010).

This participant who has been in detention in Morton Hall immigration detention centre disclosed the unfair treatments they were subjected to in the centre by some health officials that made him feel unsafe to believe in their services in the UK and that this feeling continued even after he went out of the detention centre.

In a health setup, patience are expected to confine some of their worries to the staff looking after them. In a situation where the nurse tends to be a threat in your life, it creates a scenario of untrust. That is the exact situation the participant is explaining here.

The participant recounted an incident wherein a health official made an unprofessional utterance that made him, and other migrant detainees feel unsafe. He reiterated that the fact that this utterance came from a medical professional who is guided by ethics

towards them who depend on their services makes them lose trust in the system, that it makes them lose the feeling of going to seek their services.

> I have had a similar experience in Birmingham 2019, November that even caused me to feel like never going to the hospital anymore. It occurred when I went to seek the services of my GP practices and when I got to the secretariat, I was asked to present my documents, but then I had misplaced my Biometric Residence Permit and was able to tell the receptionist my address and date of birth. The receptionist told me openly that she is checking my documents to make sure am a taxpayer, and that she will not book me in for free services if am not a taxpayer and that it is only taxpayers who are eligible to use the NHS for free. I got confused at that point because I did not have the main document, she asked of me and did not know what might happened to me next, so I left the hospital and bought an off-counter medication to drink. At that point, I felt discriminated and could not comprehend me being sick and being rejected from a healthcare institution. I was expecting her to ask for my name to check in the system if am regular, but she was bent on seeing the document.

Effect of Mistrust to medical professionals during the Covid-19 pandemic.

In response to the questions asked to the participants some issue with regards to mistrust and its' effects during the Covid-19 pandemic were raised.

Unprofessional attitudes from health providers during Pandemic is a hazard.

> …, I would not be expecting anything better. The experience I have had in the past in the hands of some health professionals is a yardstick for what I am telling you today …, If I were to have another problem or a family member of mine with same status were to have another problem, It would be more of a hazard …, as an asylum seeker, I didn't find it easy during normal period, it would be worst during a pandemic such as the covid-19'' (AjB, a Cameroonian student who came to the UK through the Tier4 visa for studies and presently seeking asylum).

AJB as earlier explained is an asylum seeker who came to the UK through the Tier4 student visa. During the data collection, he explained that the previous acts of some health professionals during his health visits make him feels unsafe whenever seeking medical redress. Comparing his experience(s) with access to health care and the

conduct of some health officials during a normal period and that of the Covid-19 pandemic where many factors have been outlined to affect the Minority Ethnic population of the UK adversely, he thinks the situation will get worse for his and the minority ethnic population with regards to accessing healthcare facilities.

Based on the poor treatment, migrants tend to stay away from all offers of state including those to control the Covid-19, rendering them more vulnerable.

> …, I was affected to near death by the covid-19 and had to stay on my own indoors without calling or telling anyone till I got healed. I had to take these measures to protect myself from any happening because one can never trust any British. It would have been different if I had my leave to remain like others but thank God I got healed''.
>
> We do not trust the services offered them by the government during the Covid-19 pandemic, and this renders them vulnerable. I got the feelings that nothing would have been done even if I called the emergency team. …, the only prayer I made was for God to heal me and avoid humiliation from those health personnel. I have suffered enough and would not like to see more in the name of going to hospital'', (AloC, Nigerian Failed asylum seeker)

This participant recounts how the treatment received by other migrants in the UK system scares him away from going close to the health facilities.

Some failed asylum seekers gone underground for no trust to the system and that prevents them from coming out to take the treatments.

> ''I got friends who are also failed asylum seeker like myself and with whom we have all gone underground and some of them keep telling me to be careful with the way I go close to hospitals and administrative offices. They say, I could be arrested and repatriated …,'', (AloC, a Nigerian failed asylum seeker who came to the UK in 2018).

As earlier mentioned, this participant is the migrant with failed asylum status who went underground as a result of the treatments received from the UK asylum system. He revealed that he had to take the risk of hiding himself indoors even when critically ill during the pandemic for fear of the unknown as a result of his immigration status. He further explained to us that his experience with the system has proven that no positive

action would have been taken for his treatment[24] during the covid-19 pandemic even if he had presented his case and that he would've received but an embarrassment.

This same participant revealed to us that because of the mistrust to the authority in the U K, there are other migrants in the community who have decided to go underground. That this decision was to hide themselves from the UK authority that they don't trust and to avoid being confronted by the law.

Political atmosphere. impacting health and access to health.

The political atmosphere does sometimes trigger agenda to be realised through the passing of a legislation or change of policy. These changes could be for the benefit of the masses during normal periods and periods of emergencies such as the Covid-19 Pandemic to keep safe the community and may also be of disadvantage to certain persons or group of persons as was the case with the ethnic minority group being affected adversely during the Covid-19 pandemic resulting from the rules put in place with intent to reduce the effects of the pandemic.

During the data collection, one participant (an asylum seeker) and one professional in the field of health and social care registered their dissatisfaction with the effects of the political intervention in the UK that affected migrants' health and access to health care.

Political influence on professional ethics.

> ''There are nurses inside detention centres who are working and regulated by the NMC, (Nursing and Midwifery Council), but these nurses do not exhibit any of the values of the NMC because they are working for and controlled by the system.
>
> …, nurse in the UK is registered with the NMC which means there are certain values they need to exhibit such as compassion and dignity for patients, but these nurses in the detention centre do not, …,
>
> Working for the system I meant some detention centres are run directly by her majesty government while that of Morton Hall where I was detained is assigned to specific agents on behalf of the government and making it easy for the agents to do anything in loyalty to those who assigned them'' (KinB, a

[24] He contracted the Covid-19 and decided not to seek hospital assistance for fear of the Unknown.

Cameroonian refugee, former Morton Hall detainee who came to the UK since 2010).

This participant is a refugee and had been in numbers of immigration detention centres in the UK including the Morton Hall detention centre held the position that immigration detention centres and all the services provided therein are influenced by politics, that these immigration centres are working for the politicians.

Treatment of migrant is systematic.

> ''The fact that the UK ratified the human rights conventions and at same time restricting migrants from accessing health care, I would say the UK approach is unfair and considering that this group of people are vulnerable.
>
> We have seen cases in the UK where children and other vulnerable persons are being are being abused health wise as a result of the policy pattern and we are left with little or nothing to offer because of the system'' (Tri, a UK solicitor based in London).

This participant who is a legal practitioner holds the same position that the approach taken by the UK policy make towards the migrants is unfair. that the system acts as a barrier in the exercise of their duty towards helping the vulnerable migrants.

These two participants are of the position that political influence in immigration control through the medical sector affects migrants' access to healthcare with the first participant giving specific examples to those in detention centres across England and Wales. To them, political influence of street-level bureaucrats in the field of health prevents (Street Level Bureaucrats) them from carrying their ethical responsibilities thereby causing a huge impact on the vulnerable service users who are mostly Asylum seekers, Failed Asylum seeker, Refugees, and other migrants with unsecure immigration status who seek medical redress through this means.

Unproductive political decisions.

> ''I think that more should be done to oppose the hostile environment which is more of a political imposition. It has no place in health care sector and any form of charging should be opposed. The economy shows that very little, if any, financial gain is made by charging migrants in the NHS and that lives are put at risk'' (MaB, NHS retired worker).

This participant is a retired NHS worker and activist of the rights of refugees in the UK who holds the position that the unfriendly or inhuman atmosphere created by

politicians such as the hostile environment should be opposed to its highest possible means, and that these approaches may ruin the life of refugees and other vulnerable migrants both health wise and socially if not opposed.

I may have not experienced similar situations as other participants, but the fact that as African, we live a communal life, whatever situation faced by one in our community, affects everyone. The situation faced by a participant (King), mentioned earlier happened when I was in the same Cameroon community with him in Birmingham and he shared his experience with me, and others and I felt how this affected him and others.

I came to the UK in 2015 and was one of those who felt the impacts of the Hostile Environment as it was interpreted in the street. My understanding of the Hostile Environment made me to live in fear from 2015 to 2017 when I started groundwork for this research.

Access to health as a fundamental human right to all.

The human right to health is a fundamental right as projected by the related conventions ratified by the UK and as earlier indicated. This research sides with the content of instruments but argues that the aims of creating such instruments do not reflect the content. It is this deviation that the research considers as a breach to the rights of the service users.

Two of the experts who took part in this research, quoted bellow, acknowledged the importance of this fundamental right to be applied to everybody. These participants hold the position that depriving migrants of this fundamental right would mean depriving them of health and their right to health.

As a legal practitioner of Cameroon and the UK and moving in line with Article 1 of the Human Rights Act 1998 on the Convention Rights, Equality Act 2010 and the NHS Act as amended, I would like to join issues with the two participants on the position that depriving people of their fundamental human rights to health or using the concept of Human Rights in executing imperialism is synonymous to denial or restricting them from accessing healthcare.

Human Rights application is a duty to all practitioners.

> ‘’…, We as practitioners have a duty of care towards them (Migrants) and in that sense, rationing access to health care facilities would to me be an unfair practice and as well breaching their human rights. I know for a fact that every human being has a right to good life, health, and housing. We act and dispense our duty in line with the equality act which enjoins us as a body to be to our best to every patient. We are not expected to differentiate race, origin, belief or sex during the dispensation of our duty’’. Migrants in the UK are victims of this form of abuse’’ (UchB, a Nigerian nurse in the UK).

This data was collected from a community nurse who is believed to be more knowledgeable in the field of healthcare, she took the position that access to health is a fundamental human right that need be made available to all citizens including migrants without strings attached to it.

That not depriving these migrants of this right by the UK government would mean depriving them of health and/or access to health. It is also revealed in the data that most of these refugees flee from persecution from their countries of origin and as a result they are subjected mental torture. It would not be humane to deprive them of their right to health which.

As a duty all practitioners should put more effort to see that the Human Rights to Health is put in place.

> ‘’I am aware of the Human rights act, the UN convention of the rights of the child which are the bases of my practices. I make sure my services are to the children as deserved and within the parameters of my work description. I push as hard to see that these less privileged children are given the best even within these restrictions. I go as far seeking help from NGOs when things are not going well with the local authority concern’’ (ShepC, social worker based in Wales).

This participant is a social worker who also acknowledges the respect of the right to health as binding to those with the responsibility to its application.

Making it a duty to uphold the right to healthcare as a fundamental right concretizes the force attached to it. Fulfilling this obligation creates an atmosphere free of health huddles for the migrant’s concern.

The negative outcome of an asylum application affects failed asylum seekers' health.

This section looks at the effect of decisions of immigration application to the health and access to healthcare of migrants in general or those with pending application in the UK.

In the data collected, a participant revealed that the negative outcome of asylum application affects them from further accessing healthcare facilities.

Some participants believe that the negative outcome is as a result of the harsh approach put in place by the system to limit and punish the asylum seekers.

This cause some of the victim to go underground as explained earlier in this section and this automatically cuts their links with the normal society.

Negative outcomes registered by applications for leave to remain in the UK, puts the applicants to mental disorder, as expressed by a participant.

> ''I had my appeal rejected and I was thrown out of my section 95 benefits, that alone gives me stress and not ready to go seek any services and ever since I have been begging and sleeping in peoples' houses. I had to go underground because of such unfair treatments towards me from the government. That alone means I got no life and of which I know my case is real. I need the protection I asked for, but it was not given to me. At times I move in the street and imagine being arrested and sent to where am fleeing from. Am just expecting a miracle from God now'' (AloC, Nigerian failed asylum seeker).

This participant claims his case is legitimate and is comfortable with the decision of the government. The treatment given to him after rejecting his claim made him lose hope in both the system and those concern.

He stated that the negative outcome of his immigration application affected his chances of accessing healthcare facility in the UK.

In reality, after a case has been decided with a negative outcome, the state withdraws its responsibility over an applicant, with 28 days quit notice to leave the 1999 Asylum and Immigration Act support. The participant saw this act as rendering him worthless and abandoned.

Personal and Professional values of street level bureaucrats.

In this section of the analysis, actions taken out of the professionals or personal values to execute professional obligations of participants are discussed.

In the data collected, two experts explained situations that had to do with their values which have an impact on the migrant's health. These situations required the persons involved to take actions that are out of the normal or actions that required participants to stretch the existing rules for the benefit of the service users.

The role of ethics in carrying out a professional function.

> ''I am aware of the Human rights act, the right to health and the UN convention of the rights of the child which are the bases of my practices. I make sure my services as a social worker are provided to the children as deserved and within the parameters of my work description. I push as hard to see that these less privileged children are given the best even within these restrictions put in place by the state. I go as far seeking help from NGOs when things are not going well with the local authority's concern. (ShepC, a social worker based in Cardiff Wales).
>
> Conflicts between Ethics and the Law.
>
> There are situations where you would want these children to receive their needs as prescribed by the Human Rights, but you get caught up by the restrictions of the laws in place and in this case, you have to do what is best to get the children going.
>
> This restriction does at times create conflicts in the sense that you are faced with law in place and your conscience. And being a parent, you keep pushing the law at times to save the children.
>
> All these factors go as far placing the children in a standstill position developmental wise and comparative to other children who are of British descent'', (ShepC, a social worker based in Cardiff Wales).

This participant was asked how he would handle issues concerning 'restrictions of the laws or the government affecting his job' of working for the interest of the public. From his position, choosing to serve the best interest of the children or service users or the population which he is called to serve is paramount.

From his explanation, making a decision of working for the needy at the expense of the laws in place or state barriers is satisfactory to his person and values as a social worker and this has an impact on the service users.

The Law has its' role same as ethics in each profession.

> ''The Hippocratic Oath is not a legal duty it is a principle of practice and has no legal standing as far as I am aware so the law over-rides it as it is the law. Ultimately, we practice medicine because we believe in the duty to do no harm and to act in the best interests of our patients but the Oath is not something that is really taught at medical school nor are the ethics of migrant health which is perhaps an area that should be explored as it is a poorly understood area'' (DRB, a medical practitioner based in *Birmingham).*

This data was provided by a medical practitioner of the British healthcare system and who in responding to his position vis-à-vis the Hippocratic oath and the law. His response placed the law and the oath on two separate platforms of application with separate values. To him, being faced with a situation of healthcare provision means faced with the law and the ethics which needs be applied accordingly. He reiterated that the duty to act for the best interest of the patient is an ethical value that needs put in place. And that at certain points in practice, the law comes in to override the putting in place of their ethical values, thereby affecting the service users.

Chapter conclusion

This chapter is the core of the research where the raw data, generates findings and transform the raw data into new knowledge, (Thome, 2000), and paving a way for the research question to be answered. It provides the perspectives of the participants used in the processes of deriving the themes and helps trace the participants' understanding of the research topic for a proper analysis.

In discussing the themes or findings, the key points raised by the participants that may have an impacts on health and access to health care are; the housing location and condition before and during the Covid-19, the financial stability of the participants, the right to work in the UK, with emphases on England and Wales, Acts of street level bureaucrats, education, identification checks at health centres, racial discrimination, unprofessionalism within the service providing sectors, trust, political influence, ethics

and respect of human rights. They factors were discussed and demonstrations on their impacts on health and access to health care linked to the data provided by the participants.

This chapter precedes the discussion and conclusion chapters, paving a way for a proper flow of the necessary and needed materials to guide the reader and other users of the thesis to the recommendations and other suggestions of the thesis.

Chapter 6- Discussion.

This chapter will discuss the research by elaborating findings on the factors affecting health and access to health care as derived from the literature and the analysed themes in line with the Marxist interpretation of these factors to answer the research question.

At this stage, the research will argue that migrant's health and access to health care is affected as a result of their (migrant's) origins, the status accorded to these migrants, migrants' housing, racism and discrimination and also as a result of imperialist tendencies for economic gain. This argument would be backed by the themes deduced from the data presented in chapter 5 of this research.

Taking cognizance of the themes derived from the data in the previous chapter and the literature in relation to the research question, this chapter will also argue in the following direction, that being a migrant in England and Wales, and of African descent, are factors affecting health and access to health care. Secondly, that the immigration status of migrants in the UK plays a huge part in migrants' health, by affecting their health and access to health care. An argument is also put forth to the effect that racism, institutional racism, marginalization, and the hostile environment created within the political sphere in the UK including other discriminatory tendencies contribute to impact migrants' health and access to health care. The argument continues that the imperialist tendencies of the UK for economic gain towards the migrant community contributes to the impact migrants face in health and access to health care.

Migrants' Origin and its' impacts on access to health care.

This section will summarise the demonstration of the thesis on how migrants' origin affects their health and access to health care in the UK, and this demonstration will be drawn from the themes arrived at from the data analysed in the previous chapter and related literature mentioned in the thesis. This goes further to explain the health impacts of the imperial and neo-colonial relationship between the UK and the countries of origin of the migrants taking part in this research.

As for the fact that ''migrants' origin'' influences their health and access to health care, the research shows that Cameroon and Nigeria are countries within the Commonwealth setup of the British imperial map after decolonization. It is also presented in the research that British immigration control has been targeting the

reduction and inflow of people from the Commonwealth with examples of the Indians who flee Uganda, Tanzania and Kenya into the UK during the decolonization processes of the 60s.

Some migrants from these countries especially those with insecure immigration status are generally subjected to the general rules of immigration control with regards to access to health. It implies here that being a migrant from this category in the UK, you are subjected to the control of the 2014 and 2016 Immigration Acts and other related legislations with regards to accessing healthcare in the UK. The outcome of the control is the fact that some of these migrants are subjected to health charges and scrutiny before accessing healthcare facilities.

The research further reveals that migrants from the Commonwealth and or the non-EU countries are covered by a separate health insurance of the Home Office, such as the Health Surcharge guided by the 2014 immigration act and other related legislations.

The data in Chapter Five shows that migrant's access to health care in the UK is highly affected by their origin or where they come from. Participants explain the difficulties peculiar to their cases as migrants from Cameroon and Nigeria and how this depreciates their health and access to health care. This tallies with the focus of British immigration control on restricting Commonwealth entrants into the UK via the visa categories as explained in the research earlier.

Still on the effects of migrants' origin to their health, the social structure of the UK, the housing effects on health of migrants and the housing type accorded to migrants of African origin in the UK in line with the disclosures from the data, demonstrates a huge impact on health and access to health care. In situating this with the sub theme ''housing'' as discussed in the previous chapter, confirms that migrants from Cameroon and Nigeria are subjected to unhealthy housing treatment by the British government through the housing assistance of the 1999 Asylum and Immigration Act.

The origin of migrants in the UK and their immigration status, determines their ''right to work in the UK and this is another theme arrived at from the data and presents to have a huge impact on the health and access to health care of migrants. Some migrants of the non-EEA are treated differently with regards to right to work in the UK. The research makes us to understand that some persons of the Ethnic Minority

Population with specificity on those from Cameroon and Nigeria need permit through a visa application to work in the UK, and this category comprises of all asylum seekers, students and others who haven't got permanent stay in the UK. It therefore implies that if you fall within this category of migrant, without a permit, then you are not allowed to work. It is also stated in the research that some members of this category such as those with Tier4 student and charity visas are given restricted work permits. The research data present this to have a very big impact on the access to health and health care of the migrants involved, as the participants consider the right to work to influence their financial strength and affordability thereby affecting their Health and access to Health.

The next theme of our discussion that affects migrants' origin is that of ''racism and discrimination''. All through the thesis, it has been demonstrated that this group of persons (Ethnic Minority population) have suffered and are still suffering from the effects of racism and discrimination and that this prevents or affects them from accessing healthcare services.

The impact of this concept of racism and discrimination is felt in both normal and time of crisis as Chapter Three of this thesis presents institutional racism and capitalism to have a negative impact on the migrant population especially during period of health crisis such as the Covid-19 pandemic and promoted by the concept of white supremacy. These impacts are reflected in the report of Public Health England during the Covid-19 pandemic which shows that racism and discrimination was the cause of people from the Ethnic Minority populations being highly affected.

The last of our themes is the impacts of imperialist tendencies for economic gains. The concept of Marxist Economics could be used to further explain this to give an understanding of the imperialist social structure of the UK. In the literature, the African Marxist, considered the law such as the immigration legislation a tool used by the imperialist to suppress these individuals and their former colonies. This could be seen through the implantation of structures or institutions that are used in implementing their rules. Participants of this research are from Cameroon and Nigeria where the British imperialist rule is at its excess as explained in chapter 2, and this has a huge impact on the health of individuals from these countries. The British trade and investment factsheets also demonstrate the economic approach used by the British government to keep the two former colonies in a constant state of underdevelopment, and

considered by Zajontz, (2021), to cause financial distress and dispossession to these countries and their citizens.

The Marxist perspective of international migration is believed to involve the division of the world into oppressed and oppressor nations and the creation of rivalry war which causes people to move towards a particular direction, (Vickers, 2012). Migrants' status in the understanding of this research is an attribute to race, which by Marx is derived from an economic perspective through an interplay of politics.

African Marxist on their part consider the utilization of racial segregation by imperialist states to degrade, supress and control their colonies. This helps us to understand why racism is mostly an attribute to the status of the ethnic minority population and to better apply the concept in answering the research question.

From this thesis, the British state through the ruling class is considered as a great determinant to people's immigration status, and doing so, gives them the upper hand over the underprivileged Ethnic Minority Population and their labour force. As demonstrated in the Marxist class structure discussed earlier in Chapter Three, the impacts of the ruling class could be seen in the class position in Britain where the ruling class manifests' control on class and status identification of the immigrant working class. This impact and control within a Marxist framework, may also be understood as aiding the capitalist class in managing the oppression of the working class in order to increase exploitation, (Vickers et al, 2018). This class stratification is further explained in Chapter Three to be the cause of the health disparity between the Ethnic Minority Population and the white race in the UK.

The explanation in this section fits the interpretations given in the three core Marxist concepts of Dialectical Materialism, Historical Materialism and Marxist Economics, which explains the difficulties migrants in the UK and their countries of origin are going through during the processes of immigration control and the role labour plays in this process.

Immigration Status of Migrants in the UK and its' impacts on health care.

Like the previous section, this section will also be discussing the demonstrations of the thesis on how the ''immigration status of migrants'' affects their health and access to health care in the UK.

The data analysed in chapter 5 reveals that the immigration status of migrants is a determining factor to their accessing health care in the UK as elaborated in both themes discussed in the earlier section. In a study, Giuntelle et al (2018), held that immigrants in general are less likely to report their health problems than the natives of Britain and that one of the reasons for this is because of their immigration status. Webber, (2014), held that the introduction the bill of immigration legislations, (that finally led to the 2014 and 2016 Immigration Acts) by the Conservative-Liberal Democrats coalition government of the UK was aimed at depriving people with poor or unstable immigration status from accessing health care and other services such as housing. In the data analysed in Chapter Five, participants expressed the feelings that the unhealthy treatments such as denial to access health care, poor housing and other forms of racial segregations they are facing in the UK is as a result of the immigration status. The history of British immigration control in Chapter Three also demonstrates that it played a role in restricting and limiting migrants from taking part in activities in the UK.

Health consequences of Migrants Housing in the UK.

The literature in chapter three of this thesis, presents health inequality and health disparity as one of the health-related outcomes of housing. After collecting data from the participants, migrant housing in the UK was presented to be one of the main causes of health related inequality and which negatively affects the participants. The main effects were presented to emanate from the allocation of migrant housing on a no choice basis, as presented in sections 4, 95, 96 and 98 of the 1999 Asylum and Immigration Act.

Participants of the research explicitly raised the issue of poor condition of housing accorded to them on no choice basis by the government under some of the sections of the 1999 Asylum and Immigration Act, earlier mentioned and how this affects their health adversely. Participants further complained that the poor conditions of the housing and the dispersal methods employed by the government exposes them to areas where they are being abused racially and that this affects their mental health.

During the Covid-19 pandemic, the housing situation for migrants in the UK and particularly that of those with insecure immigration status, was so poor, participants revealed that this exposed them to the effects of the pandemic thereby making them

more vulnerable. The literature confirms that temporal housing facilities of section 98 were being use for extended periods without ameliorating the conditions and that this further affects and exposed the migrants to the effects of the pandemic as was the case of the Napia and the Penally Barracks where migrants were being held in very poor conditions as evidenced in the case of JM and the Secretary of State for Home Department ref-[2021]EWHC2514(Admin), with the court ordering the rehousing of these migrants.

Participants of the research also raise worries on the housing conditions during the Covid-19 pandemic, such conditions ranging from poor heating, poor location of houses and inadequate PPE to cope with the season, putting them in situations where they were unable to follow the measures outlined by the government.

All the above conditions raised made it difficult for the migrants to manage their health and as well made them more vulnerable to diseases both mentally and physically.

Racism and Discrimination.

Like the previous three sections, this section will be discussing the presentation of the research on how racism and discrimination in the UK impacts migrants' health and access to health care, and this will be done in a similar approach as in the three previous sections, this section will be using the themes formulated from the data and other literature to demonstrate this.

Racism and discrimination are some of the reasons why migrants are affected Healthwise in the UK, and this occurs through ''limiting or rationing access to health care and related services directly or through the immigration control processes as outlined in chapter three''. The direct control of the 2014 and other related Immigration Acts on migrants' accessing health care and housing facilities have been discussed in the thesis to be racially motivated to affect the migrants of the Ethnic Minority Population of the UK. This could be seen on the effects of these laws on the Health Surcharge imposed upon visa application. Indirect discrimination faced by the migrants during the Covid-19 pandemic could also be seen through the provisions of the Health and Social Care Act 2008 (Regulating Activities) as amended for the Covid-19 provides for compulsory vaccination of staff and other visitors into care sector with employers given upper hand to negotiate with employees who may be reluctant to take the vaccine. People from the Ethnic Minority Group who are believed to be more

hesitant and reluctant to take the vaccine would be in this case indirectly discriminated by the provision of this law, (Shepperd, 2021).

Theme 1 (C) of the previous chapter elaborates on ‘’Discrimination’’ as a barrier to accessing health care, with participants disclosing how they are being discriminated at GP surgeries because of their race. Institutional discrimination and racism within the NHS, outlined in chapter three explains how this institution is being used by the British ruling class to target and racially profile the migrants, and how this produces a huge health effect on the migrants.

Memmi, (2000, page, 169) on his part defined racism as ‘’the generalized and final assigning of values to real or imaginary differences to the accuser’s benefit at his victim’s expense in order to justify the accuser’s own privileges or aggression’’. Assigning values in the sense of this quote could be reasoned with the position or influence of the British political actors’ and other tabloids presenting migrants as enemies of the state in order to execute their desires. The phenomenon of the hostile environment in the UK is one of the approaches that influences the establishment of a racially coded atmosphere to subject migrants to harsh health conditions during their stay in Britain.

From the data collected, the Hostile environment has placed the main participants to this research (citizens from Cameroon and Nigeria) under fear, from interacting and carrying on other social activities through the restrictions under the 2014 and 2016 Immigration Acts, thereby making them vulnerable to health situation. Participants’ declarations in the data suggest that the health charges and control instituted at the GP surgeries prevents their access to health care and this deteriorates their health.

During period of the Covid-19 pandemics, the huge and alarming impact on the Ethnic Minority Group only came to expose the existence of certain racist tendencies that have been existing and causing a systematic effect on the minority group, with the NHS which is one of the largest health care provider and employers of the UK being tagged as one of the institutions exercising racial attacks on the black race for economic gain, (Winter, 2021). Racial attack is also visible through the influence of British Social Policy and Elite discourses of ‘race’ and other related affiliations to contain the labour force by constructing a moral prescription of threat. This causes migrants of the ethnic minority group requesting to enter the British medical profession

to forcefully negotiate on terms that are not favourable to them, (Kyriakides, 2003). A survey carried by Campbell, (2018), has also proven that due lack of diversity and increase of other barriers at the senior levels of the NHS, the black medics are paid lesser than their white counterparts.

As seen in this thesis, Imperialism is the highest stage of capitalism with its development or advancement of the productive force(s) achieved only by exploiting and or attacking the working class, stepping up exploitation and intensifying oppression. As earlier mentioned in Chapter Two of this thesis, the Elite or ruling class of Britain, defines and determines the position of the working class which goes in line with an opinion from Edgerton, (2020), which holds that imperialism in Britain is imbedded in its record of elitism towards exploitation and discrimination of the vulnerable population. This discrimination exposes this vulnerable group of persons to health risk which then affects their health both physically and mentally and prevents them from accessing health care in the UK.

Imperialism and its' impacts on migrants' health care.

From the explanations given in chapter 2 of this thesis, the world at large could be seen as divided up by the imperialist countries into sectors, and 'spheres of influence', and subjecting the world into oppressor and oppressed nations. In this sphere, a handful of advanced capitalist countries turn to exploit numerous backward capitalist countries by impoverishing them and holding back their development like Britain and its' former colonies discussed in chapter 2.

This section like the previous sections of this chapter will be looking at the impacts of imperialism and its' tendencies on the general health and access to health care of migrants in the UK taking into consideration the general view of the research.

Imperialist tendencies in this case I am referring to steps taken by the imperialist British state to continue keeping migrants and their countries of origin in continuous occupation. One of these tendencies is through instruments such as the Laws and other imperialist institutions carved to keep these migrants under suppression and directed to work for the benefit of the capitalist regime in place. The instruments as described in the thesis restrict, control and subject the migrant population to conditions that are non-beneficial to their growth and other forms of advancement.

The data explains how the system of the UK and the legislations under have rendered some of the migrants hopeless. One of the participants who is an asylum seeker said she is ‘’hopeless and with no future as far as she keeps staying under the benefits of section 95 in the UK’’. One of them who is a failed asylum seeker said ‘’he has been wasted in the UK and that he is not going to be of use to his home country whenever he is made to return’’. Imperialism in this case helps to understand the situations of these participants in the sense that their hopelessness in the UK subjects them to be unable to resist the system.

In Theme 1 (b) on the ‘’Right to work and financial empowerment’’, participants considered the refusal of right to work to asylum seekers by the British government a sort of approach to handicap them from excelling in the UK. In Theme 2 (a) which deals with ‘’Identification checks, as deterrent factor for some migrants accessing health care’’, participants’ view is that this approach is used by the government to racially profile them to make sure they do not progress. This goes in line with Marxism holding that the ruling class will always put in place structures to keep the working class in a position that will always benefit them.

Theme 2 (c), which talks of ‘’Political atmosphere impacting health and access to health care’’, participants’ feelings on this point is that the atmosphere created by the ruling class on certain class of individuals (Such as those from less developed countries) through the laws and actions of street level bureaucrats affects them from exceling and having a voice in the British society. This could be seen on the various types of visa applications to enter and leave in the UK made available to European and African countries.

The research also deduced from the data that Britain relies on imperialist tendencies through the segregation and degrading of the migrant population especially those of the Black Ethnic Minority population to survive both economically and politically as Cain et al, (2016) holds that the shape of Britain and its economy depends on its international and imperial ties and how these ties were manipulated to produce the post-colonial world of today. As referenced in Solomos, (1992), it is intimated that the segregation and placing of the black race in least developed places in the UK could be interpreted as products of racism linked to the politics of social policy and labour migration.

The economic tendencies could also be seen from the government of the UK recently opening its doors to the recruitment of international health practitioners into the NHS through the ‘’Shortage Occupation list project’’**,** a programme that attracts workers mostly from India, Africa and other less developed countries and simultaneously increasing the surcharge or health charges by more than 50%, Policy paper, Budget 2020 (12th March 2020). To confirm this imperialist exploitation on the less developed parts of the world by the UK government to work in England and Wales after the presentation of this policy paper, Frey Lindsay, a senior contributor of Diversity, Equity and inclusion took the position that migrant being subjected to pay more to come to the UK may disincentivize the workforce needed at this crucial moment, (Lindsay, 2020). I like to opine here that the outcome suggested by Frey Lindsay comes as a result of the fact that the ruling class acts in line with capitalism but realising a negative outcome as intimated.

History also has it that the White Britons have a dominating tendency when it comes to people of black and ethnic minority race, (Modood, 1988) as was the approach used to create a British influenced white dominion union of South Africa during the period of apartheid, (Magubane, 1996), as seen from the Boer war that was meant to decide the ownership of gold in the world that began in 1899, through the signing of the Treaty of Vereeniging of 1902 that gave the domineering whites powers over blacks in South Africa.

The research also makes us to understand that the British continuous imperial attack targeted towards the black community has also kept this class of persons and their countries of origin in a state of dormancy with no hopes of progress, and in effect keeping them under-classed and preventing them from bringing their fight with the white political class, (Sivanandan, 1976). This in effect prevents the Black Ethnic Minority Population from fighting for their rights to health which is a fundamental human right as explained in Chapter Four of this thesis. The imperialist attack is also aimed at a systematic, organised, and continuous offensive against black and immigrant population in Britain, through all forms of harassment and torture in immigrants and black neighbourhoods, a situation that can be related to that faced by the Nationalist Population of Northern Ireland. Here am considering race as mechanism of social stratification/construction for identification in human history,

(Smedley, 1998), which is the complexity of how the British used Whiteness to rule the world as advocated in the ‘’White Man’s’ Burden of Rudyard Kipling (1865-1936).

The research continually makes us to understand that the treatment of the Black Ethnic Minority Population by the British government makes them vulnerable and prone to health issues and that this situation keeps aggravating as the British state has gone on the offensive against this group by using every available means at its disposal. In the data, it is seen that the Cameroon and Nigerian migrants interviewed are subjected to poor housing and other social condition that sometimes further subjects them to a state of fear and confusion, affecting their health and access to health care. Some of the measures exerted on blacks is that the harshest penalties are exacted by the British state for any sign of a fight back, any sign of defence provided by people of this group. So, when white racist thugs attack black people, it is the black people who defend themselves who commit a crime in the eyes of the state. An example of the 70s is when white racists attacked the Virk brothers, it was the Virk brothers who received sentences of up to 7 years for defending themselves, (Sivanandan et al, 2016). Recently in London by June 2020, a 27-year-old Black Live Matters activist Sasha, Johnson was shot, and she incurred life threatening injuries for taking part in activism and the Police concluded that it was not a targeted attack without taking statements from the victim, (Campbell, 2021). This indicates the role played by the government to silence the activist and others from further taking part in activism.

The legislation under investigation have restricted migrants so much that in the data collected, it shows that participants who are of working age and some with reputable skills like me (an advocate and solicitor of Cameroon) are not given the opportunity to work or exercise their talents or carry on easily with jobs in their areas of expertise. Deviating or restricting the career pattern of participants like me is mentally disturbing. All this caused by the barriers or repressive and restrictive imperialist tendencies put in place by the British government to continuously keep the ethnic minority groups as an oppressed section of the working class.

In the housing sector, migrants in the UK are subjected to so much unfair treatment. As described in Chapter Three, the quality of housing accorded them could be considered as another form of discrimination and violation of rights. While in the data

presented in Chapter Five, the housing allocated to asylum seekers is considered a form of deterrent approach of the British system on the migrant population.

The role of British imperialism towards the Ethnic Minority Population as presented herein does not only restrict them from excelling generally in life but restricts them from the opportunities of providing good health care to themselves and making them vulnerable to health issues.

conclusion.

This chapter helped in summarising the entire research and bringing out the points needed to provide the impacts of the British immigration control on health and access to health care.

The general discussion presented in this chapter gives an interpretation of the main concepts situated in the entire research and in line with the themes realised in chapter 5 to assist in answering the research question, and the four sections involved have separately reiterated and presented further analysis of the themes for a better understanding of the research and the steps taken.

The presentations and analysis of this chapter have linked the previous 5 chapters together by bringing out interpretation of Marx in all the concepts involved for a further understanding and a proper conclusion and recommendations needed in the 7th chapter.

CHAPTER 7. General Conclusion.

This conclusive chapter is made up of four sections that describes and elaborates on the findings of the research including the recommendations.

The first section summarises the thesis with a resume of the number of participants in the research and their positions on answering the research question. It further explains the role of the literature and other contributors to the research and the research question. It is at this stage that the Marxist position with regards to the British system in general, consisting of its' social classification, class structure and its' impacts on migrants' health and access to health care is concluded.

As preferred by this thesis, the impacts of these legislations are assessed by looking at the British immigration control processes, bearing in mind that the participants are Africa descendants and considering the contribution of the African authors in the field of Marxism and socialism with regards to this topic in question. After a synopsis of the literature and other contributions, the position of the researcher and that of the analysed data is also considered to determine the impacts of the legislations as required by the research.

The second section brings out the limitation and difficulties of the research and those encountered by the researcher during the process and the actions taken to remedy them.

The third section brings out how this research contributes to other research in this field and related fields and policies and practices of the UK and particularly England and Wales where the study is conducted.

Section four on its part is the conclusive section of the chapter which puts down the conclusion of the research and the reason for a complementary research to fill the gaps and of this research.

Summary of thesis.

As explained in chapter one, the research considers the impacts of the immigration legislation between the period of January 2010, to December 2020 just before the entering into force of the Brexit regulations in order to accommodate participants from other EU countries whose' immigration situations were affected by the Dublin regulations. Legislations and instruments promulgated prior to 2010 were taken into

consideration during this process to establish continuity in the objectives of the British immigration control from the creation of the 1905 Aliens' Act, which is aimed in restricting and limiting the rights of migrants including the right to health.

The research also considered as a recruitment criterion, participants who must have been in the UK within the period explained in the earlier paragraph and for a minimum of twelve months to permit a concrete and consistency in the data collected. As explained in the previous paragraph, the data collected for people within this period demonstrated the consistency in the impacts of the immigration control on the migrants.

One of the major objectives of the British Immigration control mentioned in the earlier paragraph was determined in the research to be the restriction of migrants who are believed to be of no economic interest to the UK and who are benefiting from the system, and the research establishes this to affect such migrants from accessing healthcare facilities.

The research also establishes that in achieving these objectives, the legislative approach of the UK puts in place structures that tend to negatively affect the healthcare systems of the countries of origin of these migrants through the process of brain draining and structural capitalism. Structural capitalism is linked with Britain's involvement in international Organizations such as the International Monetary Fund (IMF), WORLD BANK, World Health Organization (WHO) and the UN, through which they could easily exhibit their control over these less developed countries.

Twenty-six interview transcripts were collected from migrant participants, the overall contributions of the two focus groups and that of six professionals in Law, Health and social care as analysed in chapter 5, presents in one way or the other that the British immigration control effects migrants' health and access to health care. The researchers' experiences during the processes of asylum seeking in the UK, also confirms the position digested from the data in relation to the impacts of the immigration control on health and access to health care.

Though two of the presentations in the data (two transcripts) do portray the Immigration Acts or immigration control of the UK not to have an effect on the health and access to health care, most of the participants' data after analysis demonstrates that immigration control of the UK have a huge impact on migrant's health and access

to health care. In that direction, and after a further consideration of the data through Marxism, the research concluded that the role of immigration legislations in the UK represents the interest of the ruling class at the detriment of the working class.

The research also found out that the disposition of the immigration legislation presents its role to protect legitimate or regular immigrants while the actual practice and acts of some street level bureaucrats tends to create an atmosphere full of uncertainty and intimidating to the immigrants. The intention of the ruling class through the legislator here is to present the law in the direction of protecting regular migrants while it is actually meant to strictly monitor and control the migrants. The resultant acts of discrimination, racism, exclusion, and other forms of racial segregation exhibited or imposed on immigrants in the course of immigration control, especially during the processes of accessing health care puts the migrants in positions of uncertainty. One of the participants, on responding to the question on the difficulty encountered accessing health in the UK considered the checks at health institutions to be a form of racial profiling and entrapment which could lead to being interrogated by forces of law and order.

The literature base reviewed in this thesis and the context chapter consistently demonstrated a high-level health consequence from the application of immigration legislation on migrants in the UK. Marxism on its' part demonstrates and reiterate on the consequences of institutional racism, institutional capitalism and institutional imperialism on the working class using the law as instrument, at the behest of the capitalist with the UK as the main example.

The thesis in its entirety puts up the argument that the general direction in which the immigration policies of the UK from the inception of the 1905 Aliens' Acts, is to discourage and put a stop to migrants who are of no beneficial interest to the ruling class of Britain. The trend of immigration control between 2007 to 2010 when the Labour Party was under control had more focus on refugees and asylum legislation which is argued in the thesis as presenting the migrants from a negative perspective with emphasis on considering the refugees and asylum seekers as deviant and dangerous while the trend of the coalition government of the conservative and the Liberal Democrats Parties between 2010 to 2015 and the Conservative Party from 2015 to 2020 present the immigration legislation as protecting the regular migrants while the actual practice on the ground is punitive on the migrant population.

This research holds that there is continuous attack on the migrant population even after the UK have ratified most of the international conventions for the protection of the rights of the migrants such as the 1951 refugees' convention and the Universal Declaration of Human Rights. That the involvement of the UK in this international instrument is to situate themselves in the structural capitalism and structural racism and to be able to do whatever they desire. Belonging to this structure gives them an upper hand in the control and exercise of their imperialist desires against the less developed countries. That the involvement of the UK in these international organizations through foreign and economic aids does affects the development and way of life of underdeveloped countries, Wood, R, E. (1980).

After making an argument for the racist and degrading approach of the British immigration legislations, the thesis also found that the recent public discourse and policies of the UK suggest the over usage of medical facilities or health services by the migrants, but that was not the case as experienced in the interviews collected for this research. To illustrate the diverse ways in which participants' experiences diverged from the government's narrative, one of the situations faced by a participant in this research, (an asylum seeker), tells me that he was asked to pay for his medication after consultation. Another participant who holds a British passport also recounts how a student after paying the health insurance or health surcharge from Cameroon to the UK for studies, ends up not using the healthcare facilities or services. Another participant who is a failed asylum seeker thinks the multi checks and controls placed at the doorsteps of healthcare facilities are a form of entrapment for them who are irregular and that this prevents them from ever thinking of going close to the system.

Notwithstanding the positions of these participants, some partakers in the research interviews expressly made it clear not to have encountered any issues with accessing healthcare facilities in the UK but this was mostly coming from migrants with secure immigration status or those who had a strong financial background even before migrating to the UK.

It is clear from the study that the position of politicians is contradictory to that of this research. In a study carried out on the webpage of Economics Help in 2016, on the economic effects of immigration on the NHS, it was concluded that there is an excess benefit gained by the British government from health contributions of migrants as

compared to the amount of healthcare services used by the migrant population, Pettinger, (2016).

Despite the administrative position for the necessity to cut costs on ‘health tourism’ and ‘abuse’ by those they referred to as illegal immigrants, and to further the Government's push to reduce net migration overall. This research holds that cutting NHS spendings by imposing charges on migrants will be amount to segregation, discrimination and depriving them of the necessary services and in some cases slows the process of rendering the health services by increasing the waiting list in the service centres and putting more pressure on the staff and the NHS.

The research also found out that because of the barriers mentioned in the previous paragraph, the immigrants of the countries used in the data collection (mostly those with unsecured immigration status) find it difficult to integrate into the UK system. That even after they have been granted leave to remain, they still find it difficult to carry on with life due to the difficulties involved in starting life with housing, access to work and other services related to banking and finances. In the UK, when migrants who have never worked or had an address or accommodation of their own are granted asylum, the rules expect them to provide proof of address, references and in some cases experiences to be able to register with the GP and access into a job.

Going through the literature on the application of the acts with regards to access to health in both England and Wales, the research found out that there is both structural difference and cultural differences existing in the field of health provision in England and Wales, and that the application of the principles are similar to each other since they are derived from the same law(s).

The structural differences here refers to the different NHS organs involved in the dispensation of the health care services and the different rules or directives involved in the application of the 2014 Immigration Act and other immigration legislations in both England and Wales. The main cultural differences between these two countries is that of the languages. In Wales, some of the information or directives at some of the hospitals and GPs are circulated in Welsh which need interpretation in English as raised by some of the participants. The research also gathers from the data that in some areas in Cardiff Wales the Welsh language is frequently spoken in medical facilities and this keeps them in a state of fright since they don’t understand the

language. Despite these differences, the data still demonstrates that migrants residing in both Birmingham and Wales to face similar impacts of the law in accessing health care.

Going to the impacts of the immigration legislation on health and access to healthcare in the UK, the thesis pointed that, being an immigrant with an unstable immigration status in the UK, directly subjects you to the implications of the immigration control which may affects your health and access to health care and secondly that, belonging to the BAME group with specificities on those from the English-speaking part of Cameroon and Nigeria, affects their health and deters them from accessing health care. On the other hand, Africans from the countries of origin of the participants have always lived a communal life and with the customs and traditions explained in the concepts of Ubuntu, Consciencism and Ujamaa, therefore what affects one of them in a community, affects the others.

The trend in the interviews presents that migrant from the Ethnic Minority Group including those of English-Speaking Cameroon and Nigeria are among those affected by the immigration legislations. Though not all of them appears to be affected directly, most of the participants especially the refugees and undocumented migrants showed that they find it difficult to access or visit the healthcare system of the UK due to racism and discrimination.

The research also suggests that the NHS which is one of the main healthcare providers of the UK, and immigration detention and removal centres are used as some of the main tools in the execution of the objectives behind the targeted moves in the legislations representing institutional racism.

Having considered my position as an insider-outsider in the research (given my experiences during asylum seeking) and from my position and experience as a legal practitioner, I find it inhumane, unethical, and iniquitous to use health policy as a base of the enforcement of immigration control. Using this approach to me will be going against the founding principle of the NHS of equal access to health of all without exception, Taylor, (2009).

Based on this, there is a pressing need for the proper identification and consideration of the health issues emanating from the application of these legislation and to call for a redress through the recommendations at the end of this research.

Limitation of the research.

The main limitation of the research is the fact that it was conducted only on a few individuals of the English-Speaking part of Cameroon and Nigeria based in the UK, representing a very small group of the ethnic minority population of the UK and the two countries involved. This may or may not be representing the effects the Immigration Acts on health and access to health care on the entire ethnic minority population of the UK. A further research is therefore recommended to cover a bigger portion of the ethnic minority population to compare the outcomes.

The second form of limitation in this research is that about 70% of the data collection and meetings were done remotely, caused by effects of covid-19 as the university required interviews to be conducted remotely to reduce the chances of infection. I am not too certain that if I had met a good number of participants at their home for data collection, the assessment of their living condition would be same as they are giving via video and phone calls. In this regard, additional research with specificities on meeting participants at their homes could provide additional insight.

The research is conducted in English and a good number of the participants especially the refugees/asylum seekers have recently moved to the UK with little or no mastery of the language, and others had a deep African ascent that made communication difficult during the focus group conversations. In some cases, participants were trying to communicate in Pidgin-English. As earlier mentioned in the research, I belong to the same ethnic descent as these participants and with a mastery of the accent and other local languages and that permitted me to easily translate and interpret whatever was difficult to the understanding of others.

As a limitation I thought the participation of political actors is missing from the data, which would have given me a further insight of how and what the politicians rely on in bringing out law projects and decision making. In doing this, the various consultative steps carried out by the various politicians would be understood. In this direction, further research would be recommended to include the participation politicians to get their position on why certain approaches do come up during political deliberation on law making.

Implication for policy and practice.

With this research, human rights activists, legal and health practitioners of the immigration sectors could support, advocate, and improve the right to health of migrants. This could be in the form of advocating for the revision of laws or procedures that are repugnant to natural justice or through legal channels or court processes. It may also be in the form of lobbying, creating awareness and influencing the law-making bodies into understanding what is required, (Stoltz Chinchilla et al, 2009). It may also be in the form of providing health education to migrants to improve their behaviours towards healthcare seeking, (Li et al, 2020). One of the ways to get this done is by seeking the equal interest of all to be taken equally into consideration as highlighted in this research.

After applying the Marxist concepts of historical materialism, dialectical materialism and the Marxist economics to positively interpret the concepts involved in this research, this research stands that the Marxist approach of a classless society would be an ideal approach in the UK. Further suggestions stands that a system of leadership that devolves from the grassroots is a way to advocating and applying these principles to favour all citizens equally because capitalism has failed, (Castree, 2010)

Of the other hand, migrants themselves need to stand up like myself and come out in public to ask for a reform of the difficult situations they are undergoing in the process of accessing healthcare facilities in the UK. This could be in the form of social inclusion (where social media outlets could be used to expose their problems), Andrade et al, (2016), carrying out further research and recommending like I have just done, joining organisations such as the Black Lives Matter, West Cameroon Movement for Change and a host of others where their worries could be listened to and channelled as a group to the appropriate quarters. This could also be in the form of seeking for redress through the law courts in case of a breach by the authorities.

This research is aimed at advocating for the reformation of the immigration legislation to help improve migrants' access to health and healthcare facilities in the UK. In so doing, it will serve as an instrument to migrants affected by this legislation to express their views through participating. In taking particular interest in migrants from Cameroon (those from the English-speaking part of the country) and Nigeria to take

part in the research, the research will also have a transferable impact, to countries which have legislations of similar character as Britain.

This research will also serve as an enhancement to my PhD researcher's career as an international legal practitioner. The study of the processes involved in the implementation of the Acts, the assembling of data, consulting of texts, other forms of literature, and analysing same will act as precedence for a proper evaluation of situation or cases during my practice as an Advocate and Solicitor.

Recommendations and final Conclusion.

Considering there has been consistency in restricting and limiting the rights of migrants in the UK through immigration control from the inception of the 1905 Aliens' Act and taking into consideration the fact that everyone has the right to better health, as stated in Article 25 of the UDHR, (Universal declaration of Human Rights), article 6 of the ICCPR, (International Covenant on Civil and Political Rights), ICESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health and that the recent increase in the movement of people, (Migration) accompanied by health problems, Carballo et al, (2001). And considering that good and improved health care is a necessity to everyone, Scoggins et al, (2022), and considering that health and access to improved health care is a one of the problems faced by migrants in the UK and specifically in England and Wales where the research is being conducted, this thesis has embarked on investigating this aspect and recommending what is needed to accommodate and improve migrant's life health wise.

The main objective of this research is that the researcher who is at same time party to this research as well as other organisations is advocating for the improvement of the relationship between migrants and the state institutions of which the NHS is one of the principal parties. Going through the research, and specifically, the contributions of participants, there is an urgent need to reduce or remove barriers affecting migrants' access to healthcare facilities in the UK by looking into difficulties relating to financial constraints, discrimination, and racism.

Contrary to the disguised capitalist and racist driven intentions of implementing welfare services in the UK as intimated by the research, a conscience-oriented organization such as the NHS should be established on solid grounds of fairness with the target of serving everyone at their doorsteps and without discrimination.

Institutional racism is very much present within the British health system with the NHS playing a vital role in British capitalism and imperialism. A role effectively put into action through the state policies with a huge impact on the migrant population. As suggested by this research, capitalism via health institutions such as the NHS as instrument does not work for the interest of the working class but for that of the ruling class. An internationalised system of general interest should be put in place to enable organisations such as the NHS to work for the interest of the public. The requested system may be difficult for the UK since it would or may not represent the interest of the capitalist. Yet this research still holds that constant advocacy for a friendly and welcoming system to all and the discouragement of capitalism would lead to a better environment for all citizens without discrimination. The research also recommends that the less developed world or former colonies of the imperialist nations be educated on the disadvantages of imperialism and how this could be avoided by cutting any link that does not favour them.

As suggested by some of the participants, to resolve or avoid the issue of financial exploitation of the migrants during the processes of accessing health care, the government should look for alternative ways of making each resident of the UK make a fair and equitable contribution to the NHS. One of the participants who is a legal practitioner and activist for the rights of migrants in the UK considers the Immigration Health Surcharge, (HIS) as double taxing as some migrants pay in the health charges upon visa application before coming into the UK and still pay it while working.

> ‘’The Immigration Health Surcharge (IHS) is effectively a double tax. People who are working are paying towards the NHS but also pay the IHS charge’’ (S,)
>
> Another participant suggested that the government should introduce a scheme where a migrants pay for their health service when they are found sick. That instituting this type of payment would be instituting justice to those who are presumed to be paying more and unjust tax.
>
> ‘’I am of the opinion that the government should introduce a scheme where a migrant pays for his or her health service when he or she is found sick in that case, they would be doing justice to those who pay in the money and don’t get sick’’, (NiC, a Cameroonian with British nationality resident in Cardiff Wales)

After a concrete assessment of this position of the participant by the researcher, the research holds that since healthcare provision of the UK is taken out of the taxpayer's contribution, there is no need requesting for any form of charges from anyone to add on this. That giving room for any form of charges to be instituted by the government would lead to a form of exploitation.

One of the themes derived from the data collected in this research is education and in the process of analysing same this research found that it is paramount for the migrants to have a knowledge of what they are entitled to in terms of accessing health care in the UK. The research recommends the initiation of special classes to organised to both service users and providers of health services in the UK to enlighten them on what is required and most especially in various locations where migrants are concentrated. It also recommends that the NHS through the Home Office should make provision of special therapists to handle migrants from war torn countries to moderate or break the chain of mental torment they might have gone through before arriving the UK.

After collecting and analysing data from participants, the research came to the realisation that the UK migrant housing condition and most especially that of undocumented migrants are not given on the basis of the needs of the migrants, and that it is sometimes awarded to cover up political positions or avoid critiques and that this has a huge health impact in both the health and access to health care. This research after taking the position in (Egan et al, (2015), recommends that migrant housing be improved to suit their needs and that health inequality could be solved through this approach.

The research also found from the data that financial empowerment of the migrants was a factor affecting the health and access to health care of migrants in the UK. That the migrants lack this aspect of financial empowerment due to their being restricted to work and empower themselves financially in the UK. On this ground, the research recommends that the right to work be given to asylum seekers. That the requirements for refugees to work and get integrated into the society be softened, requirements such as proof of address be scrapped off the list of requirements to get access to a job and that references and deposits to rent a house be taken off as conditions. That Tier4 student visa work permit of 20 hours per week be extended to unlimited working hours.

And that all these suggestions would benefit the UK tax system and the health funding system if these individuals are not restricted from working.

The research also found that the checks and verification system instituted at the healthcare facilities for migrants are to some extent unnecessary. That checks should be instituted only when they are necessary, determined through further verifications from trained experts without breaching the rights of migrants.

Racism and racial segregation are some of the factors that causes most migrants to refrain from accessing healthcare facilities in the UK. Institutional racism within the NHS is one of the difficulties encountered by the migrant population of the UK, as described in the analysis chapter with the NHS playing a vital role in British capitalism and imperialism. A role effectively put into action through the state policies with a huge impact on the migrant population. The research recommends the reinforcement of the already existing Equality Act by instituting compulsory lessons to both employees of the healthcare sectors and the general public to overcome the issues of racism.

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Appendixes.

Appendix: 1; Participants of the research, (made of Cameroonian and Nigerians resident in Birmingham and Cardiff at the time of the research). (Column denominated sex, M=Male and F=Female, while the column denominated Status, R=Refugee, S=Student, C=citizenship or indefinite leave to stay in the UK, while Re=those who are neither students nor refugees but have leave to remain in the UK)

Column1	Name	Nationality	Sex	Status	UK Town

1	**Kin**	Cameroon	M	R	Birmingham
3	**Mau**	Cameroon	M	R	Cardiff
4	**Alo**	Nigeria	M	R	Birmingham
5	**Nd**	Cameroon	M	R	Birmingham
6	**Vic**	Nigeria	M	S	Birmingham
7	**Kab**	Cameroon	M	R	Birmingham
8	**Er**	Cameroon	M	R	Birmingham
9	**Ni**	Cameroon	M	C	Cardiff
10	**AJ**	Cameroon	M	R	Birmingham
11	**AS**	Cameroon	M	S	Cardiff
12	**Ade**	Cameroon	F	R	Birmingham
13	**Iv**	Cameroon	M	R	Cardiff
14	**Comf**	Cameroon	F	C	Birmingham
15	**Kamwif**	Cameroon	F	Re	Birmingham
16	**Uch**	Nigeria	F	C	Birmingham
17	**Fran**	Cameroon	M	R	Cardiff
18	**Bert**	Cameroon	F	R	Cardiff
19	**KinWood**	Nigeria	M	C	Birmingham
20	**Tokum**	Nigeria	M	C	Birmingham
21	**KinSis**	Cameroon	F	S	Birmingham
22	**Co**	Nigeria	F	C	Birmingham

23	**VJ**	Nigeria	M	C	Birmingham
24	**MamaHus**	Cameroon	M	C	Birmingham
25	**Vic**	Nigeria	M	S	Birmingham
26	**Mes**	Cameroon	M	R	Birmingham
27	**Edw**	Nigeria	M	S	Birmingham
28	**MOG**	Nigeria	M	R	Birmingham

Appendix:2, Showing the focus groups involved in the research, made of Cameroonian. Nigerians and residents of British origin, residing in Birmingham and Cardiff at the time of the research. (Column denominated sex, M=Male and F=Female, while the column denominated Status, R=Refugee, S=Student, C=citizenship or indefinite leave to stay in the UK).

FOCUS GROUP AND NUMBER OF PERSONS	ETHNIC ORIGIN	STATUS	SEX
FOCUS GROUP MADE UP OF ONLY BIRMINGHAM RESIDENTS. SIX PERSONS INVOLVED.	ER, (CAMEROON), BASED IN BIRMINGHAM.	R	M
	AJ, (CAMEROON). BASED IN BIRMINGHAM.	R	M
	Kin, (CAMEROON), BASED IN BIRMINGHAM.	R	M
	CO, (NIGERIA), BASED IN BIRMINGHAM.	C	F
	ED, (NIGERIA), BASED IN BIRMINGHAM.	R	M
	COB, (BRITISH AND WORKS FOR REFUGEE COUNCIL BIRMINGHAM, Health specialist).	C	M
FOCUS GROUP MADE UP OF CARDIFF AND BIRMINGHAM RESIDENTS. SIX PERSONS INVOLVED.	ER, (CAMEROON). BASED IN BIRMINGHAM.	R	M
	MAU, (CAMEROON). BASED IN Cardiff.	R	M
	NI, (CAMEROON). BASED IN CARDIFF	C	M
	ALO, (NIGERIA), BASED IN Birmingham.	R	M
	RO, (BRITISH AND WORKS FOR CITY OF SANCTUARY CARDIFF with legal background)	C	F
	Kin, (CAMEROON). BASED IN BIRMINGHAM.	R	M

APPENDIX 3. List of the six professionals who took part in the research and town of their office addresses.

PROFESSIONALS	FIELD(S) OF PRACTICE AND TOWN OF OFFICE ADDRESS..

MA	HEALTH, London
DR	HEALTH, Birmingham
Uch	Health, Birmingham
Tri	LAW, London.
S	Law, Birmingham
SHEP	SOCIAL WORK, Cardiff.

Appendix 4. Consent to Participate in Research

As a refugee and someone who went through the asylum-seeking process in the UK and realising the difficulties undergone by people of ethnic minority group in accessing health care facilities, I got interest in carrying out a research on the impacts of the British immigration control on health and access to health to advocate for a way forward.
Am of the opinion that through this research, the voices of people affected will be heard to create awareness and room for reforms.

Who is running the study?
The study is being conducted by Ernest Acha, a PhD candidate at Nottingham Trent University, and supervised by Dr Tom Vickers.

What do you need to do?
I would like you to take part in an interview lasting approximately one hour, on phone and via selected social media platforms or at a location that suits you. Interviews will be taking place between 1 October 2019 and 30 September 2021, and I will contact you to arrange a time, location and any means suitable for you. The interview will be carried out by me (Ernest Acha), and I would like your permission to record the interview with a digital voice recorder in order to ensure that the data is accurately recorded. You may decide not to take part in the research or that you do not wish to be recorded. You will be asked questions relating to your experiences in accessing health care in the UK and most specifically England and Wales with focus on Birmingham and Cardiff, and your opinions of the health sector. At any time during the interview, you may choose not to answer, and we will move on to the next question.

What will happen to the information you provide?
The recording of the interview will be transcribed and analysed by me (Ernest Acha). This information will then be incorporated into the findings and conclusions of the research. At the end of the study, all transcripts will be kept securely in anonymized form for purposes of publications, teaching, and advocacy. You should be aware that I may be legally required to report incidents of harm, risk of harm, or criminal acts.

How will the research protect your anonymity?
Your words may be directly quoted, but your identity will be made anonymous. Your name will be replaced with a pseudonym and other information that could identify you will not be included. Demographic data (e.g. age or gender) will be included where relevant to the research, but care will be taken not to include details or any form of information which when combined could lead to your identification. An anonymous identifier will be recorded in place of your name. Every possible step will be taken to protect your identity, but anonymity cannot be completely guaranteed.

You have the right to view a transcript of your interview, and to provide clarifications or additional information up to 1 October 2021. You have the right to withdraw your interview with no questions asked and no consequences before 1 November 2021. The interview recording and the written transcript of it will be viewed only by the researcher (Ernest Acha).

What will happen to the results of the research?
The research will be written up into a PhD thesis. It will also form the basis for articles in academic journals, journalistic publications, and online media. It may contribute to an academic book after the completion of the PhD project.

Has the study been reviewed by anyone?
The research has been subject to ethical approval by the College of Business, Law and Social Sciences Research Ethics Committee at Nottingham Trent University. It has been designed with reference to the British Sociological Associations code of ethics.

Resources
You may wish to disclose concerns about harm, potential harm, or criminal activity at your workplace. Your employer will have a whistleblowing policy; but you can also get free, independent and confidential advice from the Whistleblowing Helpline for NHS and Social Care on 08000 724 725.

Contact and further information
If you have any questions, or would like further information, please contact the researcher Ernest Acha at ernest.acha2018@my.ntu.ac.uk

Alternatively, you may contact my supervisor:

Dr. Tom Vickers,
Nottingham Trent University
50 Shakespeare Street
Nottingham
NG1 4FQ
Tel: 0115 848 4898
Email: tom.vickers@ntu.ac.uk

Agreement to consent

- ☐ I have read and understand the purpose of this research and my part in it.
- ☐ I understand that the content of my interview in response to the project's research questions will be used in a report and subsequent academic publications.
- ☐ I understand that I have the right to withdraw my data at any point up until the deadline date and understand that all personal and confidential information will be destroyed after completion of the project.
- ☐ I have asked questions if needed and understand that I can contact the investigator at any time with queries or concerns.
- ☐ I voluntarily agree to take part in this study.

Name: _____ Date: _____

Appendix 5. participants questions excluding follow-up questions.

Questions to migrant participants excluding follow-up questions, and same questions were asked to the migrants present at the focused group.

1-As a migrant, what is your experiences in accessing healthcare facilities in the UK?

2-Comparatively, give us your views in accessing health facilities here in the UK and back in your country of origin?

3-What is your opinion on how migrants are treated here in the UK vis-a-vis accessing healthcare facilities?

Main questions to Legal professionals with experience in working with migrants excluding follow-up questions.

1-Britain is a state party to the UNCRC (United Nation Convention to the Rights of a Child), ICCPR (International Covenant on Civil and Political Rights), the Universal Declaration of Human Rights and a host of other instruments, of which the right to health to every being without exception is binding to all state parties. What will you consider the enactment of the 2014 and 2016 Immigration Acts and other instruments of immigration control by Britain vis-à-vis their involvement with the above international conventions?

2-What is your view on the development of migrant's rights in the UK in terms of the implementation of the instruments earlier mentioned and what special appreciation would you give to the access to health and other healthcare related services by migrants?

Questions for medical practitioners and social workers excluding follow-up questions, and same questions asked to medical experts present at the focus group.

1-The British general medical council's document ''Good Medical Practice'' makes it clear that the decision about access to health care should be based on clinical judgement of patient's need and without discrimination, what is your view on this statement and the fact that the immigration legislations and the immigration control process in the UK does rations access to health by migrants.

2-As a medical expert or social worker, what developments with regards to access to health and health care services can you recount from the British immigration control processes via the instruments involved (Laws and other control mechanisms involved).

3-Taking into consideration the Hippocratic Oath taken as Medical experts/oaths taken by social workers to dispense your duty at its best, what is your opinion on this obligation and the fact that the legislation under investigation and the immigration control process in general rations migrant's access to health and other healthcare services in the UK.

4- Taking into consideration your position as a practitioner and in creating an environment free of infections, what is your appreciation on the approach of these legislations vis-à-vis other forms of terminal illness and contagious diseases with focus

on the present Covid-19 Pandemic, faced by these group of persons (migrants) in the UK.