Immigrant Health in Germany

An intersectional perspective on migration policies and the example of Bremen

Bachelor Thesis

Lisa Brünig

Universiteit Twente
Westfälische Wilhelms-Universität Münster
Supervisors:
Dr. Joy S. Clancy
Le Anh Nguyen Long

Content

Abstract

This Bachelor thesis aims to apply an intersectional perspective on immigrant health in Germany. The social construction theory by Schneider and Ingram is applied to reveal that German migration policies construct different populations, leading to different forms of discrimination and exclusion from health care services.

The literature review shows that the interaction of migration and health is deeply gendered, for women are exposed to specific health risks and vulnerabilities, often arising from stereotypical gender roles and bad living conditions in respective accommodations. In the public discourse around immigrant women are mostly perceived only in their role as mothers and caregivers, while their contribution to health care and their own health needs is neglected. The analysis refers to Bremen as a positive example for access to health care for immigrants in Germany with the "Bremer model" being exemplary for other German federal states.

The Intersectionality Based Policy Analysis finally highlights that the constructed target groups are not homogeneous, but that their various needs, stories, vulnerabilities and potentials have to be incorporated into policy making to work towards health equity in Germany.

1. Introduction

Migration is an issue which receives major media attention during the last years. With the ongoing refugee crisis migration lies at the center of public discourse not only in Germany, but even in the European discourse. The specific issue of health care for migrants is often neglected, however effective ways and policies to tackle problems and adapt the health system to migration trends could improve the current health situation for immigrants. In the context of migration specific health situations and risks arise, for example traumas caused by the long process of migration. When looking at existing policy approaches and studies around migration it can be revealed that most of them are gender blind, meaning they do not pay attention to gender, but in fact are deeply gendered with men seen as the prototype of migrants, decision maker and bread winners and with women left out of sight (Anthias, 2012, p.205). The interaction of migration and health is deeply gendered, for women are exposed to specific health risks and vulnerabilities, often arising from stereotypical gender roles (Anthias, 2012, p.205). Overall immigrants in Germany face different forms of exclusion from health care services, are confronted with many barriers, and are discriminated against in various ways (see HUMA, 2009, pp.60).

Generally the paper aims to combine two complementary perspectives on the health of immigrants in Germany. In contrast to for example an economic perspective the application of the social construction theory reveals that migration policies in Germany construct different target populations characterized by different levels of power. The construction of target groups, such as asylum seekers and undocumented immigrants, has a significant impact on the differences in access to health care for these people.

Through an intersectional lens it further becomes clear that these target groups are not homogeneous and that different dimensions like gender, age and class are playing a role in determining immigrants' health in Germany. An intersectional approach can reveal the social ignorance and discriminatory legislation regarding the limited access to health care. By applying intersectionality a more nuanced view of the different aspects constituting exclusion from the health system can be provided. Due to the high complexity of intersectionality theory this paper will concentrate on the structural and policy level with a focus on gender, migration and health in Bremen.

The main research question of this paper is: How do migration policies in Germany construct different target groups and how do these constructions lead to different forms of discrimination? This question can be specified for the application of the social construction theory and the intersectionality theory. Concerning the method a literature review will be conducted to answer questions derived from the theoretical framework of the Intersectionality Based Policy Analysis (IBPA). Several questions from this framework will be selected to guide the analysis.

The specific case of Germany is chosen for this paper since in comparison with the EU Germany is the country with the largest number of people born outside the EU with 6.4 million, followed by France (5.2 million) and the UK (4.7 million) (Eurostat). In 2014 it accounted for 30 percent of the asylum claims in the EU[1] (UNHCR, 2014, pp.2). Historically Germany is a migration country, however asylum laws had been tightened and there were and still are few legal options for people from outside the EU to immigrate[2]. To be precise the term immigrant will be used in this paper to encompass all people migrating into Germany, mostly from non-European countries.

As a specific case for Germany I chose to have a closer look at Bremen, as the "Bremer model" is a positive example regarding easier and less bureaucratic access to health care services for asylum seekers. Recent debates are concerned with the application of this model in other German federal states and cities (Preker, 2015). Current debates as reported by the "Tagesspiegel" and represented by comments for example from Karamba Diaby for Zeit Online[3] also refer to the national level and demand not only a German Migration Act, but also less stereotypical arguments used in the discourse leading to increased discrimination and exclusion. Instead they ask for more tolerance and the acknowledgement of the right to asylum. Moreover one should emphasize the responsibility of policy makers and officials, but also the potential of civil society and non-governmental organizations to improve the integration of immigrants into society and to enforce their human right to health care.

---

[1] The number of asylum claims submitted in Germany rose sharply from 2013 to 2014 due to a high number of people from Syria, Serbia, Kosovo and Eritrea (UNCHCR, 2014, p.9). For a comparison of asylum claims in the 10 major receiving countries see Appendix IV.
[2] For latest data and developments, see Appendix V.
[3] For the article see Karamba (2015): Asylmissbrauch gibt es nicht. Retrieved from: http://www.zeit.de/gesellschaft/zeitgeschehen/2015-08/asylmissbrauch-unwort-asylrecht-fluechtling [10/08/2015].

2. Analytical Framework

2.1 An Intersectional approach

2.1.1 Intersectionality theory

Intersectionality is a theory originating in the work of African American feminist scholars, especially Kimberlé W. Crenshaw. It is inspired by feminist and antiracist scholarship, which recognizes that there are important differences among women and men, not only between them (see Creshaw (1991, 2013); Bürkner (2012)). Until the 1990s the discourse was dominated by the "Big 3" of gender, race and class, which were analysed as a triple oppression of women. From the late 1980s on there were increasing doubts about the additive quality of these categories, especially articulated by black feminists in the US like Crenshaw. She highlighted that the reality of discrimination against black women in the US is much more complex and that it is defined by "intersecting oppressions" (Crenshaw, 1989; cited in: Bürkner, 2012, p.182). In her works Crenshaw harshly criticizes the missing and ineligible legal protection for black women and demands to look at the intersection of gender, race and class instead of reducing their situation down to one factor (Chebout, 2011, p.49; see also Crenshaw (1991, 2013)). The main question Crenshaw poses is: „What difference does the difference make?" (Kosnick, 2011, p.165) She claimed for not adding the dimensions but for looking at overlays and interactions, which vary according to social context.

In the further development of intersectionality it was taken up by various scholars and disciplines, leading to a wide scope of approaches considering various axes of analysis (Hankivsky, 2012). In this paper the theory will be applied to migration and therefore incorporates the dimension of migration status in intersection with other factors, leading to specific health inequalities for immigrants in Germany. Veenstra explains how these axes "mutually constitute and reinforce one another and as such cannot be disentangled from one another" (2011, pp.2). They form a matrix of domination and "specific forms of complex disadvantage" (Anthias, 2012, p.106), called "complex social locations" (Veenstra, 2011, p.2). Multiple features of disadvantage, under privileging and exclusion are considered, as well as the impact of systems of oppression, being aware of time, place and the historical context. Groups of people as well as individuals are affected by their position in different systems of power on different levels (Degele & Winker, 2011, p.58).

According to Jones et al. (n.d.) and McCall (2005) there are at least three different intersectional approaches, defined in terms of understanding and use of categories to examine

the complexity of intersectionality. The first ones are the "Inclusion/Voice Models", in which intersectionality refers clearly to the social inclusion of a disadvantaged, previously marginalized group. McCall (2005) defines these models as "intracategorical" (p.1773). This approach is used to break down status categories by highlighting the heterogeneity within one respective group (McCall, 2005, p.1781). According to Crenshaw the main goal should always be to integrate marginalized groups and to fight discrimination (Crenshaw, 2013, p.56).

A second approach comprises "relational/process models" (Jones et al., n.d., p.2). This type considers the transformations that arise when different statuses come together. McCall calls this approach "intercategorical". It is applied to examine interactions between different factors such as gender and race for different groups, to see for example how gender is raced and how race is gendered. This approach requires adopting existing analytical categories to document relationships of inequality and the distribution of resources among social groups (see Yuval-Davis, 2011, p.158).

The "system" or "anticategorical models" are the third type and are described as a "fully intersectional model, which does not see any category as more salient than another". This approach rejects categories itself as "artificial and exclusionary" (Jones et al., n.d., p.2) and it aims to deconstruct analytical categories and replace them with "multiple and fluid determinations of both subjects and structures" (McCall, 2005, p.1773).

For the following application to immigrant health in Germany the intercategorial (also called categorical) approach will be used, which looks at relationships of inequality among already constituted social groups (McCall, 2005, p.1785). This approach is selected, because in this case the structural relationships are the focus of analysis and therefore categorization is inevitable. Thereby questions of definitions and representation of such groups as well as the inequalities among and between the groups are of interest. Crenshaw argues that intersectionality "presumes that categories have meaning and consequences" and that examining intersecting categories is more fruitful than "challenging the possibility of talking about categories at all" (Crenshaw, 1991, p.1299; Ferree, 2013, p.75). To look at the complexities and heterogeneity within groups, the intracategorical approach will be used.[4] Additionally the aim is not to be exhaustive of all possibly involved dimensions and levels[5], as this would go beyond the scope of this paper and lead to less coherence. Regarding the

---

[4] Yuval-Davis (2011) proposes to combine the intracategorical approach with the intercategorical approach, to consider different facets of a social analysis, people's positionings in society, their perspectives of where they belong and of the value system they live in (p.158).
[5] For example Winker and Degele (2011) advocate a multi-level intersectional approach including inequality on the levels of representation, identity constructions and inequality-creating structures.

level of analysis, a focus will lie on the structures and policies in Germany, leading to specific health situations for immigrant women in Bremen.

Looking at intersections generates a more realistic view of modes of discrimination against immigrants and possesses potential to uncover and explicate health inequalities, showing an "important gap in the health determinants literature" (Veenstra, 2011, p.2). In this case the focus will lie on the structural level, because intersections have to be explored carefully before generating ideas for good practice or policy recommendations.

2.1.2   Intersectionality Based Policy Analysis (IBPA)

The Intersectionality Based Policy Analysis (IBPA) is based on the intersectionality approaches as portrayed above and has been developed in the light of increasing awareness that policy alone cannot transform society, but has an important impact on the creation of more equitable and just societies. Policies can be defined as guidelines for action, a plan or a framework, designed to deal with previously identified problems (Hankivsky, 2012a, p.9). The analyses of such policies are essential, because they study their social, political and economic implications, and thereby make future improvements possible. A main message is that "policy is not neutral as it is not experienced in the same way by all populations" (Paléncia et al., 2014, p.4).

Due to the fact that people's lives are created by intersecting social locations and experiences, targeted policies can be as ineffective as general policies "in that both fail to address multiple identities and within-group diversity" (Hankivsky & Cormier, 2011, p.218). This means on the one hand a one-size-fits-all approach does not work, and on the other hand a focus on a single social characteristic might also lead to false, rigid classifications of people that do not reflect reality and rather contribute to existing inequalities.

> Therefore the "IBPA provides a new and effective method for understanding the varied equity-relevant implications of policy and for promoting equity-based improvements and social justice within an increasingly diverse and complex population base" (Hankivsky, 2012a, p.33)

The IBPA framework as developed by Hankivsky et al. (2012) consists of a set of questions and principles to guide the analysis (see Appendix I). Some of the questions are descriptive, others transformative and all in all they are supposed to ensure equitable policy recommendations (Hankivsky, 2012a, p.34). The principles include not only the intersection

5

of categories and the multiple levels involved, but also power relations as being produced through intersections. An important principle is reflexivity, meaning to consider different perspectives, "while privileging those voices typically excluded from policy 'expert' roles" (Paléncia et al., 2014, p.5). Another main principle is the focus on social justice and equity as being related to fairness[6]. The IBPA provides a method for understanding how policy might produce and reinforce oppressive structures, and aims for promoting equity and social justice.

The advantage of an intersectional view on policies is that one-dimensional analyses of policies can hide their real health effects, policy makers can pick a category of interest and deal with it in isolation, without paying attention to how it intersects with others. As a consequence actions should explore the relationship between various factors for an effective policy to change for example the distribution of resources towards a more just allocation (Hankivsky & Cormier, 2011, p.218).

In the case of health policies[7] socio-economic position is the most studied form of social inequality. However there are many more social relations generating health inequalities for example, gender, ethnicity or migration status (Paléncia, 2014, p.3). There is still a lot of potential for improvement to better understand how policy affects the diversity of populations, examining who is benefiting and who is excluded from (health) policy goals (Hankivsky, 2012a, p.8). When analyzing health policies it should be considered what problems are seen as important or are ignored, whether groups or individuals benefit, suffer or are being disregarded by policies.

All in all "the lens of intersectionality can better illuminate how policy constructs citizens' relative power and privileges vis-á-vis their status, health and well-being" (Hankivsky, 2012a, p.8).

Simien has demonstrated the potential of intersectionality to understand the construction and perpetuation of inequities in public policy "by tracing how certain persons get labeled as different, troubled and in some instances, marginalized" (cited in Hankivsky & Cormier, 2011, p.219). Constructs of different subjects and target groups function as justifications for specific policy measures. Bacchi and Eveline even argue: "Policies do not simply "impact" on people; they "create" people", as well as their social locations and their access to power and

---

[6] Braveman and Gruskin (2003) state that equity in public policy exists, when social systems are designed to equalize outcomes between more and less advantaged groups (Hankivsky, 2012a, p.38).
[7] Hankivsky (2012a) defines health policy analysis as "a social, political and intellectual endeavor carried out by diverse stakeholders, including university-based researchers, bureaucrats, health professions and other policy actors, such as community-based groups and organizations" (p.11).

resources (Bacchi & Eveline, 2010, p.110). This can be further illustrated through taking a look at the social construction theory (see 2.2) and the target groups created concerning immigrant health in Germany.

2.1.3 The challenges of implementing an Intersectional Approach to Policy Analysis

Hankivsky reports some crucial components for a good intersectional policy analysis such as explicitness and visibility of certain inequalities, the mentioning of intersecting categories, a structural understanding of the dimension of inequality, as well as the challenging of biases and unveiling stigmatization of people and groups at different points of intersections (Lombardo & Agustin, 2009, p.4; cited in: Hankvisky, 2012a, p.19).

The biggest challenge is to operationalize this concept. The translation of theoretical considerations of interacting dimensions into methodological practices is hard to do and a problem that is not fully solved yet.[8] Hankivsky (2011) notes that the lack of operationalization might cause problems for "appropriate information for policy application" (p.220). Another aspect is that some policy approaches remain one-dimensional such as gender mainstreaming. In temporary research there are some approaches trying to move beyond additive policy in the direction of equality or diversity mainstreaming, intersectional public policy analysis and multistrand mainstreaming (Hankivsky & Cormier, 2011, p.220). Some key questions like how, when and where to apply intersectionality framework and which dimensions or categories to include are important in recent debates. This shows a knowledge gap between the theoretical construct of intersectionality and its practical application (Hankvisky & Cormier, 2011, p.225).

In addition to effective tools and methods a certain political will is essential for adopting intersectional approaches to policy making. Moreover adequate resources and training for a multifaceted view of actors involved, is needed. As a possibility coalition building and alliances are important for the operationalization of intersectionality to make transformative changes in public policies (ibid.).

---

[8] Some examples for different models for operationalization and application of Intersectionality to public policy can be found in Hankivsky, 2012a, pp.19.

2.2 The Social Construction Theory

The Social Construction Theory by Schneider and Ingram argues that the social construction[9] of target populations is an important and often overlooked political phenomenon that should be studied when looking at public policies. Such constructions are said to influence the policy agenda, the policy tools selected and the ground for legitimating policies. The theory helps to explain and understand why some groups are more and some less advantaged in a specific policy field (Schneider & Ingram, 1993, p.334).

Social construction refers to shared characteristics that distinguish a target population from others. It includes the attribution of specific, value-oriented, normative terms and symbols, which, together with metaphors, symbolic language or stories, create stereotypes. These can arise in the context of politics, the media, culture, socialization, history and literature.[10] Moreover these constructions are reinforced and disseminated through policies and policy designs (Schneider & Sidney, 2009, p.106).

As described by Schneider and Ingram the "convergence of power and social constructions creates four types of target populations": The high power, positively constructed group of "The Advantaged", the high power but negatively constructed "Contenders", the weak/low power, positively constructed "Dependents" and the low power and negatively constructed "Deviants" (Schneider & Ingram, 1993, pp. 335). The groups with positive images are describes as intelligent, deserving and motivated, while negatively constructed groups are described to be stupid, selfish and undeserving. Public officials develop target populations based on their own stereotypes and the ones they think dominate in public. This interplay of power, social constructions and the connection of target groups to specific goals leads to the allocation of benefits and burdens towards the different groups. The powerful groups generally gain more benefits, even if these are covert in the case of the Contenders, who are negatively constructed and the public wants to see them punished. The lower power groups have their benefits undersubscribed and receive burdens (see Appendix II).

---

[9] Schneider & Sidney (2009) define social constructions as referring "to an underlying understanding of the social world that places meaning-making at the center. That is, humans´ interpretations of the world produce social reality; shared understandings among people give rise to rules, norms, identities, concepts and institutions" (p.106).
[10] Concerning research methods Schneider & Sidney (2009) point out that looking at social constructions requires interpretive research methods, which take literature, language and problems of meaning into account. Analyzing the characteristics of the target populations for example requires some kind of a discourse analysis, analyzing the policies itself also means considering administrative and legislative texts and guidelines.

Furthermore the policy rationales[11] differ according to the social construction of the target population, for example it is argued that the Advantaged have to be favored as they contribute to the efficiency and economic competitiveness, the control of power might be an argument to punish the Contenders. The rationales for beneficial policy towards the Dependents are more justice-oriented. In the case of Deviants such policies might be legitimated as unavoidable in order to ensure constitutional principles and human rights or even public safety (Schneider & Ingram, 1993, p.340).

These policy rationales, the agenda and tools used by policy makers convey different messages to those who belong to certain target populations telling them what they "deserve from government", what their status as citizens is, and thereby influencing their opinions, agency and participation (Schneider & Ingram, 1993, p.340). Policy makers want to influence the peoples' behavior to support their aims and enforce their interest of being reelected and addressing acknowledged public problems. This includes "the reaction of others to whether the target group should be the beneficiary (or loser) for a particular policy proposal" (Schneider & Ingram, 1993, p.335). Table 1 shows the different messages, orientations and their effect on participation of the four different target groups (Schneider & Ingram, 1993, p.341).

TABLE 1

Policy Design Impacts on Different Target Populations

	TYPES OF TARGET POPULATIONS			
TYPES OF IMPACTS	ADVANTAGED	CONTENDERS	DEPENDENTS	DEVIANTS
Messages				
Personal	good, intelligent	controversial	helpless, needy	bad
"Your" problems are	important public problems	in conflict with others' interests	the responsibility of the private sector	your own personal responsibility
Government treats you	with respect	with fear or caution	with pity	with disrespect or hate
Orientations				
Toward government	supportive	suspicious, vigilant	disinterested passive	angry, oppressed
Toward own interests	coincide with the public interest	conflictive with others	private responsibility	personal responsibility
Toward other's claims on government	not legitimate	competitive rivals	more important	simply privileges
Toward political game	open, fair, winnable	involving raw use of power and crooked	hierarchical and elitist	abusive of power and fixed
Participation				
Mobilization potential				
for conventional forms (voting, interest groups)	high	moderate	low	low
for disruptive forms (strikes, riots)	low	moderate	low	moderate
for private provisions of services	high	moderate	low	low
Citizen–agency interaction	agency outreach	targets subvert implementation	client-initiated contacts	avoidance

---

[11] Rationales are defined as "the explicit or implicit justifications and legitimations for the policy including those used in debates about the policy" (Schneider & Sidney, 2009, p.105).

Schneider and Ingram themselves use immigration policy as one example to show that it "distinguishes among illegal aliens, refugees, migrant workers, those seeking asylum, and highly skilled workers who receive waivers" (Schneider & Ingram, 1993, p.336). In the case of immigration in Germany the Advantaged might be the highly skilled immigrant workers, which were for example recruited in the 1960s and 70s. This recruitment was a selective process, because immigrants between the age of 20 and 40 were hired according to the economic needs in Germany. Moreover it was a health- and qualification related selection, as immigrants had to undergo a medical examination in Germany, meaning that only young, motivated and healthy people were allowed to come and work. This is called the principle of the Healthy Migrant Effect (Müller, 2011, p.174). Another recent example for the Advantaged are those highly educated non-EU immigrants who get an EU blue card to live and work in Germany (bluecar-eu.de). The second powerful group consists of negatively constructed Contenders in this case migrant workers, who in the German public discourse are said to be taking jobs away. In this thesis the focus is on the low power target populations, including the asylum seekers as the Dependents, who are positively constructed as in need for help especially including women and children, and the powerless negatively constructed Deviants, who are the undocumented (also called "illegal") immigrants in Germany. The way these two low-power groups are constructed in German migration policy and its effects on the health situation of these people will be examined in chapter 5.

3. Methodology

In order to apply the theoretical framework described above a literature review will be conducted. According to Hart (1998) a literature review is "an objective, thorough summary and critical analysis of the relevant available research and non-research literature on the topic being studied" (cited in Cronin et al., 2008, p.38).

The aim is to get an overview over current literature on the question of health care services for immigrants in Germany, and to explore the different perspectives and standpoints expressed by officials, journalists, politicians, political parties and civil society in the public discourse. Different types of literature are selected according to several questions derived from the theoretical framework, especially from the IBPA, to finally draw conclusions concerning the main research question. Literature is selected for the general part concerning information on the access to health care for immigrants in Germany and in Bremen. For this part, official documents from the local health authority Bremen, the Germany Ministry of the Interior, as

well as laws and statistics for example from the UNHCR and the German Federal Office for Migration and Refugees are used. Sources from different levels are chosen to get a thorough insight into the debate on health care for immigrants in Germany. For the analysis of the two different target groups of migration policy mostly country and policy reports for Germany are consulted and media online articles were analyzed. In order to examine the access to health care for members of the different target groups from an intersectional perspective many theoretical papers, also from Crenshaw and Hankisvsky were used, as well as papers and studies applying the intersectionality approach on health care, like for example Veenstras' paper for the case of Canada or the paper by Schoevers et al. on health for undocumented immigrants in the Netherlands. I could derive valuable results and examples from these studies to finally apply an intersectional perspective on the case of Bremen, Germany, which has not been done yet.

In the end this literature review is used not only to review current policies, but also to evaluate them, to develop guidelines for new approaches, and to derive concrete recommendations for practice.

4. Access to health care for asylum seekers and undocumented immigrants in Bremen, Germany

4.1 Definitions and legislation towards health care for asylum seekers and undocumented immigrants in Germany

The legal framework for migrants in Germany basically includes the Basic Law (Grundgesetz) with its right to asylum in section 16a, the Residence Act (Aufenthaltsgesetz, AufenthG), which defines the different migration statuses, the Asylum Procedure Act (Asylverfahrensgesetz, AsylVfG) and the Asylum Seekers' Benefits Act (Asylbewerberleistungsgesetz, AsylbLG). The Asylum Seekers Benefits Act regulates the entitlement of refugees, asylum seekers, persons with a residence permit for humanitarian reasons and persons with a "Duldung" (temporary suspension of deportation)[12] to social services from the state. "The Asylum Seekers Benefits Law reduces entitlements to health care services compared to regular health insurance or provisions made by social welfare for German nationals and migrants not falling under the Asylum Seekers Benefits Law" (PICUM, 2007, p.37)[13].

---

[12] See Section 60a AufenthG

[13] For example quota refugees from Iraq or Syria are given a residence permit and are treated according to the Sozialgesetzbuch (Social Act, SGB). (see: Anordnung des Bundesministeriums des Innern (disposal of the Ministry of the Interior) gemäß §23 Absatz 2, Absatz 3 i.V.m. §24 Aufenthaltsgesetz zur vorübergehenden Aufnahme von Schutzbedürftigen aus Syrien, Juli 2014).

The health situation of immigrants is characterized by (1) the conditions in their country of origin like nutrition, health care, war and torture, (2) the conditions during the migration process like psychosocial burdens, stress, hunger, violence, segregation of families and (3) the conditions in the destination country determined by hope, separation of loved family members, racism[14], language and communication difficulties and a low social position with bad working and living conditions (Spallek & Razum, 2007, p.452). Legal entitlements, administrative conditions and the existence of active policies on national and federal states level further affect their access to health care to a substantial extent (HUMA, 2010, p.3).

4.1.1 Access to health care for asylum seekers in Germany

In Germany the federal states (Bundesländer) and local authorities are responsible for accommodation, care,and support for asylum seekers. According to the HUMA (Health for Undocumented migrants and Asylum seekers) network report, asylum seekers are significantly discriminated against in the German legislation during their first four years of residence. In this time asylum seekers are only entitled to access free of charge medical treatment in cases of "serious illness or acute pain" and everything necessary for recovery, improvement or relief of illnesses and their consequences" (HUMA report, 2010, p.7).

The basis to entitlement to health care in the German system is affiliation to insurance, but asylum seekers mostly cannot afford this. Therefore the social welfare office covers the costs for health care by paying a part of or the whole health insurance fees or by directly paying for medical treatment (PICUM, 2007, p.36). Asylum seekers can only access the German Statutory Health Insurance System under the same conditions as the national population after 48 months of residence in Germany.

Section 1 No. 1 of the 1997 AsylbLG defines that the act applies to foreigners with a residence permit according to the Asylum Seekers Act. Recipients of the AsylbLG are not allowed to work nor have an income. The entitlements include ante and post natal care, vaccinations, and cases of sexually transmitted diseases such as Tuberculosis and HIV (HUMA, 2009, p.61). The AsylbLG identifies specific groups, namely children, traumatized people and pregnant women, who are mentioned in section 4 and 6 with specific entitlements. Pregnant women have access to preventive medical care and services concerning child

---

[14] More studies for example by Ferreira or Krieger examine the effects of racism on immigrants and their health, arguing that racism in its different forms can increase health-vulnerability, fear and traumatize people. This includes violence against (female) immigrants or inter-ethnic violence. See Prasad (2009).

delivery. The "Ärzte Der Welt – Germany"[15] (2009) state that "medical care for asylum seekers is generally linked to administrative difficulties, which, in addition to the frequent language barriers and the lack of knowledge about the German health system, make access difficult and in some cases (for example in cases of severe trauma) almost impossible" (p.80).

To become entitled to treatment asylum seekers and also undocumented immigrants in Germany need to apply for a "Krankenschein" from the social welfare office. This document entitles them to charge the services they can get according to the AsylbLG. However the federal city states Bremen, Hamburg and Berlin have different regulations and abolished the need for the Krankenschein (HUMA, 2009, p.61)[16].

4.1.2   Access to health care for undocumented immigrants in Germany

Undocumented immigrants are "foreign nationals who are not able to legitimize their residence or work or both in accordance with the rules of law of the specific country" (UWT, 2008, p.9). Irregular immigrants are liable to be deported due to matters such as enter using false documents, overstay visas, have a rejected asylum claim but remain in the country, have no papers or generally violate any of the conditions attached to the immigration status (UWT, 2008, pp.12).

Estimated numbers of undocumented immigrants in Germany range from 100 000 to 1 500 000 (Sinn et al., 2010, p.6). Moreover for Germany the concept of "toleration" ("Duldung") is central. It means the person is granted a "toleration certificate", "implying a suspension of deportation, whilst still under a legal obligation to leave the country, where expulsion or deportation cannot be enforced for factual or legal reasons" (Björngren Cuadra, 2010, p.7). As the deportation is only suspended this is not a legal residency status.[17] People without residence permit cannot enroll for health insurance. In case of accidents or sickness they have to either rely on charity or disclose their irregular residence status to public services.

The AsylbLG defines in Section 1 No.4 that it applies to foreigners that have a toleration, No.5 that it applies to "foreigners, who have the enforceable duty to leave the country, even if this duty cannot yet be enforced or not anymore enforced" and section No.6 says "husbands, spouses or under age children associated to the persons according to No. 1 to No. 5"

---

[15] Humanitarian Organisation Médecins du Monde (MdM); engl. Doctors of the World

[16] See chapter 4.2

[17] In case of severe health problems (or pregnancy) which preclude(s) travelling by the applicants or a member of the family the expulsion can be suspended for six months maximum. It can be renewed on discretionary decision of the respective authority. After 18 months of suspension, they can apply for a residence permit on humanitarian grounds (HUMA, 2009, p.74).

(Björngren Cuadra, 2010, pp.10). This shows that generally undocumented immigrants are entitled to the same care benefits as asylum seekers in their first 48 months of residence meaning that in most federal states they have to successfully apply for a "Krankenschein".

Until 2009 the welfare offices were in any case obligated to report undocumented migrants to the immigration office. This would lead to deportation unless the person successfully applies for a "Duldung" to be eligible for public subsidies from the social welfare office. This is also true for maternity care and childcare, which is only possible with a "Duldung", that is also granted during the "period of maternity" ("Mutterschutz") from 6 weeks before and 8 to 12 weeks after delivery (PICUM, 2007, p.38).

Björngren Cuadra (2010) argues the "health of undocumented migrants is at great risk due to difficult living and working conditions, often characterized by uncertainty, exploitation and dependency" (p.3). This uncertainty exists because on the one hand there are regional and local variations in Germany and on the other hand because of legal barriers such as the duty to denounce and the penalization of assistance. As a consequence the parallelism of entitlements between undocumented immigrants and asylum seekers is not implemented in practice (PICUM, 2007, p.39). The duty to denounce is based on section 87 AufenthG, but however health workers have been involved only indirectly (as they are bound by the medical code and professional secrecy), when those who treat undocumented migrants claimed reimbursement from social assistance offices (Gray & van Ginneken, 2012, p.8). Since September 2009 there is a new instruction including an interdiction to denounce for social services and hospital staff involved in the reimbursement process (Section 88 AufenthG; HUMA, 2010, p.7; PICUM, 2007, p.38). This means that an enormous legal obstacle for access to health care for undocumented immigrants has been partly abolished. However there is still a "great risk that their whereabouts become known to the authorities" (PICUM, 2007, p.38). In practice, cases are reported where health administrations and medical personnel spontaneously denounce undocumented migrants despite the inexistence of laws obliging them to do so (HUMA, 2010, p.21).

Another legal barrier is the penalization of assistance. The Residence Act (section 96 AufenthG) states that anyone who assists undocumented migrants will be penalized if acting for financial gain, if they do it repeatedly or for the benefit of several foreigners (PICUM,

2007, p.40; HUMA, 2009, p.63)[18]. All in all it is to say that for most of their health care needs, undocumented migrants rely on professionals' willingness to offer free treatment or on the ability of charitable, religious, or aid organizations to provide assistance (Gray & van Ginneken, 2012, p.8).

The mentioned fear of being denounced, the lack of information about ones´ rights, the lack of legal entitlements, costs of services and discriminatory attitudes among health professionals, all prevent undocumented migrants to claim their right to health care and to actually seek treatment (Björngren Cuadra, 2010, p.13; PICUM, 2007; HUMA, 2009). In the long run alternative options such as self-treatment, family or civil-service networks cannot compensate this.

4.2   Bremen

Measures to combat prevailing health inequalities concerning migrants in Germany are not a high priority aspect on the policy agenda. However the national integration plan 2007 included the goal of improving integration through reducing barriers for access to health care for immigrants on federal states level (Berens et al., 2008, p.9). The shared competences and decision-making powers among the federal states, federal government and civil society organizations is a specific characteristic of the German health system. Bremen was the first federal state that started working effectively towards the objective of reducing barriers for example through their integration concept passed by the Bremer Senate in 2000 (Mohammadzadeh, 2003, p.7).

4.2.1   The Bremer model of health care for asylum seekers

The "Bremer Modell" of health care for asylum seekers as such exists since 1993. The main goal is to ensure health care for asylum seekers in Bremen, including for example regular doctor's consultation hours to address the actual health needs of immigrants in community facilities, where they stay during the first time after arrival (Jung, 2011, p.7). Policy makers in Bremen aim to apply the principle of "primärärztliche Versorgung" meaning that asylum seekers should be treated locally by experienced physicians. Free examinations by the public health department of Bremen for all new asylum-seekers are another part of the program (RAZUM et al., 2008, p.59).

---

[18] People providing assistance (except for emergency aid) for undocumented migrants can be sentenced to a fine or imprisonment for up to 5 years according to section 96 AufenthG.

The core idea of this model, which is not only directed at new arrivals, but also at those waiting for their application response, is to lower the barriers, to provide culturally sensitive treatment and to perform a gate-keeper function to refer patients to medical specialists or other health institutions (Jung, 2011, p.21). Results of the data collection and evaluation of the program showed that about half of the patients were successfully treated without referring them to hospitals etc. Very specific for the Bremer model is the intercultural access, aiming to tackle the crucial language and cultural barriers regarding access, treatment and communication between doctor and patient, which is also being guaranteed through various practitioners with migration backgrounds (Jung, 2011, p.68). In her report Jung argues that the Bremer model always set a focus on the networking between different actors, including the social resort, the health ministry, medical associations, churches, hospitals and welfare organisations in the health sector to integrate immigrants into the system (Wiesner et al., 2008, p.7). As described by Jung (2011) (Gesundheitsamt Bremen) the program considers itself as a connecting link between asylum seekers and the existing medical treatment (p.21).

Since 2005 another essential regulation is in place: The introduction of an electronic health card, allowing asylum seekers to get direct access to basic and regular care, except for psychiatric care (Jung, 2011, p.7). From 2012 on Hamburg also applies this model. The crucial fact is that both city states have contracts with the AOK Bremen/Bremerhaven (health insurance company Bremen/Bremerhaven). These contracts regulate that asylum seekers get an electronic chip card instead of the "Krankenschein", thereby abolishing one major barrier to health care (Classen, 2013, p.23). The city-states Bremen and Hamburg are paying a fixed rate of 10 € per person to the AOK health insurance and 8€ for the health card per person. Furthermore it is important to note that some providers can get reimbursement for treatment costs from the tax-funded welfare office. For asylum seekers this means they can access medical treatment by professionals directly with their own health card.

The main advantages of this model are on the one hand that it benefits not only the asylum seekers, but also the cities as they reduce costs for administration such as for contracts with doctors and other health care providers, and their personnel. In the case of Hamburg, savings of 1.6 million euros in the social security office are registered (Eubel, 2015). On the other hand, the AOK personnel have the competences to actually assess the adequacy of treatment according to the health situation of the asylum seeker. Another potential advantage is that this system is less likely to cause discrimination in the process of accessing care as their status is not revealed through their health chip card. Asylum seekers are supposed to get their chip

card within 14 days after they are recognized as an asylum seeker, but in practice this might take more than 2 weeks, which is again a bureaucratic problem (Jung, 2011, p.41).

4.2.2 Health care for undocumented immigrants in Bremen

The number of undocumented immigrants in Bremen is estimated at 4000 people without legal residence status with increasing numbers since the 1990s (Wiesner et al., 2008, pp.4). According to Razum et al. (2008) until now treatment and health services for people without legal residence status in Germany mainly depend on non governmental organisations (NGOs) and private people eager to support these groups(p.63). Examples for NGOs providing health care for undocumented immigrants are the Malteser Migranten Medizin (MMM) or the "Büros für medizinische Flüchtlingshilfe" in Berlin and many other German cities (so called MediNetze in 11 cities). They often are the only options for people without health insurance.

The MediNetz Bremen serves as a medical advice agency for refugees and undocumented immigrants. Their main objective is to extend the network for health care provision for undocumented immigrants and to relocate this task into the public sphere (Wiesner et al., 2008, p.7). They refer people to doctors, hospitals or midwives where they can receive free treatment (Sinn et al., 2005, p.65; Razum et al., 2008, p.63). In a study from 2008 it was found that about 52% of the physicians that took part in their survey had experiences with undocumented people and carried out about 334 treatments a year (Wiesner et al., 2008, p.20). Additionally they offer support for people who have to live with a "Duldung", they assist in writing letters and objections, prepare the hearing during the asylum procedure, accompany people to public authorities and establish contact to qualified lawyers. They define themselves as an independent human rights organization and they work confidentially, anonymous and free of charge. Furthermore women can get advice by women if desired and consultations can be held in many different languages including Arab and Turkish.

The Flüchtlingsinitiative Bremen informs about further organisations and groups working in Bremen to support immigrants like "Acompa", a volunteer group for the accompaniment of migrants to government agencies, also offering translations services and "promoting solidarity and antiracism" (acompabremen.de). "Ahoi" is a project for legal consultation, it also helps in terms of educational and language training and to find work. Another big organization in Bremen in "Refugio Bremen e.V.", which is making an essential contribution to the services

provided through the "Bremer model" as they fill existing gaps[19] and provide also psycho-social and therapeutic help for asylum seekers and undocumented immigrants (refugio-bremen.de). Most of these organizations are connected through the "paritätischer Wohlfahrtsverband" (social welfare network) and the "Interkulturelles Gesundheitsnetzwerk Bremen" (IGN; intercultural health-network Bremen). Since 2008 the IGN includes 60 institutions sharing the objective of health equity and improved psycho-social health care for immigrants in Bremen. They work on different themes like intercultural opening of the Bremer health-care system, health of undocumented immigrants, health of female migrants in Bremen, migration and disability etc.

The main objective of these initiatives is to provide access and "adequate treatment" (Sinn et al., 2005, p.65). However these solutions are mainly temporary, based on voluntary work and private donations, and often do not have the capacity to compensate the lack of access to the German public health care system.

5. The social inequalities concerning health care for asylum seekers and undocumented immigrants in Bremen

To finally apply an intersectional perspective on immigrant health key questions of the IBPA will be used to analyze the problem and policies in Germany and more precisely in Bremen, to conclude recommendations from this analysis. The main research question is: How do migration policies in Germany construct different target groups and how do these constructions lead to different forms of discrimination?

5.1 Asylum seekers and undocumented immigrants as socially constructed target groups and the effects for their health situation

A question of the IBPA framework, adjoined to the policy problem itself is: **"How are the groups differently affected by the representation of the problem?"** The first sub question asks **who is considered the most advantaged and who is the least advantaged within this representation? Why and how?** When applying the social construction theory to the health situation of immigrants in Bremen and Germany as a whole it can be seen how current policies construct different target groups, if they are seen as homogeneous or heterogeneous and if they are stigmatized by these policies.

---

[19] The report about the Bremer model states that psychical illnesses show significant gaps in the health care for asylum seekers, which are not specific for Bremen but exist in many federal states and also in many European countries. These gaps cannot be filled through the health care program only but professionals in organisations such as Refugio are needed (Jung, 2011, p.9).

The focus of this analysis will be on the low power groups, as explained above. The first low power group consists of the Dependents. They are positively constructed and seen as "in need". In the case of German immigration policies the asylum seekers, especially mothers and children are constructed as Dependents.[20] Dependents are characterized by a lack of power, which makes it difficult for them to demand resources and often symbolic policies are used by officials to show concern without actually allocating resources towards them. Policies in this field tend to be left to lower levels of government or to the private sector (Schneider & Ingram, 1993, p.338). This is also the case for asylum seekers in Germany, because the competences for health care and social services provision are in the hands of the federal states and municipalities. Policy tools for this group include for example subsidies. However these will only be given on the basis of certain requirements, which might involve labeling and stigmatizing recipients. On state level Classen (Flüchtlingsrat Berlin; refugee council) criticises that a "Krankenschein" is only given to an immigrant, if he or she proves the case of acute illness or pain. Additionally the application for a "Krankenschein" often requires a long process for people to finally receive treatment which is then paid by the federal state. Furthermore it remains unclear according to which criteria officials in social welfare offices check the need for treatment as they are no medical professionals. Therefore this procedure is seen as harassment by people concerned (Classen, 2013, p.22). According to Classen a possible solution for this failure and inhumane practice would be to include beneficiaries of the AsylbLG into the statutory health insurance according to section 5 SGB V (German social act[21]).

It can be argued that the limitation to treatment in the AsylbLG for "serious illness" is not in accordance with the law for example chronic diseases may also cause acute pain (Classen, 2013, p.22). Additionally people in this group are not encouraged to find their own solutions but actually rely on agencies to help them (Schneider & Ingram, 1993, p.339). Overall "public officials simply do not like to spend money on powerless groups and will use other tools whenever possible" (Schneider & Ingram, 1993, p.339).

The messages those policies imply for Dependents highlight that they are powerless and in need of help from the state. The typical requirement is to apply to the agency through bureaucratic processes for benefits, for example applying for a "Krankenschein" in Germany

---

[20] For the different target groups constructed by German migration policy see Appendix III.

[21] Critics of the AsylbLG in Germany query its constitutionality because treatment is often delayed due to bureaucratic barriers, which also leads to higher costs in the end. Amnesty International for example calls for abolishing the AsylbLG because of its discriminatory nature and services below the subsistence minimum (https://www.amnesty.de/presse/2014/7/15/stellungnahme-zum-referentenentwurf-asylbewerberleistungsgesetz). For further information see Classen, 2013, pp. 22.

requires them to expose their dependency status. Concerning migrant women Winker and Degele (2011) argue that "a migrant mother has to confront pervasive accusations and images portraying her as a 'social freeloader', whose motivation for coming to Germany with her children is to profit from the state social security system. Here class, race and body-relations converge." (p.64)

The second sub question is: "How do current representations shape understandings of different groups of people?" and "what differences, variations and similarities are considered to exist between and among relevant groups?" The Deviants are the second low power group and are not only powerless but also negatively constructed. In the case of German migration policies undocumented or "illegal" immigrants can be identified as Deviants. They are negatively portrayed by politics, the media, literature etc. This can be illustrated through the use of the term "illegal immigrants", which leads to denying humanity or basic human rights for a person or group and suggests a linkage to criminality. Therefore for example the Council of Europe or the United Nations High Commissioner for Refugees (UNHCR) prefer the terms undocumented, unauthorized or irregular immigrant (UWT, 2008, p.9). Moreover this illegalization, which is socially constructed and ideologically loaded, has serious health consequences, can be seen as one form of social exclusion of immigrants and refers also to debates of health-related deservingness.[22]

Undocumented immigrants are often portrayed as social freeloaders in the German public debate, which is mainly framed by two positions: The humanitarian position constructing them as "unauthorised refugee" and the public order side portraying them as "the criminally unauthorised" (Björngren Cuadra, 2010, pp.14). On the one hand undocumented migrants are seen as a security concern for example by the Ministry of the Interior focusing on border and migration control (Cyrus, 2009, p.17). Clandestino (2009) states that "responsible German policy makers strictly oppose regularization programs under the rationale that illegal behavior should not be rewarded and that regularization creates pull effects. Irregular entry and stay, and its support is a criminal offence to be punished with a sentence of up to one year's imprisonment" (p.4). On the other hand human rights groups as well as welfare associations and churches emphasize the potential of immigration and demand legal reforms for better integration and less discrimination.

---

[22] For more information on health-related deservingness see Willen, S. (2011): Migration, "illegality", and health.

The current debate in Germany and the concepts referred to are linked to the historical development in this policy field. Until 2001 the German federal government officially denied that Germany is "a country of immigration", which is not true especially since the guest worker programs of the 1960s and 70s (Castaneda, 2008, p.4). Policy reports argue that Germany is perceived to never accept irregular immigration (Cyrus, 2009, p.17). In sum the experiences of "high amount of unwanted and allegedly uncontrollable immigration of recruited workers and their families" and since the 1990s the immigration of refugees, asylum seekers and migrant workers still influence the opinion of policy makers and public, and "give politicians the argument to follow an immigration policy that aims to strictly control and reduce immigration" (Cyrus, 2009, p.18).

The negative construction of undocumented immigrants is also executed through media reporting. Since the mid-1990s the media stated the number of irregular immigrants in Germany is estimated by (often not named) experts with 1 million people. The introduction of this figure had an illustrative purpose, underlining that the phenomenon should not be underestimated. However there is a problem of quantification and in the meanwhile the media tends to inform that the volume is estimated between 100,000 and 1 million persons but that no reliable, figures can be provided (Cyrus, 2009, p.19).

Undocumented immigrants are referred to with metaphors of waves of people coming into the country ("Flut-, Zustrom- und Wellenmethaphern") posing a threat on society. This is identified as semantic mechanisms of exclusion in the media migration discourse (Müller, 2011, p.150). Studies from 2006 show how undocumented immigrants in Germany are portrayed as illegal, coming to exploit the welfare system and being associated with crime and danger. Recent debates might show another group of Deviants in German migration policy, meaning the "economic migrants" who are accused of trying to exploit the German welfare state and trying to take away the jobs for the host population (analyzed by Bade, 2013). The party AfD (Alternative für Deutschland) for example demands also in Bremen to stop the immigration of economic refugees in Germany arguing asylum laws are misused and rejected asylum seekers do not have to fear deportation, which has motivating effects on economic refugees for example from Kosovo (AfD Bremen, 2015). In this respect one needs' to be aware of terminological choices to be certain not to inadvertently convey ideological messages about who does and does not merit inclusion within the social, political, and national communities studied. Willen (2011) therefore enjoins scholars to deploy immigration-related terminology responsibly.

Simultaneously (legal) immigrants or asylum seekers are constructed as a part that has to be or already is integrated into society. This is called "paradoxe Pluralität" (paradox plurality) (Müller, 2011, p. 151). As a result the portrayal in the media often activates and strengthens stereotypes even if it has the potential for realignment, as well as social and cultural development (Müller, 2011, p.155).

The tools used by policy makers for the group of Deviants might be more coercive and include sanctions, force etc. "At best they will be left free but denied information, discouraged from organizing, and subjected to the authority of others" (Schneider & Ingram, 1993, p.339). Messages conveyed to them emphasize they are bad people and a problem for others, showing stigmatization and labeling. Political participation of these target populations is very weak and "there are virtually no opportunities for illegally resident migrants for political participation in Germany as this involves the risk that their status will be disclosed" (Sinn et al., 2010, p.10).

Accordingly these people fail to claim government benefits for which they are eligible (Schneider & Ingram, 1994, p.342). This is also true concerning health care for undocumented immigrants in Germany who in practice fear to be denounced and deported when trying to access health services. Overall access to health care for them is difficult as they cannot enroll for German health insurance. In case of accidents or sickness they have to either rely on charity or disclose their irregular residence status to public services. As a result many delay a visit to the doctor and serious consequences both for the health of the concerned person and for public health arise because minor problems grow and require much more expensive medical treatment in a later point of time(Clandestino, 2009, p.2). All in all MdM call health care for undocumented immigrants in Germany "substandard" with especially high risks associated with pregnancy and childbirth (HUMA, 2009, p.78). Taking into account the difficulty to address these problems under the existing administrative, legal and political structures, the Federal Working Group on Access to Health Care for Undocumented Migrants in Germany strongly recommends the abolishment of the penalization of assistance for humanitarian reasons and the duty to denounce as well as the creation of a specific public fund that would cover the costs for medical treatment for undocumented immigrants (PICUM, 2007, p.47).

Castaneda researched the effects of laws criminalizing medical aid for undocumented immigrants. She figures out that in fact "local municipalities address the needs of undocumented migrants in ways that approach to run counter to national-level policy"

(Castaneda, 2008, p.5). The reliance on the NGO sector is high for helping undocumented migrants with their health needs, but NGO staff and physicians describe their frustration of feeling as "Lückenbüßer" (stop gaps) in Germany for the failing social welfare system (Castaneda, 2008, p.5).

In 2009 there has been a policy change because undocumented immigrants do not have to pay the costs of treatment themselves if they do not want to risk being registered by the immigration authorities, due to the interdiction to denounce in the process of reimbursement of costs. Still Germanys' response to irregular migration consists of intermediate solutions such as the "Duldung". Additionally there are a few ad-hoc measures for specific groups such as war refugees or temporary and contingent refugees for example those from Syria in 2014/15. "However, permanent residence permits appear to be granted to a minority of applicants" with the toleration resulting from economic considerations (Björngren Cuadra, 2010, p.7). Undocumented immigrants still seem negatively constructed as they are often portrayed as "illegal", but one can assume that a change in society is being initiated as more and more non-governmental organizations and clinics offer medical treatment for undocumented migrants, as can be seen in Bremen.

Finally in comparison to undocumented immigrants, asylum seekers have an authorized status which seems to make them less negatively perceived and punished. Furthermore asylum seekers have the same entitlements as nationals if they reside in Germany more than 48 months. Prior to this they are entitled to access health care free of charge, but only in cases of serious illness or acute pain, which equals the legal entitlements of undocumented migrants. However in practice the different policy tools directed at the target groups become clear, as undocumented migrants are punished through a limited applicability of the entitlements through the duty to denounce (even if restricted since 2009), the punishment of assistance and the actual practices towards pregnant women and their children.

Moreover Harzig points out how sexist and racist concepts work in this politically motivated construction of immigrant groups, also in Germany. He highlights the subtle ways of social construction with hidden assumptions behind categories often failing "to notice the diversity and heterogeneity of and among immigrant groups" (Harzig, 2003, p.52).This will be further analyzed in the following part.

5.2 An intersectional perspective on health, migration status and gender in Bremen

The specified research question for this paragraph is: How do existing policies address, maintain or create inequalities and more specifically health inequities between and within different target groups?

5.2.1 An intracategorical approach: Migrants are not a homogeneous group

A concrete tie point regarding the intersectional perspective is that there are not only discrimination and health inequities between immigrants and the host population in Germany[23] and not only between the different constructed target groups, but also within those groups.

From an **intracategorical intersectionality perspective it can be argued that asylum seekers and undocumented immigrants in Germany are not homogeneous groups.**

According to Anthias (2012) migrants are portrayed "as an originally abstract category presupposing an undifferentiated human subject" (p.102). In recent years this has been partly corrected with more recognition about the multifaceted forms of migration "ranging from settler, sojourner, exile, asylum seeker, temporary worker and so on and these are not always mutually exclusive" (p.102). From an intersectional standpoint the fact that these dimensions or forms are not mutually exclusive is a core aspect, because human lives cannot be reduced to singular, distinct categories. Instead migration status is one category that interacts for example with nationality, gender, age, health situation, religion and ability, and thereby creates unique social locations in the destination country (Hankivsky, 2012a, p.35).

When looking at health it makes sense to focus on health equity and thereby apply a social justice approach as this has "the potential to transform social structures, which is essential in addressing the root causes of inequities" (Hankivsky, 2012a, p.38). Health equity is constituted by fairness as the key principle. According to Hankivsky (2012a) "equity in public policy exists when social systems are designed to equalize outcomes between more and less advantaged groups" (p.38). This means policies have to consider that migrants are not a homogeneous group to address their health needs adequately and work towards health equity.

---

[23] Social inequalities between immigrants and the host population in regard to social and health services are manifested in the laws as the host population is treated according to the social act, and asylum seekers according to the AsylbLG which limits their legal entitlements. Other migrants only get services according to the social act when their asylum application has been accepted, which takes between 6 months and 10 years' time.

Dr. Mohammadzadeh from the Ministry of Health in Bremen argues in favor of policies towards health equity referring to recent claims for intercultural opening/tolerance of the health system. Politics, health services and administrations should work towards health equity together. She describes this as a challenge to do justice to the growing, many-faceted group of immigrants in Germany with social and cultural differences that have to be considered when opening the regular health system towards them (Mohammadzadeh, 2003, p.8). Mohammadzadeh clearly argues in favor of an intersectional approach as she highlights that it is a question of not seeing immigrants as a homogeneous mass, but as a population group, which is not only characterized by the factor of migration, but is diverse concerning language, background, culture, nationality, education and related to many single lives and stories. (Mohammadzadeh, 2003, p.8).

By applying the social construction theory it was shown that different target groups are being created by policy makers and that this has an effect on the access to health care for the groups. Hereby it is pointed towards an "intercategorical" approach with a focus on inequalities among and between constructed groups.

5.2.2 Inequalities concerning migration and health in Bremen

As portrayed above, migrants are not a homogenous group, which is also true for the two powerless target groups analyzed in this paper. When looking at the health situation of asylum seekers and undocumented immigrants in Bremen it is often shown how immigrant women are especially vulnerable and exposed to health risks (Jung, 2011, pp.7). Therefore the following analysis will focus on gender, migration and health in Bremen from an intercategorical perspective to examine how migration status affects health for women and men differently. Therefore it is important to be aware that gender is a relational concept "referring to processes and constructions and not to seemingly homogeneous entities. […] The functioning of gender has to be tracked again and again in peoples' everyday activities, in the construction of meaning as well as in the unspoken assumptions that form the essence of institutions and laws" (Harzig, 2003, p.50).

The following questions of the IBPA framework will be considered: **What inequities actually exist in relation to the problem?** (See question 6, Appendix I) **Which are the important intersecting social locations and systems? For example, how do 'race', ethnicity, class, sexuality and other social locations and systems of inequality (racism, classism, sexism) interact in relation to this policy problem?**

First of all, concerning the different intersecting social locations it is important how migration status influences health differently concerning the target populations of migration policy in Bremen and for people from different genders. As an example migration status has a positive influence for asylum seekers and their health status because they are seen as in need and dependent on the system, especially in the case of unemployment. For undocumented immigrants their status (in interaction with other factors) causes different forms of discrimination manifested in exclusion from the health system. Within the group of undocumented immigrants, women potentially have a higher vulnerability and suffer in cases of double exclusion, as explained below. It will be shown how gender and policy construct each other and how special policy programs and services for women might also re-construct them as weak, oppressed and deviant in their traditional role as mother and wife.

Secondly, existing inequalities and forms of discrimination can be analyzed when looking at the differentiated social positions that women and men occupy in the receiving country with immigrants being perceived as part of the lower, poorer classes. For example Piper (2005) points out that financial issues, legal issues and health care services, availability of "linguistically and culturally appropriate care" and the different illnesses are often related not only to the types of jobs and work done, if done at all, but also to gender (p.31).

When looking at problems regarding the medical treatment of immigrants it is often referred to cultural differences in understandings and concepts of sickness and health practices. One can speak of "culturalization", which is the problem "when culture becomes the only story, the lack of attention to other problem representations is apparent, and the focus is exclusively on particular groups without offering real solutions to their problems" (Rolandsen Agustín, 2013, p.155). Furthermore it contributes to exclusion and othering in society when target groups are constructed. Therefore Domenig recommends focusing more on structural components of health care (Viruell-Fuentes et al., 2012).

One such structural problem is the lack of information on the German health care system and its programs and ways of financing the services. Some measures are taken, for example brochures with detailed information about health insurance, medicals, pharmacies, dentists, hospitals and public health services in different languages. For Bremen there is the so called "Gesundheitswegweiser für Migrantinnen und Migranten" (health-guidebook for migrants) developed by the Ministry of Health as part of the concept for integration of immigrants in Bremen with the aim of addressing integration in a systematic and structural way focusing on

the improvement of immigrants´ everyday life (Röpke, 2003, p.5). The guidebook gives an overview of the language competences of different general practitioners, institutions and midwives with contact information in Bremen. Moreover the Federal Ministry of Health, the patient information service of the German Cancer Society and other initiatives provide telephone services or leaflets in foreign languages (Berens et al., 2008, p.8).

Language is a factor that can lead to problems of accessing health services or knowing about the right to health care in the destination country. Berens et al. (2008) report that "in most healthcare settings, patients with limited German language skills themselves have to find an interpreter." (p.8). In Bremen the "Dolmetscherdienst für Migrantinnen und Migranten" (interpreter-service for migrants) has been founded to help with language and communication problems but also intercultural misunderstandings in the health sector. It offers neutral services like for the communication between migrants and medical personnel (Gesundheitsamt, 2005).

The third subquestion is about how different factors and social locations affect the health situation of immigrant women in Bremen**.** What Vaiou and Stratigaki (2008) call a "double exclusion" for women, can be identified as the intersection of migrant status and gender, the combination of racism and sexism. On the one hand women are excluded as foreigners and immigrants who face specific difficulties in accessing services for example denied work permits or social security payments, meaning they are confronted with racism on the street and in institutions. On the other hand they face discrimination as subjects to patriarchal structures within their communities and families, in which men are in charge of more power and resources and where "social rights are derived from husbands and/or fathers" (p.120). Thereby women are pushed into the private sphere and their vulnerability (to health risks) rises. In the whole process of the migration experience women are only seen in their role as mothers and are associated with dependents, meaning mainly children, pointing towards little autonomy. As mentioned in the introduction migrant women access health services mostly in cases of ill health of their children or other family members underlining their role as caregivers (Vaiou & Stratigaki, 2008, p.126). It is often neglected that women also contribute to community development and health care in the destination country themselves by creating community institutions to provide care, welfare and charity and that they also have own health needs themselves (Harzig, 2003, p.54).

The importance of gender roles and stereotypes for the health situation of immigrant women in Germany can be shown through the example of section 31 AufenthG, which explicitly shows how women rely on a partner for access to social services like health care. It says that non-German wives (or husbands) have to live together with their partner two years before they get their own residence permit and the existence of the marriage has to be proven in individual cases. If the marriage fails earlier, the (mostly female) foreign partner and non-German children have to leave the country immediately. For many migrant women this means they are not protected against violence by the law, because if they do not live together with their German husband for example due to domestic violence, they are likely to be deported. As a result many migrant women do not raise their voices in cases of domestic violence until they get their own residence permit. This is a specific case of vulnerability for women, which also contributes to physical and psychical injuries (Hunkeler/Müller, 2004, p.166).

The case for female asylum seekers in Bremen it is shown in the report of the "Bremer Modell" that women used services significantly more often than men did. Women were seeking services between 3.6 and 11 times a year, while men only utilized care 2.1 to 6.1 times a year (Jung, 2011, p.7). Pregnancy tests and questions about health of their children contribute to these numbers. If women are portrayed only as mothers this results in diffuse diagnoses resulting from high stress levels, for example high blood pressure and headaches. As reported by Jung this might result from gender-specific and traditionally patriarchal cultures and contexts where women are subjected to especially high burdens in the migration process and the new living situation (Jung, 2011, p.8). Women are often seen as being responsible for the social cohesion within the family and for everyday care. In communal accommodation situations right after the arrival in Bremen, living conditions are restricted with bad hygienic conditions etc. In such settings it is not possible for women to serve their traditional gender roles and stereotypical duties that are demanded from them, which causes additional stress and raises the risk of violence. There is a high risk of rape and sexual harassment for women in such crowded accommodations with traumatized people around (Jung, 2011, p.41). This shows the gendered aspects also of psychological health. Moreover women's possibilities to escape the difficult situation for example in communal accommodation places are less than men's, especially when they have children and are not able to work, meaning that they are less mobile.

Concerning the possibilities to work it is to say that asylum seekers are allowed to work earliest after 3 months of residence and only if no German citizen applies for the same job.

The report of the Bremer health model highlights that access to work can have a stabilizing effect on the health situation (Jung, 2011, p.10). However this depends on the sector and kinds of work. As migrant women often work informally in the care sector and in employers' homes, or as prostitutes, for them working and earning money does not necessarily contribute to more independence or autonomy in the destination country (Vaiou & Stratigaki, 2008, p.122).

The discriminatory laws and working restrictions like the mandatory residence[24] have many consequences that take different shapes for men and women. Asylum seeking women are not only discriminated against in terms of pregnancy compared to national pregnant women, but there are further forms of health inequity between asylum seeking and undocumented women (HUMA, 2010, p.19). When comparing pregnant asylum seeking and pregnant undocumented immigrants the findings of the HUMA report show that undocumented women are highly discriminated against as the duty to denounce overrides entitlements, even if this was changed in 2009 in the case of application for reimbursement. Moreover a look at ante and post natal care shows that for undocumented women the applicability of their legal entitlements to access care free of charge and paid with public funds is nearly not given as "the Duldung ends up being the only possibility to receive care" (HUMA, 2009, p.67). It is granted for pregnant women from 6 weeks before to 8 to 12 weeks after delivery, but deportation is only temporary suspended and the chance of getting a birth certificate for the child without residence status in Germany is another significant problem leading to discrimination against these women and their children (Razum et al., 2008, p.63). Twelve weeks after delivery mother and children lose their status and run risk of deportation (PICUM, 2007, p.42). If the mother is unregistered and loses her residence permit the child will not get a birth certificate and "is born into illegality", meaning the mother cannot prove parenthood and they might be separated for example in the process of deportation (PICUM, 2007, p.42).[25]

To sum up, if women access health care services in Bremen it is mostly in their role as caregiver and mother (in relation to pregnancy, delivery or concerning the health of their children), and policies address them as the female other, which has shaped the understandings of the function of women in the migration process determined by stereotypical gender roles.

---

[24] The mandatory residence is a requirement for asylum applicants and those with a Duldung to live within certain boundaries in Germany as defined by the local foreigners' office, which often means they have to stay within the boundaries of their federal state (Section 61 AufenthG).
[25] Some cities have special arrangements of organizations and hospitals allowing women to give birth without having a "Duldung" for example the Büro für medizinische Flüchtlingshilfe Berlin or the Malteser Migranten Medizin (MMM). (For further information see PICUM, 2007, pp.43).

This process "encapsulated men and women in specific roles which leaves little room for agency and self-positioning" (Harzig, 2003, p.55). Undocumented immigrant women are the most affected by the intersecting social locations for example between stereotypes and host country legislation, leading to social stigma and discrimination concerning their health situation. However to go into depth concerning these dimensions further analysis and research in Bremen is needed.

In the case of Bremen Dr. Mohammadzadeh (2003) demands that: "Eine wahrhaft aufsuchende Versorgung holt, bildlich gesprochen, ihre Patienten und Klienten da ab, wo sie sind", meaning that health care has to be available if needed - for every person and without inhumane conditions such as learning the German language as a condition for accessing health services (p.7).With the "Arbeitskreis Migrantinnengesundheit"(working group on the health of female migrants) Bremen takes many actions to especially promote health care for immigrant women with many projects and information services for example focused on the situation of sex workers or socially disadvantaged women (see: ZGF, 2013).

6. Conclusion and recommendations

To finally derive recommendations for the design of immigration and health policies the different intersections in the lifes of immigrants in Germany as well as ongoing trends in irregular migration must be taken into account. A last question from the IBPA framework is**: "Where and how interventions can be made to be more humane?" including examples of successes and the way policy interventions could build on these examples.**
When looking at Germany as a whole Bremen can be seen as a positive example for health care services for asylum seekers and undocumented immigrants due to their own complex model, their extended services for women, and because of the many organizations and doctors who care for undocumented immigrants in Bremen, like Refugio. As explained above policy interventions already seem to build on these examples as other federal states and cities like Brandenburg try to implement the "Bremer model" and demand for support from the state. In the discussion about a nation-wide approach Bremen is a positive example in some respects, however the state laws set a narrow framework of entitlements for these people. A head of the AWO health insurance company Bremen argued that the asylum situation takes the dignity of those people away and that considering humanitarian and health equity aspects the existing judicial and political margin should be used in a more effective way to improve health and living conditions beyond acute pain and bodily illnesses for immigrants in Germany (Jung, 2011, p.29).

When thinking about possible policy interventions an intersectional perspective "opens the door for creating policy that may be far more effective in responding to all those in need [of health care]" while reducing costs (Hankivsky & Cormier, 2011, p.219). A concrete advice is to establish minimum social standards for undocumented immigrants as well as asylum seekers to ensure that their right to health care can be enforced. Moreover intersectionality demands to keep in mind that migrants are a very heterogeneous group, meaning that a balance between minimum standards and special services for example for pregnant women have to be introduced as generalizing approaches are often not possible (Spallek & Razum, 2007, p.454).

Concrete recommendations are to abolish the residence-obligation for asylum seekers and to reduce the time span during which asylum seekers have to stay in the first, communal accommodation places with bad living conditions as done in Bremen already. Since March 2011 asylum seekers have the chance to apply for a flat already after 12 months, instead of 3 years (Jung, 2011, p.24). Another concrete measure is to implement a more regular availability of interpreters for the communication in the case of language problems concerning health care and other social services (Jung, 2011, p.10). Moreover sociopolitical debates are important, concerning the restriction of legal entitlements through the AsylbLG, pointing to a debate of deservingness of care and financial burdens for the recipient countries. In the long-term, a development towards more awareness of health care as a human right for immigrants has to be fostered, to shift policy agendas away from using the asylum procedure as a deterrence instrument.

A further aspect for new policy approaches is concerned with combination of levels where interventions can be made (question 7, IBPA framework). In Germany the local level, the federal and city states level, as well as the national level interact in the policy-making process for finding long-term solutions towards health equity. Intersectionality can be used as a multi-level analysis to understand effects between and across such levels. In the case of health equity in Germany the EU is a very relevant level, where undocumented migrants are one of the most excluded social groups (HUMA, 2010, p.3). An EU directive is establishing the minimum reception standards for asylum seekers, including the minimum health care protection that member states should guarantee. However, there is no such provision for undocumented migrants and nothing really prevents member states from using health care as a migration control instrument. All in all the EU has the means and policy instruments to establish minimum standards for all migrants to support health equity in Europe.

To extend this argument Winker and Degele (2011) mention that single actors and groups cannot fight the discriminatory structures alone, but that especially because of the intersection of social inequalities on different levels, like those of migration status and gender, the forms of resistance need to be widened.

Diverse actors play a role in the interventions and can be meaningfully engaged to actively contribute to policy solutions. A positive example for a project in Germany is the "Mit Migranten für Migranten" (With Migrants For Migrants) project, which consists of a cooperation of 80 institutions from 21 cities and municipalities in Germany. The core of this project is the idea that immigrants are being trained to become intercultural health-mediators to inform others about their rights and the way to access health care in Germany. The main aim is to reduce health inequalities as well as cultural and language barriers to health care and to encourage immigrants to actually use services (Salman, n.d., pp.1). The results of this project show that health education through immigrant-mediators is an effective way to inform migrants in their own language and in a culturally sensitive way about the German health system and their entitlements to avoid non-take up and foster equal opportunities and health equity. An appropriate summary for the future developments in Germany is provided by the Clandestino research project (2009):

"If responsible politicians proceed with a restrictive line and do not open channels for legal immigration in spite of the increasing demand, Germany will be confronted with increasing irregular immigration [...and] a more enlightened migration policy should not always prioritize migration control but answer to the interests of the different actors involved in immigration. The search for pragmatic solutions including tailor-made status adjustment schemes would be more beneficial to migrants and the receiving society" (p.4).

All in all the social construction theory revealed that German migration policies construct different target populations as low power groups, leading to different forms of discrimination and exclusion from health care services for immigrants. An intersectional perspective highlights that these groups are not homogeneous, but that their various needs, stories, vulnerabilities and potentials have to be highlighted and incorporated into policy making to work towards health equity in Germany.

7. References

Act on the Residence, Economic Activity and Integration of Foreigners in the Federal Territory. Retrieved from. http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p1138 [02/07/2015].

Aida. Asylum Information Database: Germany. Retrieved from: http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care [04/04/2015].

Allemann-Ghionda, C., & Hallal, H. (2011): Interkulturalität, Gesundheit und Medizin. In: Allemann-Ghionda, C., & Bukow, W.-D. (Hrsg.): Orte der Diversität. Formate, Arrangements und Inszenierungen.VS Verlag für Sozialwissenschaften, Springer Fachmedien Wiesbaden, pp.173-190.

AfD Bremen (2015): Unser Asylrecht lädt zum Missbrauch ein. Retrieved from: http://www.alternative-rlp.de/afd-bremen-unser-asylrecht-laedt-zum-missbrauch-ein/ [01/07/2015].

Anthias, F. (2012): Transnational Mobilities, Migration Research and Intersectionality. Towards a translocational frame. In: Nordic Journal of Migration Research. Versita, pp.102-110.

Bacchi, C., & Eveline, J. (2010): Mainstreaming and Neoliberalism: A Contested Relationship.

Bade, Klaus J. (2013): Die Angst vor den Armen. In: Zeit Online. Retrieved from: http://www.zeit.de/politik/deutschland/2013-10/armutsfluechtlinge [11/07/2015].

BAMF (2015): Aktuelle Zahlen zu Asyl. Tabellen, Diagramme, Erläuterungen. Mai 2015.

Berens et al. (2008): Summary of State oft he Art Report. Germany. Retrieved from:http://mighealth.net/index.php?title=State_of_the_Art_Reports [08/07/2015].

Björngren Cuadra, C. (2010): Policies on Health Care for Undocumented Migrants in EU27. Country Report. Germany. In: Health Care in NOWHERELAND. Improving services for undocumented migrants in the EU. MIM/ Health and Society, Malmö University.

Blue Card EU for Germany. Retrieved from: http://www.bluecard-eu.de/eu-blue-card-germany/ [04/07/2015].

Bürkner, H.-J. (2012): Intersectionality: How Gender Studies Might Inspire the Analysis of Social Inequality among Migrants. In: Population, Space and Place. Published online 2 March 2011. Wiley Online Library, Erkner, pp.181-195.

Castaneda, H.(2008): Undocumented Migration, Health Care and Public Policy in Germany. In: Anthropology News. In Focus, May 2008.University of South Florida, pp.4-5.

Chebout, L. N. (2011): Wo ist Intersectionality in bundesdeutschen Intersektionalitätsdiskursen? – Exzerpte aus dem Reisetagebuch einer Traveling Theory. In: Smykalla, S. & Vinz, D. (2011): Intersektionalität zwischen Gender und Diversity. Theorien, Methoden und Politiken der Chancengleichheit.Westfälisches Dampfboot, Münster, pp.46-60.

Cho,S., Crenshaw, K.W., & McCall, L. (2013): Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis. In: Hawkesworth (ed.): SIGNS. Journal of Women in Culture and Society. The University of Chicago Press, pp.785-810.

Clandestino (2009): Irregular migration in Germany. Clandestino Research Project. Counting the Uncountable: Data and Trends across Europe. Retrieved from: http://irregular-migration.net/index.php?id=177 [09/07/2015].

Classen, G. (2013): Sozialleistungen für MigrantInnen nach SGB II, SBG XII und AsylbLG.

Collantes, S. (2009): HUMA (Health for Undocumented Migrants and Asylum seekers) Network: Access to health care for undocumented migrants and asylum seekers in 10 EU countries. Law and Practice.

Collantes, S. (2010): HUMA Network: Are undocumented migrants and asylum seekers entitled to access health care in the EU? A comparative overview in 16 countries.

Crenshaw, K. (1991): Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review, pp.1241-1299.

Crenshaw, K. (2013): Die Intersektion von "Rasse" und Geschlecht demarginalisieren: Eine Schwarze feministische Kritik am Antidiskriminierungsrecht, der feministischen Theorie und der antirassistischen Politik. In: Lutz, H., Herrera Vivar, M. R., & Supik, L. (Hrsg.) (2013): Fokus Intersektionalität. Bewegungen und Verortungen eines vielschichtigen Konzeptes. 2. Auflage, Springer VS, Wiesbaden, pp.35-58.

Cronin, P., Ryan, F., & Coughlan, M. (2008): Undertaking a literature review: a step-by-step approach. In: British Journal of Nursing (2008), pp.38-43.

Cyrus , N. (2009): Clandestino Report Germany. Undocumented Migration. Counting the Uncountable. Data and Trends across Europe. Retrieved from: http://irregular-migration.net/index.php?id=229 [09/07/2015].

Desai, V., & Potter, R.B. (ed.) (2012): The Companion to Development Studies. Second Edition. Routledge, Abingdon, New York.

Doyal, L. (2002): Putting gender into health and globalisation debates: new perspectives and old challenges. In: Third World Quarterly. Carfax Publishing,Taylor & Francis Group, London, pp.233-250.

Eubel, C. (2015): Gesundheitskarte für Asylbewerber. Direkt zum Arzt. In: Der Tagesspiegel. Retrieved from: http://www.tagesspiegel.de/politik/gesundheitskarte-fuer-asylbewerber-direkt-zum-arzt/11442014.html [25/06/2015].

Ferree, M.M. (2013): Die diskursiven Politiken feministischer Intersektionalität. In: Lutz, H., Herrera Vivar, M. R., & Supik, L. (Hrsg.) (2013): Fokus Intersektionalität. Bewegungen und Verortungen eines vielschichtigen Konzeptes. 2. Auflage, Springer VS, Wiesbaden, pp.75-89.

Flüchtlingsinitiative Bremen: MediNetz. Retrieved from: http://www.fluechtlingsinitiative-bremen.de/?q=medinetz [01/07/2015].

Gesundheitsamt Bremen: Migration. Das Gesundheitsprogramm – Hintergrund. Retrieved from: http://www.gesundheitsamt.bremen.de/sixcms/detail.php?gsid=bremen125.c.1933.de [07/07/2015].

Gesundheitsamt (2005): Dolmetscherdienst für Migratinnen und Migranten. Retrieved from: http://www.gesundheitsamt.bremen.de/sixcms/detail.php?gsid=bremen125.c.1962.de [16/07/2015].

Gray, B.H., & van Ginneken, E. (2012): Health Care for Undocumented Migrants: European Approaches. In: The Commonwealth Fund (2012): Issues in International Health Policy. New York, Washington, Vol. 33.

Grove, N.J., & Zwi, A.B. (2006): Our health and theirs: Forced migration, othering and public health. In: Social Science & Medicine, 62, 2006. The University of New South Wales, Sydney, pp.1931-1942.

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C. & Brotman, S.. (2010): Exploring the promises of intersectionality for advancing women's health research. In: International Journal for Equity in Health, 2010. BioMed Central Ltd, Vancouver.

Hankivsky, O., & Cormier, R. (2011): Intersectionality and Public Policy: Some Lessons from Existing Models. In: Political Research Quarterly, 64(1). Sage Publications, University of Utah, pp. 217-229.

Hankivsky, O. (2012): Women's health, men's health, and gender and health: Implications of intersectionality. In: Social Science & Medicine 74 (2012). Vancouver, pp.1712-1720.

Hankivsky, O. (ed.) (2012a): An Intersectionality- Based Policy Analysis Framework. Institute for Intersectionality Research and Policy, Simon Fraser University, Vancouver.

Harzig, C. (2003): Immigration policies: a gendered historical comparison. In: Morokvasic-Müller, M., Erel, U., & Shinozaki, K. (ed.) (2003): Crossing Borders and Shifting Boundaries. Vol I.: Gender on the Move. Leske + Budrich, Opladen, pp.35-58.

Jones, K.C., Misra, J., & McCurley, K.. (n.d.): Intersectionality in Sociology.

Jung, F. (2011): Das Bremer Modell – Gesundheitsversorgung Asylsuchender. Freie Hansestadt Bremen. Gesundheitsamt Bremen (Hrsg.). Bremen.

Kosnick, K. (2011): Gender and Diversity. In: Allemann-Ghionda, C., & Bukow, W.-D. (Hrsg.): Orte der Diversität. Formate, Arrangements und Inszenierungen.VS Verlag für Sozialwissenschaften, Springer Fachmedien Wiesbaden, pp.161-169.

Langreiter, N. & Timm, E. (2011): Intersektionalität als kritisches Werkzeug der Gesellschaftsanalyse. Ein E-Mail-Interview mit Nina Degele und Gabriele Winker. In: Hess, S., Langreiter, N., & Timm, E. (2011): Intersektionalität revisited. Empirische, theoretische und methodische Erkundungen. Transcript, Bielefeld.

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008): Mental health, health care utilisation of migrants in Europe. European Psychiatry, 23, pp.14-20.

Malmusi, D., Borrell, C., & Benach, J. (2010): Migration-related health inequalities: Showing the complex interactions between gender, social class and place of origin. In: Social Science & Medicine 71 (2010), Barcelona, pp.1610-1619.

McCall, L. (2005): The Complexity of Intersectionality. In: SIGNS. Journal of Women in Culture and Society. Vol. 30, no.3. University of Chicago, pp.1771-1800.

Mohammadzadeh, Z. (2003): Der Gesundheitswegweiser für Migrantinnen und Migranten, ein Beitrag zum Bremer Integrationskonzept. Gesundheitsamt Bremen (Hrsg.). Bremen.

Müller, A. (2011): Das Kopftuch als Verdichtungssymbol. In: Allemann-Ghionda, C., & Bukow, W.-D. (Hrsg.): Orte der Diversität. Formate, Arrangements und Inszenierungen.VS Verlag für Sozialwissenschaften, Springer Fachmedien Wiesbaden, pp.145-159.

Oso, L., & Ribas-Mateos, N. (ed.) (2013): The International Handbook on Gender, Migration and Transnationalism. Global and Development Perspectives. International Handbooks on Gender. Cheltenham, UK. Northampton, MA, USA.

Paléncia, L., Malmusi, D., Borrell, C. (2014): SOPHIE: Evaluating the impact of structural policies on health inequalities and their social determinants and fostering change.

Incorporating Intersectionality in Evaluation of Policy Impacts on Health Equity. A quick guide. Agéncia de Salut Pública de Barcelona, CIBERESP.

PICUM (Platform for International Cooperation on Undocumented Migrants) (2007): Access to Health Care for Undocumented Migrants in Europe. Retrieved from: http://picum.org/en/publications/reports/ [06/07/2015].

Piper, N. (2005): Gender and migration. A paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration. Asia Research Institute, National University of Singapore.

Prasad, N. (2008): Gewalt gegen Migrantinnen und die Gefahr ihrer Instrumentalisierung im Kontext von Migrationsbeschränkung. Soziale Arbeit als Menschenrechtsprofession mit ethischer Verantwortung.

Prasad, N. (2009): Gewalt und Rassismus als Risikofaktoren für die Gesundheit von Migrantinnen. Retrieved from: heimatkunde.boell.de/2013/11/18/gewalt-und-rassismus-als-risikofaktoren-f%C3%BCr-die-gesundheit-von-migrantinnen [05/07/2015].

Preker, A. (2015): Wenn Flüchtlinge einfach mit Karte zum Arzt können. In: Die Welt. Regionales. Bremer Modell. Retrieved from: http://www.welt.de/regionales/hamburg/article136077740/Wenn-Fluechtlinge-einfach-mit-Karte-zum-Arzt-koennen.html [17/07/2015].

ProAsyl (2014): „Frauen sind nicht in Deutschland, um zu essen und zu schlafen". Retrieved from:www.proasyl.de/de/news/detail/news/frauen_sind_nicht_nur_in_deutschland_um_zu_essen_und_zu_schlafen/ [02/07/2015].

Razum et al. (2008): Schwerpunktbericht der Gesundheitsberichterstattung des Bundes. Migration und Gesundheit. Robert Koch-Institut, Berlin.

Röpke, K. (2003): Bremen. Der Gesundheitswegweiser für Migrantinnen und Migranten. Vorwort. Gesundheitsamt Bremen (Hrsg.), Bremen.

Rolandsen Agustín, L. (2013): Gender equality, intersectionality and diversity in Europe. Palgrave macmillan, New York.

Salman, R. (n.d.): Mit Migranten für Migranten (MiMi) – Gesundheit Hand in Hand oder wie interkulturelle Gesundheitsmediatoren in einem bundesweiten Modellprojekt die Zugangsbarrieren zur Gesundheitsversorgung senken.

Sayed, M. (2014): Die Gesundheitsversorgung von Menschen ohne legalen Aufenthaltsstatus – papierlos, schutzlos, rechtlos? Universität Bremen.

Schneider, A., & Ingram, H.(1993): Social Construction of Target Populations: Implications for Politics and Policy.in: The American Political Science Review , pp.334-347.

Schneider, A., & Sidney, M. (2009): What Is Next for Policy Design and Social Construction Theory? In: The Policy Studies Journal. Wiley Periodicals, Malden, Oxford, pp.103-119.

Schoevers, M. A., Loeffen, M. J., van den Muijsenbergh, M. E., & Lagro-Janssen, A. L. (2010). Health care utilisation and problems in accessing health care of female undocumented immigrants in the Netherlands. International journal of public health, 55(5), pp. 421-428.

Sinn, A., Kreienbrink, A., & von Loeffelholz, H.D. (2005): Illegally resident third-country nationals in Germany. Policy approaches, profile and social situation. Research Study 2005 within the framework of the European Migration Network. Federal Office for Migration and Refugees, Nürnberg.

Spallek, J. & Razum, O. (2007): Gesundheit von Migranten: Defizite im Bereich der Prävention. In: Medizinische Klinik. 2007; 201; 151-6 NR. 6. Prävention und Versorgungsforschung. Urban & Vogel, München, pp.451-456.

Springer, K., Hankivsky, O., & Bates, L.M. (2012): Gender and health: Relational, intersectional and biosocial approaches. In: Social Science & Medicine 74. New Jersey, pp.1661-1666.

Schulz, A.J., & Mullings, L. (ed.) (2006): Gender, race, class and health: Intersectional approaches. Jossey-Bass. A Wiley Imprint, San Francisco.

Truong, T.-D./Marin, M./ Quesada-Bondad, A.: Intersectionality, Structural Vulnerability, and Access to Sexual and Reproductive Health Services: Filipina Domestic Workers in Hong Kong, Singapore, and Qatar. In: Truong, T.-D. (2014): Migration, gender and social justice. Springer, pp.227-239.

UNHCR (2014): Asylum Trends 2014. Levels and Trends in Industrialized Countries.Retrieved from: http://www.unhcr.de/service/zahlen-und-statistiken.html [01/07/2015].

UWT (Undocumented Worker Transitions, 2008): Undocumented Migration Glossary. Work Package 5. EU Sixth Framework Programme. Roskilde University.

Vaiou, D., & Stratigaki, M. (2008). FronSettlement'toIntegration'Informal Practices and Social Services for Women Migrants in Athens. In: European Urban and Regional Studies, 15(2). Athens, pp.119-131.

Veenstra, G. (2011): Race, gender, class and sexual orientation: intersecting axes of inequality and self-related health in Canada. In: International Journal for Equity in Health. BioMed Central. British Columbia.

Walby, S. (2007): Complexity Theory, Systems Theory, and Multiple Intersecting Social Inequalities. In: Philosophy of the Social Sciences. Sage Publications, Lancaster University, pp.449-470.

Willen, S. (2011): Migration, "illegality", and health: Mapping embodied vulnerability and debating health-related deservingness. In: Social Science & Medicine (2012). Elsevier, Conneticut.

Winker, G., & Degele, N. (2011): Intersectionality as multi-level analysis: Dealing with social inequality. In: European Journal of Women's Studies. Sage Publications, Hamburg, pp.51-66.

Yuval-Davis, N. (2011): Beyond the Recognition and Re-distribution Dichotomy: Intersectionality and Stratification. In: Lutz, H., Herrera Vivar, M.T., & Supik, L. (ed.) (2011): Framing Intersectionality. Debates on a Multi-Faceted Concept in Gender Studies. Ashgate, Farnham, Burlington, pp.155-169.

ZGF (Bremische Zentralstell für die Verwirklichung der Gleichberechtigung der Frau) (2013): Frauengesundheit(en) in Bremen: Dokumentation eines Projektes des Arbeitskreises Migrantinnengesundheit. ZGF, Bremen.

Appendix

When performing an IBPA there are certain principles that one has to keep in mind during the entire research process. These aspects are summarised as follows:

- Social categories interact with and co-constitute one another to create unique social locations that vary according to time and place, namely, **intersecting categories**.
- There exist **multiple levels** in society and intersectionality aims to understand the effects between and across the various levels, including macro (global and national-level institutions and policies), meso or intermediate (provincial and regional-level institutions and policies) and micro levels (community-level, grassroots institutions and policies as well as the individual or 'self').
- **Power** is a central concept in intersectionality. The focus is not just on domination or marginalization, but on the intersecting processes, by which power and inequity are produced, reproduced and actively resisted.
- **Reflexivity** recognises multiple truths and a diversity of perspectives, while privileging those voices typically excluded from policy 'expert' roles.
- Privileges and disadvantages, including intersecting identities and the processes that determine their value, change over **time and place**.
- Power has also a role in knowledge production. Intersectionality analysis expands understandings of what is typically constituted as "evidence" by recognizing a **diversity of knowledge**, paradigms and theoretical perspectives that can be included in policy analysis.
- Intersectionality places an emphasis on **social justice**.
- **Equity** is concerned with fairness. Inequities exist where differences in outcomes of interest are unfair or unjust. The intersectional lenses mean looking not only at gender equity, but also at the impacts of the intersections of multiple positions of privilege and oppression.

Descriptive

1. What knowledge, values and experiences do you bring to this area of policy analysis?
   - What is your experience with policy and policy analysis? What type of policy areas have you worked in?
   - What are your personal values, experiences, interests, beliefs and political commitments?
   - How do these personal experiences relate to social and structural locations and processes (for example gender, 'race' and ethnicity, socio-economic status, sexuality, gender expression and age; patriarchy, colonialism, capitalism, racism and heterosexism) in this policy area?

2. **What is the policy 'problem' under consideration?**
   - **What assumptions (for example, beliefs about what causes the problem and which population(s) is/are most affected) underlie this representation of the 'problem'?**

3. How have representations of the 'problem' come about?
   - What was the process in framing the 'problem' this way?
   - Who was involved and why was the 'problem' defined in this way?
   - What types of evidence were used?
   - How has the framing of the 'problem' changed over time (for example historically) or across different places (for example geographically)?

4. **How are groups differentially affected by this representation of the 'problem'?**
   - **Who is considered the most advantaged and who is the least advantaged within this representation? Why and how?**
   - **How do the current representations shape understandings of different groups of people?**
   - **What differences, variations and similarities are considered to exist between and among relevant groups?**

5. **What are the current policy responses to the 'problem'?**

    -   Who has responded to the 'problem' and how? For example, how have governments and affected populations and communities responded to the framing of the 'problem'?

    -   What are the current policy responses trying to achieve?

    -   **Do current policies focus on target groups? If so, are they seen as homogenous or heterogeneous? Are they stigmatized by existing policy responses?**

    -   **How do existing policies address, maintain or create inequities between different groups?**

    -   Do existing responses create competition for resources and political attention among differently situated groups?

    -   What levels or combination of levels of analysis exist (for example micro, meso, macro) in relation to the policy 'problem'?

Transformative

6. What inequities actually exist in relation to the problem?

    -   **Which are the important intersecting social locations and systems? For example, how do 'race', ethnicity, class, sexuality and other social locations and systems of inequality (racism, colonialism, classism, heterosexism) interact in relation to this policy problem?**

    -   Where will you look to find necessary information to help you answer this question (for example evidence from academic sources, grey literature and policy reports focusing on intersectionality-informed analyses)?

    -   What potential approaches can be used to promote discussion of the problem across differently affected groups (for example Parken's (2010) Multi-Strand Method, which lays out a process for understanding intersecting inequities in the evidence gathering phase of policy)?

    -   What are the knowledge/evidence gaps about this problem across the diversity of the population?

7. **Where and how can interventions be made to improve the problem?**
    - What are the logical entry points? What are the available policy levers (for example research/data, political champions/allies, laws/regulations/conventions, resources)?
    - **What are other examples of successes? How could policy interventions build on these examples?**
    - Who is part of the proposed intervention? Who is positioned to influence and implement the intervention?
    - **What role can diverse communities play in these interventions? How will they be meaningfully engaged and supported in providing input?**
    - **At what level or combination of levels (for example micro, meso, macro) can interventions be made?**

8. What are feasible short, medium and long-term solutions?
    - How can solutions be pragmatically positioned and promoted in relation to government policy priorities
    - (for example budget allocations, ministerial priorities and departmental plans)?
    - How can proposed solutions be synthesized into a clear and persuasive message?

9. **How will proposed policy responses reduce inequities?**
    - How will proposed options address intersectional inequities and promote social justice? How will you ensure that the proposed options do not reinforce existing stereotypes and biases or produce further inequities for some populations?
    - How will the solutions interact with other existing policies?
    - What might be the challenges and opportunities for proposed policy solutions?

10. How will implementation and uptake be assured?
    - Who will be responsible (and who is best positioned) to ensure the implementation of the policy recommendations?
    - What time frames and accountability mechanisms are identified for implementation?
    - How do the policy solutions encourage solidarity and coalition building across divergent interests and groups?
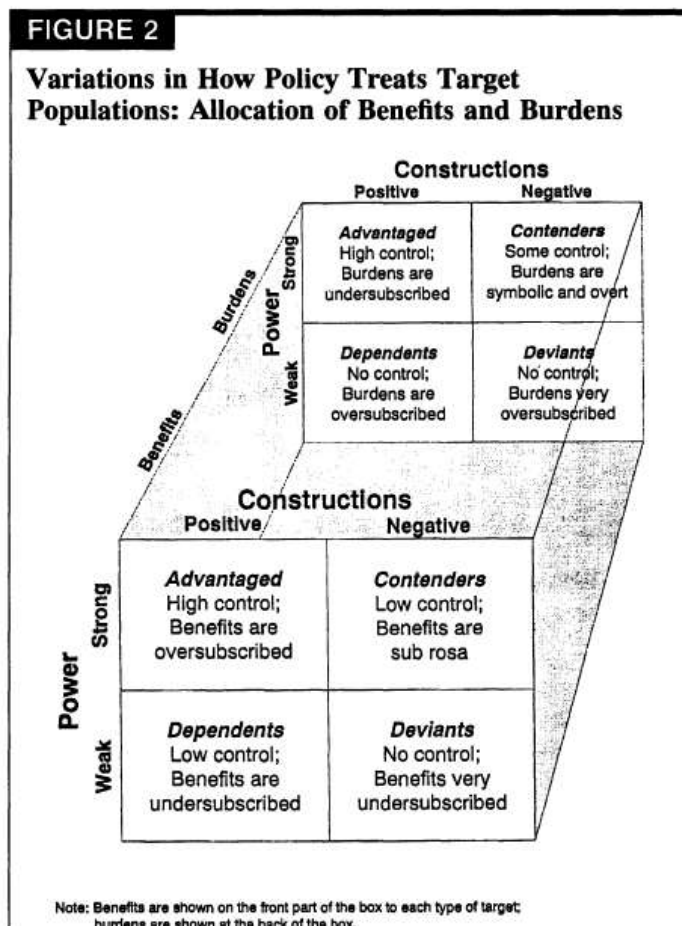
11. How will you know if inequities have been reduced?

- How will you measure policy implementation and outcomes?
- What intersectional factors will be measured in the evaluation process? How will they be measured?
- How will affected communities be meaningfully engaged in assessing the reduction of inequities?
- What will be the measure of success?

12. How has the process of engaging in an intersectionality- based policy analysis transformed the following:

- Your thinking about relations and structures of power and inequity?
- The ways in which you and others engage in the work of policy development, implementation and evaluation?
- Broader conceptualizations, relations and effects of power asymmetry in the everyday world?

## II. How Policy treats target populations

FIGURE 2

Variations in How Policy Treats Target Populations: Allocation of Benefits and Burdens

Note: Benefits are shown on the front part of the box to each type of target; burdens are shown at the back of the box.

III. Social Construction of migrants in Germany

High power, positively constructed: The Advantaged	High power, negatively constructed: The Contenders
- Highly skilled workers/professionals	- Migrant workers
Low power, positively constructed: The Dependents	Low power, negatively constructed: The Deviants
- Refugees - Asylum seekers/ people entitled to asylum - Immigrant children and mother	- Illegal/ undocumented migrants - (Economic immigrants)

Own graphic, inspired by: Schneider/Ingram (1993): Social Construction of Target Populations: Implications for Politics and Policy
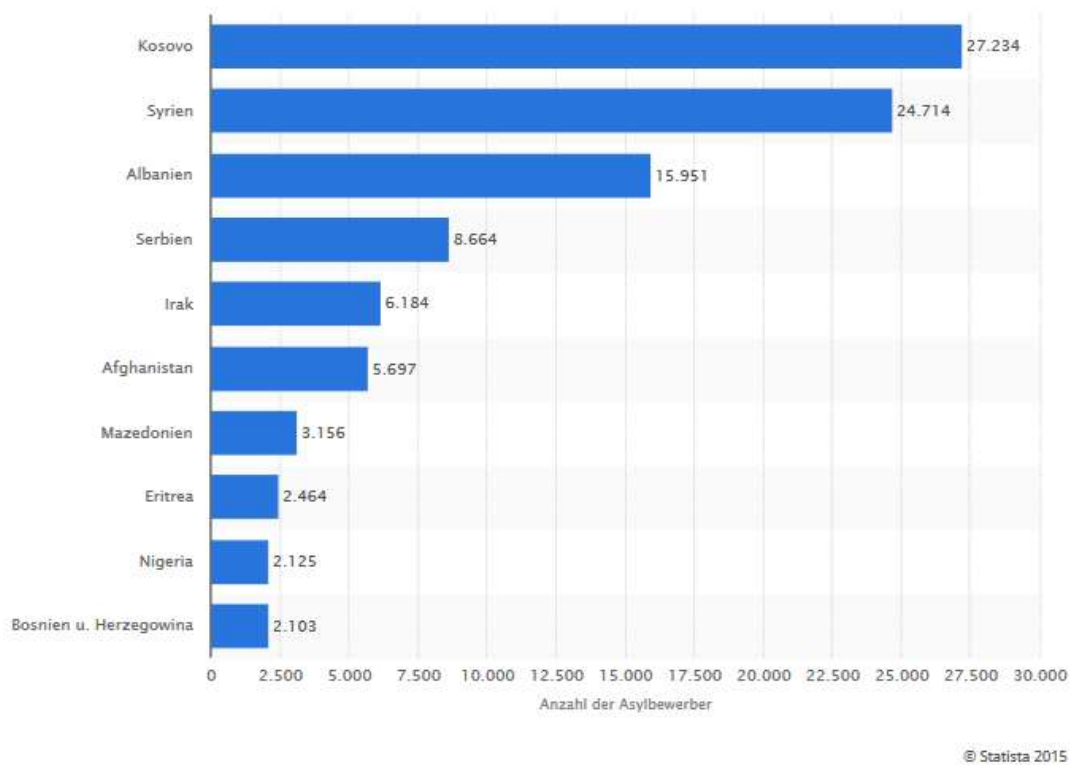
IV. The 10 major receiving countries
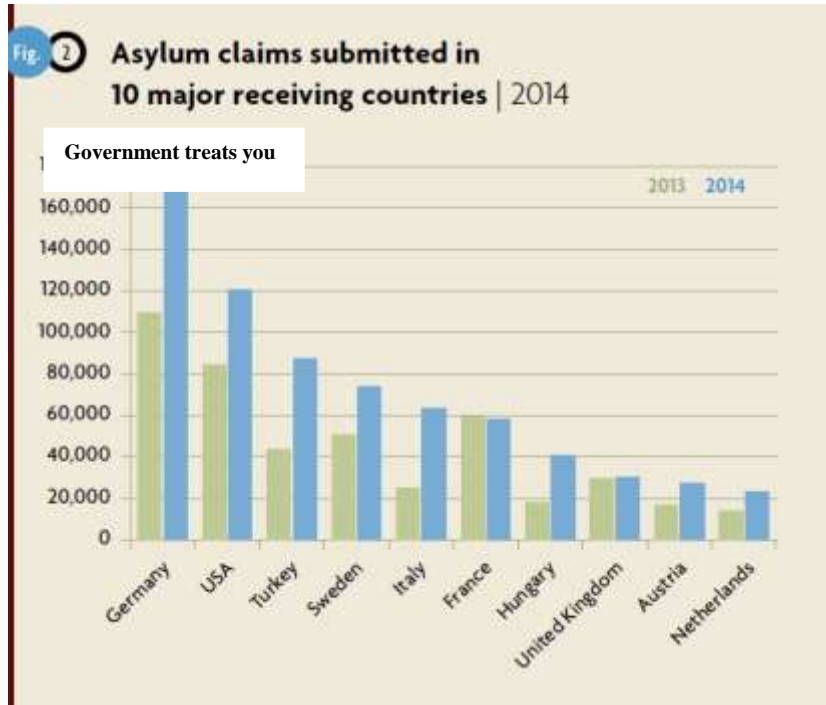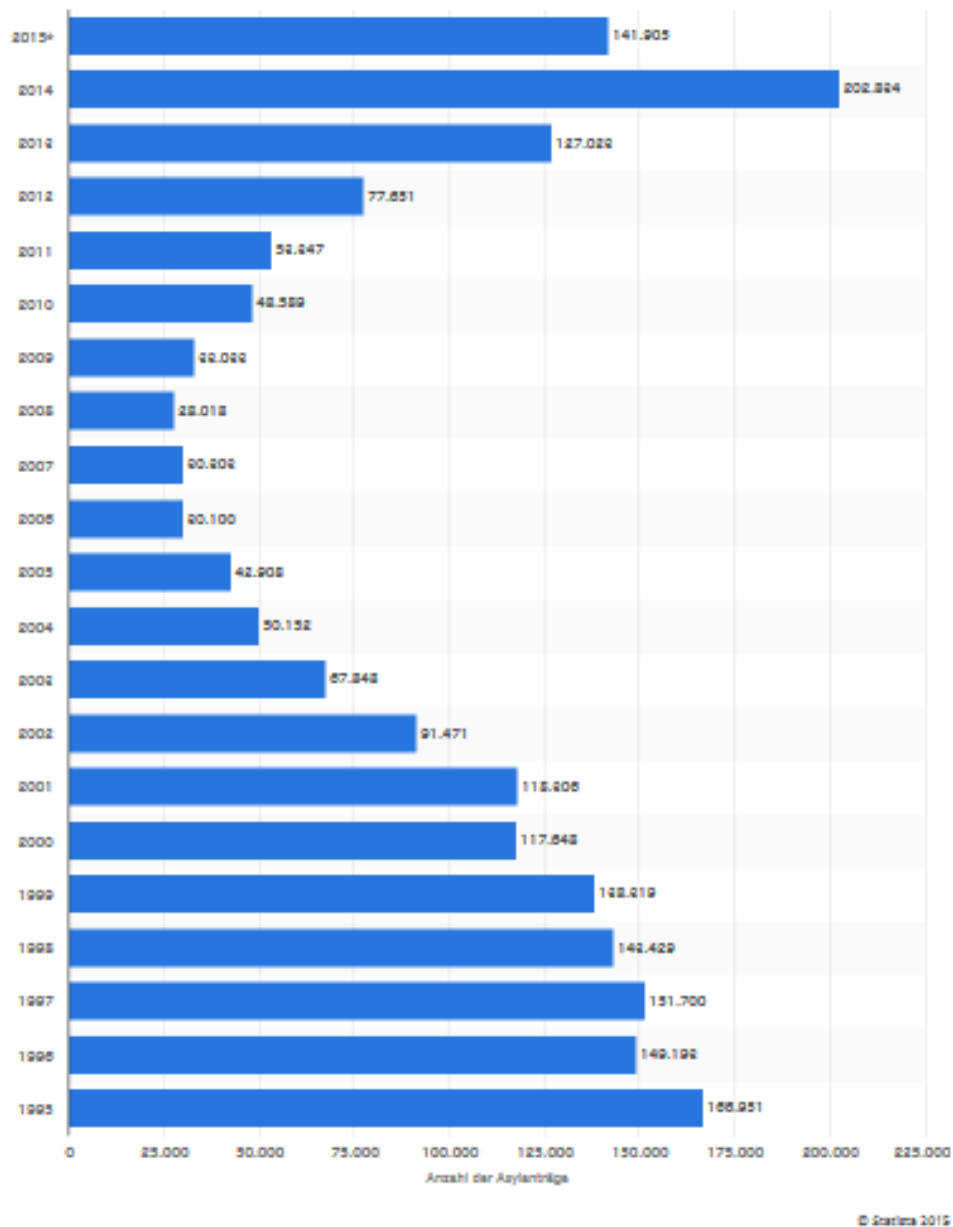

UNCHR Asylum Trends 2014, p.9.

V.   Latest data and developments

Number of asylum claims in Germany

Statista, Retrieved from:
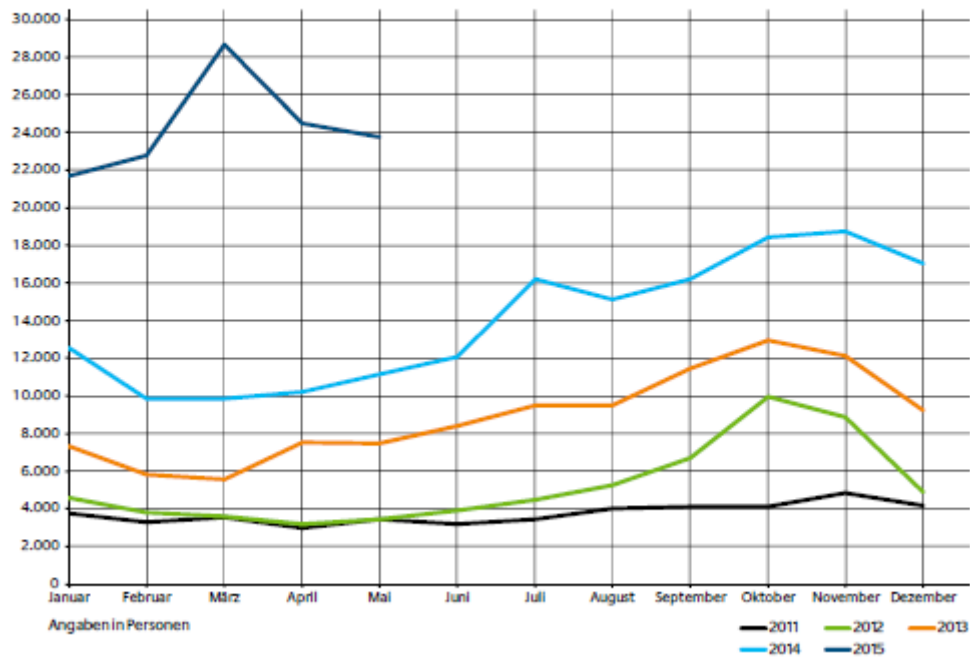http://de.statista.com/statistik/daten/studie/154287/umfrage/hauptherkunftslaender-von-asylbewerbern/ [12/007/2015].

Statista. Retrieved from:
http://de.statista.com/statistik/daten/studie/76095/umfrage/asylantraege-insgesamt-in-deutschland-seit-1995/ [12/07/2015].

Asylum claims in a comparison of 5 years

Asylzugangszahlen im 5-Jahresvergleich

Entwicklung der Asylerstantragszahlen im Jahresvergleich (2011 bis 2015)

BAMF (2015): Aktuelle Zahlen zu Asyl, p.6.