Healing or fleeing?
Reflecting on international protection and health challenges from three refugee pathways

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ABSTRACT: The situation of contemporary refugees can be reflected as paradigmatic of the international efforts and challenges to provide universal access to human rights, namely the right to health. Yet, refugees' experiences might denote meanings of health services that do not correspond to places where health care is provided. After acknowledging the protection principles of international asylum systems, three critical events are considered, as narrated by refugees while reflecting on their pathways from Ethiopia to Italy, passing through Libya, both before and after the completion of the asylum request procedure. These events, contextualized in health services' settings, allow us to reflect on: health services as safer spaces and least regulated than detention facilities, and health care as a relatively important issue in contexts where freedom and survival are threatened; and health services as spaces of restricted healthcare and assistance in situations of limited freedom, such as in the EU refugee context of limited rights of mobility. This paper follows a human/health ecology approach, proposing a critical and intersected reading of protection and health issues, and suggests that efforts to recognize refugees' right to health demands changes in the overall asylum system.

1. Introduction: background of international protection and health challenges for refugees

Within the 'transnational turn' in diverse policy fields over the last decades, mobility and protection issues have been considerably pondered in the international agenda. Yet, it is possible to observe a distance between the legal framework for the protection of persons of concern at the international scale, and the practical aspects of that protection. Moving from the background of international protection regimes for refugees and other forced migrant

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groups, this paper aims to contribute to present debates while grasping the sense conferred to 'protection', mainly at the European scale, and its distance from the health challenges faced by these groups.

In the aftermath of the Second World War, in a context of high pressure in the international agenda of issues relating to refugees and displaced persons, the international regime for refugee protection was established. This regime is rooted in the United Nations (UN) Geneva Convention of 1951 (UN, 2010; grounded in Article 14 of the Universal Declaration of Human Rights, 1948), generalized in its temporal and geographical extent through the New York Protocol of 1967. The Convention defined the refugee status as applicable to situations of "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" (Article 1, point 2), provided the person is out of the country of origin or habitual residence and cannot be protected by that country. The Geneva Convention followed the creation of UN's High Commissioner for Refugees (UNHCR), a key institution with the aim of finding permanent and long-lasting solutions for refugees, namely through integration in an asylum country or resettlement in a second host country. The mandate of UNHCR covers the majority of refugee situations in the world, exception made to Palestinian refugees, which are assisted by the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

Within European Union (EU) legislation, persons seeking asylum who do not qualify as refugees can be eligible for subsidiary protection, as stated in Directive 2004/83/EC[1] (EU, 2004) and Directive 2011/95/EU (EU, 2011). According to these acts, a person can be eligible for subsidiary protection status if he/she is a third-country national or stateless person facing a real risk of suffering serious harm if returning to the country of origin or habitual residence, among which: (a) death penalty or execution; or (b) torture or inhuman or degrading treatment or punishment of an applicant in the country of origin; or (c) serious and individual threat to a civilian's life or person by reasons of indiscriminate violence in situations of international or internal armed conflict (EU, 2004, articles 2 and 15).

[1] No longer in force, validity ended on 21/12/2013.

Since the 1990s there has been a particular effort to create a Common European Asylum System (CEAS)[2], aiming to improve the current legislative framework towards harmonization of common minimum standards for asylum and cooperation between Member States (MS). Within this system, besides the aforementioned protection regimes, special Directives have been created regarding Temporary Protection (EU, 2001) and Family Reunification (EU, 2003). This system also includes the (now under revision) Dublin Regulation (European Union, 2013a), which determines the State responsible for examining the asylum application and clarifies the rules governing relations between states (so far on the premises that, for the facilitation of asylum administrative procedures, only one asylum request should be presented and, upon its acceptance, the protected person should remain in that country); and the EURODAC Regulation (EU, 2013b), that rules the EU database of asylum seekers' fingerprints.

Also within the EU, from 2015 to 2017, a relocation scheme was developed to facilitate the transfer of asylum seekers in clear need of international protection from one MS (Italy or Greece) to another one (EU, 2015)[3]. Additionally, under the UN Convention on Human Rights (UN, 1948) and legislation of individual states, special protection can be granted based on humanitarian needs that may go beyond the scopes of refugee and subsidiary protection schemes.

Which definition of protection can be underlying all these international devices? According to the Inter-Agency Standing Committee (IASC), which is the primary mechanism for inter-agency coordination of humanitarian assistance involving UN and non-UN partners, protection can be defined as "all activities aimed at ensuring full respect for the rights of the individual in accordance with the letter and spirit of the relevant bodies of law (i.e. human rights law, international humanitarian law and refugee law)" (European Commission, 2016: 5). Despite being criticized for its ubiquity and difficult operability, this wide concept allows capturing different dimensions of protection, not only regarding material needs but also at the level of personal safety and dignity. Regarding protection in humanitarian situations, the

[2] European Commission, Migration and Home Affairs – Common European Asylum System, available at: https://ec.europa.eu/home-affairs/what-we-do/policies/asylum_en.

[3] No longer in force, validity ended on 26/09/2017. Further information on this program can be found in European Asylum Support Office - Questions and answers on relocation, available at: https://www.easo.europa.eu/operational-support/hotspot-relocation/relocation/questions-and-answers-relocation.

European Commission fosters "material assistance, such as food, water, shelter and medical assistance, as well as physical integrity, psychological wellbeing and dignity", particularly when these needs are "a consequence of violence, deliberate deprivation and restrictions of access" (European Commission, 2016: 5).

Within the asylum law, refugee, subsidiary and humanitarian protection can thus be considered paradigmatic of the international efforts to provide universal access to basic human rights, including the right to health care. Yet, these frameworks do not directly assure practical provision of health care. Even in the EU context alone, there is a considerable variability on the types of health services and assistance available for refugees and other vulnerable groups. Besides the considerable inequalities between migrants and non-migrants in EU countries, asylum seekers and undocumented migrants are the groups that face more restrictions in their statutory rights to health care (Mladovsky, 2011).

Furthermore, within the specific case of the 'forced migration continuum' – considered as "the movement of migrants who transit through and then outside their region of origin" – many protection gaps and challenges can be identified against the intention to provide safety, security and reduce vulnerability for people who are forced to move (Zetter, 2014: 13).

With an ecological and holistic approach to health care and services (Honari, 2005), if we ponder the specific challenges for forced migrants, it is important to acknowledge the need of an intersectional view of health within economic, political and psycho-social factors. These challenges can range from: (a) the epidemiological level, which goes beyond genetic predisposition when considering the effect of different patterns of exclusion and segregation in the exposition to diverse diseases and reproductive health issues, and adding to it a lower access to information on prevention and healing options; to (b) the consequences of migrants' pathways, often associated to stress and traumatic processes, and to their needed adaptation, namely to new food patterns and deep changes in life style; and (c) the lower access to health services, mainly by undocumented migrants, further confirming this group as one of the most vulnerable in the international scene (Fernandes *et al.*, 2007). Related to the difficulties in accessing health services, barriers to refugees' and asylum seekers' registration within public health structures, lack of language support, and a scarce consideration of these groups' particular needs (namely regarding mental health and chronic illnesses) have been repeatedly reported (Feldman, 2006).

If we ponder these health issues in constrained situations – namely in prisons or detention centers and, in a different level, within the overall limited right to mobility for refugees in Europe –, how can we consider the nexus between the background concept of protection and the empirical realities of health care?

In this paper, after presenting the methodological approach, critical events narrated by three refugees will be presented, about health care and services in their pathways from Ethiopia to Italy, passing through Libya, both before and after the completion of the asylum request procedure. These events will allow us to explore some of the complex meanings and challenges that health care and services might assume for refugees, particularly regarding (1) health services as safer spaces and less regulated than detention facilities, and health care as a relatively important issue in contexts where freedom and survival are threatened; and (2) health services as spaces of restricted health care and assistance in situations of limited freedom, such as in the EU refugee context of limited rights of mobility.

2. Methodological approach

This paper brings into discussion critical events narrated in three out of 32 interviews developed with Ethiopian and Eritrean refugees and migrants in Bologna, in 2012 (this PhD project[4] further included 22 interviews with Cape Verdean migrants in Lisbon, Portugal, 2013-2015). The aim of this work was to explore the reflexivity of migrants and refugees from countries with environmental risk, observing their representations of environmental factors in the countries of origin, interrelated with other drivers of mobility (mainly economic and political), and the framing within their experiences of mobility towards Southern Europe.

The chosen method for most of this research was the interview, which can capture different senses that social actors attribute to their practices and experiences, as well as retrace past processes and occurrences (Quivy & Campenhoudt, 2008). The interview guide was built before holding the interviews, following a phase of theoretical reading and review of empirical studies (Vieira, 2010). The guide included six sections: (1) identification of the interviewee; (2) former pathways of mobility; (3) social networking; (4) work on the land and strategies of adaptation in the context of origin; (5) factors in the context of origin that

[4] This research was supported by a FCT grant (SFRH/BD/68730/2010).

influenced migration; (6) memories and present life in Italy and Portugal. The guide was written in Portuguese and Italian and, when needed (particularly with recently arrived refugees in Italy), was translated into English.

Sampling was initiated through contact with migrant associations and through participant observation in significant spaces for Ethiopian and Eritrean groups in Bologna, Italy, and for Cape Verdean groups in Lisbon, Portugal. Interviews were conducted using a research process of contextualization (framing the content and process in which the interviews were gathered, so as to better understand the connections between text and context) and interaction (acknowledging the social interactions in the research process, deepening the listening and translation skills of the interviewer, and assuming the 'inter-view' bilateral dimension within the methodological approach) followed by verification (observing and categorizing the gathered information, so as to observe its recurrences, yet trying to avoid the risk of over-standardizing life experiences) that suggested saturation of the information gathered (Ferrarotti, 2011). Interviews had a medium length of one hour and were held in places chosen by each interviewee: associations, shops, cafes and bars, gardens and other public spaces, work and residential places.

All interviews were preceded by an introductory presentation of the research project and subject to a written consent declaration as a safeguard to interviewees' anonymity. Whenever authorized, interviews were audio recorded and transcribed. Interviews were subject to content analysis with a thematic focus, proceeding to an analytical synthesis of the gathered texts through a regrouping of content into structural categories of analysis (Bardin, 2004).

Besides this primary source of data, for the specific aim of this paper it was necessary to consult secondary sources to update the political framing of refugees and the right to healthcare. Secondary sources include documentation on rights and policies for migrants' health – particularly in the case of international protection in the EU.

Regarding the theoretical framework, this research derived from a PhD program on Human Ecology at the *Faculdade de Ciências Sociais e Humanas da Universidade Nova de Lisboa*. On the one hand, this approach to Human Ecology is sustained in the urban ecological Chicago School (Park *et al*., 1992; Wirth, 1938), which fosters an interpretation of the city as having an innovative character as human habitat, thus generating new social dynamics, and an environmental effect considered determinant on society. On the other hand,

it also embeds the perspective of socially focused environmental sciences (Catton & Dunlap, 1978; Hawley, 1950) that proposes to look not only at the adaptation of human beings to environmental factors, but also at the ways in which humans impact the environment.

Two concepts are considered central in the PhD thesis underlying this work – mobilities and environment, which are allusive to the social production of movement and nature, in a context of modern abstraction of space and time (Cresswell, 2006), and interpreted on a constructivist reading of territory and environmental issues. Such concepts are considered against a background of growing affirmation of the environment as a global social problem (Yearley, 2009) and of rising assertions about a paradigm of mobilities, including but not limited to international migrations (Sheller & Urry, 2006; Urry, 2007).

Considering that neither the overall debate on mobilities and international migrations, nor environmental issues are at the focus of this paper, we propose to specify the discussion around issues of limited mobility (including detainment, detention and asylum), care and international protection, in a health ecology perspective (Honari, 2005) and considering health and migration challenges as observed from the EU arrival contexts.

A final observation regards the usage of the term 'refugee' in this paper. The concept of refugee is rather specified in international protection jurisdiction and can be distinguished from other types of international protection and from concepts of forced migrations, asylum seekers, resettlement and relocation, internally displaced persons, and other categories of displacees and persons of concern (Castles *et al.*, 2014: 221-223). Bearing in mind that the cases to be presented in the next section regard the contexts of origin, transit and arrival – both prior and after the recognition of international protection –, the term 'refugee' will be used to refer to all the considered situations, as a rather descriptive category instead of a juridical one, thus contributing to grasp repeated experiences in this type of pathways (in line with the broad field of forced migration and refugee experiences).

3. Refugees' contexts and critical events regarding health care and services

In this section, brief syntheses of the biographies, pathways and critical events (regarding health care and services) of three refugees will be presented. The three refugees escaped from

Ethiopia, between 2006 and 2007, and applied for international protection in Italy, where they arrived between 2008 and 2011. The reference to critical events regards episodes in the interviewees' biographical narratives that had a markedly negative impact on their lives; these events can be considered as part of the mobility drivers, as they provoked or contributed to the decision of rapidly changing location. These critical events were related to incidents within health services in the contexts of origin, transit and arrival: (3.1) escaping from a hospital after an aggression in an Ethiopian prison; (3.2) escaping from a hospital while imprisoned for being undocumented in Libya; and (3.3) refused chronic disease follow-up in Italy, after irregularities in the asylum process (attempt to live in other countries).

3.1 Escaping from a hospital after an aggression in an Ethiopian prison

A man from Addis Ababa, the capital city of Ethiopia, described the first critical event that happened in his country of origin. He was 23 years old when he arrived in Italy, in 2009. He didn't know any person in Italy before arriving; all the fleeing people that he knew went to Kenya. He had been arrested in 2006, in Ethiopia, for political reasons (explained further below in the text). He fled from Ethiopia and spent six months in Khartoum, Sudan, and two years in Tripoli, Libya. Only after six traumatizing attempts to cross the Mediterranean Sea, by paying approximately $1000 (around 700€) for each attempt, he was able to reach Italy and ask for political asylum, which was approved. Once in Italy, after six months waiting for his administrative process to be concluded, and thereafter lacking official financial support or family support networks in the new country, he had trouble at work, specially receiving the due payments (he worked in the same transport and handling companies of his co-nationals) to arrange accommodation, which resulted in some months of homelessness. After living in Italy for a while, he suffered a physical and verbal aggression motivated by racism, about which he won the judicial procedure against his offenders. He considered his integration in this country difficult for all the experiences so far, and aimed to reach another country for final resettlement.

To provide the context for the critical event (escaping from a hospital after an aggression in an Ethiopian prison), the interviewee participated in a political demonstration in Ethiopia against the 2006 electoral process, in which he aimed to defend the rights of Eritrean

descendants in Ethiopia. His father is Eritrean, living in Ethiopia for nearly 40 years; all other family members are Ethiopians. Ethiopian authorities considered him one of the organizers of the demonstration, in a context of limited political freedom and widespread political imprisonment[5]. He was considered an Eritrean due to his father's origin (an argument that other Eritrean descendant interviewees referred as being enough to be "returned" to Eritrea or at least to have limited rights while living in Ethiopia) and detained in the Ethiopian city of Gondar for four months. While in jail, he was aggressed and tortured by the Ethiopian authorities. After one of the beatings he needed hospital assistance to amputate one finger. Once in the hospital, while recovering after the surgery, he escaped and took the route out of Ethiopia.

3.2. Escaping from a hospital while imprisoned for being undocumented in Libya

A woman from Addis Ababa was the narrator of this second critical event, passed in Libya, one of the transit countries during her flee. She was 22 years old when she arrived in Italy, in 2011. She was the first person in her family having migrated. After the killing of her father due to political issues and ethnic persecution, the interviewee was also persecuted and therefore not safe in her country of origin. She decided to ask for political asylum in a European country, which was granted after her request in Italy. Since she arrived in Italy, her main integration issue was the lack of work opportunities; whenever possible, she worked as a cook in Ethiopian and Eritrean restaurants and bars in different Italian cities.

She began her flee back in 2007, passing Sudan in a short time but having been stuck in Libya for three years. In Libya, due to the long and unforeseen stay (which surpassed all the financial support that her family back in Ethiopia could give to her) and the additional money needed to cross the Mediterranean Sea, she needed to work and the only job offer she found

[5] The Ethiopian context of limited political freedom has been identified in diverse editions of the yearly world reports by Human Rights Watch Organization (https://www.hrw.org/publications). For the specific case of political imprisonment, recently the Ethiopian Prime Minister affirmed the intention to release all political prisoners, in an effort to promote national reconciliation (see, for example: "Etiopía anuncia que liberará a todos sus presos políticos", El País, with the agency from Addis Ababa, 03/01/2018, available at: https://elpais.com/internacional/2018/01/03/actualidad/1514988296_790123.html.

was in cleaning and house care. Due to the public exposition characterizing this work activity, Libyan authorities identified her undocumented situation and she was detained.

During imprisonment, she needed medical assistance, although it was not possible to clearly ascertain the main reason for this need, since throughout the interview she was accompanied by another refugee who translated her silence on this issue by “being sick” and “having been attacked”. Other interviewed Ethiopians and Eritreans mentioned that permanence in Libya was generally difficult for them, mostly due to their situation as undocumented migrants. Particularly in the case of working while undocumented, local authorities were seen as a threat, with some reports on corrupt practices (namely through collaboration with smugglers), as well as physical and sexual attacks, particularly towards women. Besides, all the interviewees needed to approach smugglers so as to cross the Sahara desert and the Mediterranean Sea, to then cross from the Libyan to the Italian coast. Smugglers were described as being violent and focused on the financial gains from migrants, disregarding migrants’ situation and commonly abandoning them in difficult contexts. Additionally, in a context of growing Islamic extremism in the region (even though extremism was not associated by the interviewees to the majority population in the country), Ethiopians and Eritreans were associated with the Orthodox Christian religion (many had visible religious scarifications and tattoos) and consequently attacked. In this context, when the interviewee understood that she was somehow less observed by the Libyan authorities in the hospital, with limited security considering her medical condition, she escaped and soon left the country towards Italy.

3.3. Refused chronic disease follow-up in Italy after irregularities in the asylum process

A man from Addis Ababa narrated this third critical event, occurred in Italy, his arrival country in the EU. He was 23 years old when he arrived there, in 2008. Other members of his family and friends had fled to the United Arab Emirates and the United States of America. He was an Ethiopian descendant from Eritreans, a situation that granted fewer rights while living in Ethiopia and that could end up in an order to live in Eritrea, as it was referred in the first story (3.1). Additionally, considering his family’s memory of many armed conflicts in Ethiopia and in Eritrea, he was one of the only three children chosen, in his family of eight

siblings, to be officially declared to the Ethiopian state, in an effort to avoid that all siblings would eventually be called to military conscription. After shorter travels between Ethiopia and Eritrea, he took the route to Sudan, Libya and the Mediterranean Sea, which took him two years to complete. His longer stay was in Sudan, where he was repeatedly identified by authorities, put in jail or sent back to the Eritrean frontier. His most traumatizing memory was related to the long stays in the Sudanese part of the Sahara desert. Upon arrival, Italy conferred him humanitarian protection.

After years of unemployment or bad working and living conditions in Italy, he escaped towards France and the United Kingdom, trying to find a better life. In both countries, and in more than one flight attempt (2009 and 2012), he was found by authorities and sent back to Italy – considering that this attempt to live in a country different from the one which granted him international protection was forbidden according to the asylum regulation.

Soon after having returned from the second flight attempt, he was hospitalized in Italy, in need of a surgery. He was waiting for the surgery for a long time already, having been followed in the Italian hospital for a chronic kidney problem. Nevertheless, the surgery did not proceed; irregularities were found in his administrative process, due to his attempts to live outside of Italy, and this blocked the official medical follow-up of his chronic condition.

4. Possibilities and challenges of protection and health suggested in the refugees' pathways

The three life and mobility pathways presented in the previous section can provide us with different clues for further exploring the places and challenges of protection and health that refugees can face in their countries of origin, transit and arrival.

A first, general observation regards the political trigger factors underlying the decision to leave the country of origin. Situations of political imprisonment, political and ethnic persecution, but also the minor rights granted as Eritrean descendants, and the fear of being conscribed in military activity in a context of repeated national and international conflict and war, have been considered sound arguments for the international protection of these refugees. This type of political background is important to acknowledge while recalling the dignity and safety dimensions of the concept of protection (European Commission, 2016: 5).

All the mobilities took a long time to complete, from two to four years. Indeed, these could have ended as cases of ‘protracted refugee situations’, a term applied by UNHCR to refugee populations of 25.000 persons or more, who spend five or more years in exile. In these cases, refugees tend to remain in poor countries, which can have a limited capacity of protection and material assistance, and where there are few possibilities for work or education. Resettlement to another country would be the hope for these cases, but chances are few: projections in 2014 concluded it would take up to 80 years to resettle all the refugees in protracted exile, provided no new refugees would arrive; this can explain the spontaneous movements to seek asylum through a direct application in different potential host countries (Castles *et al*., 2014: 229-230).

Another remark regards the traumatic experiences that the three refugees endured on their ways towards the EU. Physical aggression and risk have been observed in different settings and situations in the three pathways: in detainment structures, in the relation with smugglers and authorities, during long stays in the Sahara desert and in the attempts to cross the Mediterranean Sea. Presently, these issues can already be known to the public: they have been broadly mediatized in EU countries, associated with the political crisis that followed an unprecedented number of asylum seekers in Europe since 2015 (Vieira, 2016). Instead of echoing the risk of sensationalism through these stories, our proposal is to question how these traumatic experiences can be further considered in protection frameworks and in the health dimension of these pathways.

Focusing on the detention experiences, the first two critical events were contextualized in prisons in the country of origin and in a transit country. Different levels of aggression have been alluded by different agents within these settings, including torture and sexual attack. In both cases, refugees needed and were permitted the access to health services – hospitals – where they could be assisted; and, in both cases, these were the places through which they could escape from political- and undocumented-related confinement.

Following these cases, we can ponder health services as safer spaces and least regulated than detention structures, thus allowing to escape from detention. In such contexts where survival and freedom were threatened, health care has been seen as an only relatively important issue. In this situation, instead of having completed their treatments, refugees opted

for escaping and proceeding their pathways up to the recognition of their political situation and their need of international protection.

These cases can be seen from the standpoint of international protection frameworks, namely in what regards the Common European Asylum System. On the one hand, prospects would be different if migrants would not need to follow a strategy of spontaneous multi-country asylum seeking, as referred before, if a resettlement program would actually guarantee that refugees in different arrival places could be resettled in a safe host country in a reduced amount of time. This would avoid, at least up to a certain level, traumatizing experiences of people in more vulnerable and undocumented situations, as those previously referred, who do not seek asylum in countries considered more insecure, which are a needed part of their pathways but not the final destination. On the other hand, one should also reflect on the violence reported in these detention settings and their overall context, namely regarding political imprisonment[6] and inhumane detention practices. Of particular remark is to ponder if countries of origin and transit can be considered 'safe countries', where asylum seekers denied international protection in the EU can be returned to, live safely and with dignity. If these basic protection conditions are not guaranteed by the principles of asylum procedure and return, the possibility of health and care seems threatened by definition.

The third critical event must be considered at a different level than the previous cases. In this case, after asylum acceptance in Italy, the country of arrival, there has been a clinical monitoring of a chronic situation. The medical follow-up was stopped when irregularities have been found in the asylum process, related to the refugee's attempt to live in other countries. In this example we are not referring to detention situations, but rather to the limited rights of mobility of refugees.

Within the Common European Asylum System (and particularly the Dublin regime), so as to facilitate the administrative management of asylum requests, each process can only be processed in one country, possibly the country where the asylum seeker entered the EU (or a third country where he/she was sent to with a resettlement program). Once the asylum is accepted, the refugee is compelled to live in that country. This turns out to be a problem, for example, for the refugees to whom the country of arrival (or resettlement) was not their destination, or those who find it difficult to live in the host country for economic and social

[6] See note 3, on the announcement of the presumed end of political imprisonment in Ethiopia.

reasons (e.g. labor, income and cost of living, housing, language issues, discrimination and racism, lack of family support, among other factors).

In this third case, health services were turned into places of restricted health care and assistance, in a situation of limited rights of mobility. Observing it critically, this EU approach to refugees' international protection risks threatening other social rights – namely the right to health care – due to the focus on their administrative procedures. Furthermore, it can represent a heavier burden in individual states' health systems, considering that chronic conditions like the one in this example could later derive into acute problems demanding other types and costs of care; besides the 'waste' of previous investment in the medical follow-up of this patient, who will probably need to repeat previous steps and procedures.

5. Final remarks

In this paper, contexts (of origin, transit and arrival) and critical events regarding the use of health services by three Ethiopian refugees have been presented. These cases have been reflected against the protection principles of international asylum systems, in an effort to understand some of the possibilities and challenges faced by refugees when seeking protection and health care. Instead of reflecting directly on health care, services and systems, a critical and intersected reading of protection and health issues has been followed, along with the (re)construction of overall political frameworks that condition these experiences of asylum.

The three cases presented in this paper can also be reflected upon considering the continuous exposure to risk (including, but going beyond the risk of lacking health care) within the particularly vulnerable situations of (1) persecuted/oppressed people in the countries of origin, (2) undocumented migrants in transit countries, and (3) refugees in countries of arrival. These correspond to three repeatedly observed stages of a pathway that can be generalized to other refugee-like situations (as observed in other interviews with refugees in Italy coming from Ethiopia and Eritrea, as well as in other studies, namely in pathways from Africa to Europe. Yet, such a reflection cannot occur without acknowledging the risk to generalize 'a refugee experience'– an essentialized anthropological category, a kind of culture, identity, social world or community sharing a common condition or nature,

besides sharing a common legal status (Malkki, 1995: 511). With no intention of contributing to such an essentialized construction of 'the refugee', we consider these three cases as pertinent to observe how the vulnerability associated to them can be related to the aggressiveness of social and political regimes, but also to important restrictions and barriers in the international asylum regime.

On the other hand, these critical events, and the inscription of these refugees' experiences in different phases of their paths and biographical narratives, can allow to grasp the agency of persons in refugee-like situations, thus contrasting the risk of portraying refugees as merely victims and not agents on their pathways of mobility. Besides, they can also contribute to deepen the comprehension of certain refugee-related labels while going beyond their political use – for example, surpassing the use of the 'transit migration' label for the externalization of EU migration control, a political site where it can be used as a justification for increasing border control (Düvell, 2012).

With these critical events, contextualized in health services' settings, one can grasp a meaning attributed to health services that does not correspond to 'places where health care is provided'. Instead, these places can be faced as similar to 'facilitating factors' for the continuity of these persons' spatial mobility (considering their lesser control and confinement when compared to prisons, as it was seen in the first two cases), and as 'blocking factors' for the effective integration of refugees in their countries of resettlement (in the context of limited rights of mobility for refugees in Europe and possible consequences of unauthorized mobility in health care provision, exemplified in the third case). This mismatch – between 'escape' or 'disintegration' meanings of health services for refugees, and these services' mission of providing health care – can be alluded to in the form of the question on whether 'healing or fleeing?', a kind of a metaphor for this paradoxical situation.

In the aftermath of this discussion, further attention can be put on the importance of attending to both the specificities of each national context/host country, and to the spaces and gaps in the common/international structures of refugee protection. Efforts to recognize refugees' right to health (among other social rights) must be accompanied by effective practices at each local level, but also by the challenging introduction of changes in the overall asylum system, so as to improve the global framework of refugees' protection and rights.

With the progressive shift towards a safer framing of the international asylum regime, the departing question on whether 'healing or fleeing?' would more possibly cease.

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