





Deservingness: migration and health in social context

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To cite: Holmes SM, Castañeda E, Geeraert J, *et al*. Deservingness: migration and health in social context. *BMJ Global Health* 2021;**6**:e005107. doi:10.1136/bmjgh-2021-005107

This article is submitted as part of the BMJ Global Health "Migration and Health in Social Context" collection edited by Emily Mendenhall and Seth M. Holmes.

Received 25 January 2021
Accepted 30 January 2021

ABSTRACT

This article brings the social science concept of 'deservingness' to bear on clinical cases of transnational migrant patients. Based on the authors' medical social science research, health delivery practice and clinical work from multiple locations in Africa, Europe and the Americas, the article describes three clinical cases in which assumptions of deservingness have significant implications for the morbidity and mortality of migrant patients. The concept of deservingness allows us to maintain a critical awareness of the often unspoken presumptions of which categories of patients are more or less deserving of access to and quality of care, regardless of their formal legal eligibility. Many transnational migrants with ambiguous legal status who rely on public healthcare experience exclusion from care or poor treatment based on notions of deservingness held by health clinic staff, clinicians and health system planners. The article proposes several implications for clinicians, health professional education, policymaking and advocacy. A critical lens on deservingness can help global health professionals, systems and policymakers confront and change entrenched patterns of unequal access to and differential quality of care for migrant patients. In this way, health professionals can work more effectively for global health equity.

INTRODUCTION

Whose health matters? Who deserves care? The social determination of health¹ systematically structures which people are made more or less vulnerable to sickness and disease (see structural vulnerability article in this collection), especially evident during the COVID-19 pandemic.² Access to healthcare is unequally distributed across and within population groups, depending on the formal structuring of entitlements in health systems and on legal status and 'position within the social hierarchy'³ (p 1). Importantly, the concept of *deservingness* shows how implicit moral assessments influence routine, yet high-stakes decisions regarding what kind of care is provided to which patients. Questions of deservingness

Summary box

- ▶ Every day, health professionals make complex moral evaluations grounded in implicit assumptions about who deserves access to high-quality care, especially in contexts in which health and immigration policies are in tension.
- ▶ Assessments of certain patients as less deserving than others can exacerbate unequal access to and experiences of healthcare, with serious implications for health, disease and sickness.
- ▶ Clinicians, health systems and health policymakers must develop a critical lens on deservingness—in all instances, and especially in relation to migrant patients—in order to improve healthcare, health outcomes and global health equity.

affect the care of racialised patients, those experiencing addiction, women, as well as transgender and non-binary people.⁴⁻⁷ In this article, we focus on the ways in which decisions around who is deserving of care, and who is not, play a central role in unauthorised or undocumented migrants' health and healthcare. This article considers clinical cases in order to challenge the ways in which migrants are sometimes sidelined from these decisions and may be portrayed or perceived as *undeserving* of otherwise established standards of care. Bringing together the social science concept of deservingness and the clinical cases related to migrant patients, we argue that health professionals must critically assess the moral negotiations of deservingness that are inherent parts of their routine clinical and health systems practice in order to engage more effectively and equitably with migrant patients. (Here, we use the term 'migrant' as an umbrella term to indicate those actively migrating, those considered immigrants, refugees, as well as asylum seekers.) To improve health outcomes and advance health equity, a critical approach to



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Definition box

Deservingness

This social science concept highlights the ways in which assumptions about whose health deserves attention and care influence every aspect of healthcare provision. Groups with considerable health needs—including migrants, asylum seekers and refugees—may be treated as though they are less deserving than other patients, with significant consequences for morbidity and mortality. Clinicians and health systems must confront and counteract presumptions of deservingness through critical reflection and action.

assumptions of deservingness is necessary in the field of migrant health.

Every clinical encounter with migrant patients is shaped by medical considerations and formal healthcare entitlements, and by informal, often unstated, assessments about whose health deserves attention, investment or care.^{8 9} Despite calls for the establishment of ‘firewalls’ between immigration enforcement and service provision,¹⁰ health outcomes and immigration policies often conflict. At times, healthcare professionals must manoeuvre between contradictory concerns and loyalties. These microdecisions can play an important role in migrant health outcomes.¹¹ The interplay between clinical decisions, political and economic structures and societal systems is extremely important for the health and healthcare of migrants.

MIGRATION AND HEALTH IN SOCIAL CONTEXT

Many people choose to move for work, studies and relationships (eg, Case 1), and many others are displaced by economic hardship, political conflict, war, natural disasters and environmental change (eg, Case 2 and 3). Migration has been an important aspect of human experience throughout history, with approximately 3% of the world’s population now living outside their country of birth.^{12 13} While migration brings advantages to many,¹⁴ this movement causes hardship for many other migrants due to changing places of residence and social networks, precarious legal status and limited access to health and social services. Moreover, substantial evidence shows that racism has an impact on many migrant patients^{15–17} and fuels differential outcomes in care.¹⁴ Despite increasing recognition that medical training should prepare clinicians to care for a diverse range of patients, clinicians often experience challenges in caring for migrant patients, who may not fit pre-existing expectations regarding who constitutes a deserving patient.^{18 19}

First, we argue that often unstated assessments of deservingness influence decisions about what kind of treatment migrant patients should receive—or whether they should receive treatment at all. Such assessments of deservingness are at work in clinical encounters and in health and immigration policy-making. Assessments of deservingness are at play in the

Case 1. Ms. N: Differential valuation of human lives in an Ebola treatment unit

After receiving an Ebola diagnosis, Ms N, a 27-year-old woman from South Eastern Sierra Leone, was transferred to a non-governmental organisation (NGO)-run Ebola treatment unit nearby. There, she was isolated and offered oral rehydration therapy. Despite persistent vomiting, she was not offered intravenous fluid resuscitation with repletion of electrolytes. Her condition rapidly declined. Like many other patients with Ebola treated based on isolation-focused protocols, Ms N died soon thereafter.

During the 2013–2016 Ebola outbreak in West Africa, large numbers of foreign clinicians travelled to assist in response efforts. Because NGOs sponsoring foreign clinicians feared that their staff might be infected with the Ebola virus while caring for West African patients, many instituted protocols of ‘no needle’ care (with no intravenous fluid resuscitation) for West African patients rather than offering patient-centred, ambitious clinical services for critically ill patients. Yet, when foreign clinicians were infected with Ebola, the same NGOs routinely treated them using distinct protocols including intravenous fluid resuscitation and evacuation to overseas hospitals.

In general, healthcare workers at Ebola treatment units were not constrained by resources. Intravenous lines, bags of lactated Ringer’s and frustrated foreign clinicians agitating to use them were omnipresent. Rather, substandard care was deemed pragmatic, and therefore ‘ethical’, in this context. While infected foreigners were given intravenous fluid resuscitation and evacuated to foreign hospitals with intensive care capacity as standard of care, this level of care was codified as too risky to provide for West African patients who were disproportionately affected by Ebola.

As a result, patients like Ms N and foreign clinical volunteers received systematically different care, contributing to an Ebola case fatality rate in West Africa of 64.3%. Although significantly fewer American health workers in West Africa were infected with Ebola, the case fatality rate was 0 among infected American citizens (for further discussion, see Richardson ET³³).

differential treatment in Case 1, where racialisation, class and nationality fundamentally position foreign migrants working amidst the Ebola outbreak as more deserving of medical treatment than local patients they were treating. This case shows how assessments of deservingness—including valuations of human lives—were instituted through differential clinical protocols with life and death consequences. Similar assessments of deservingness lead to negative health outcomes in Cases 2 and 3. These decisions made by clinicians and non-clinical staff have a significant impact on individual patient health outcomes as well as population-level health as seen in each of the cases presented. These cases are composites of multiple real, similar clinical cases, anonymised to protect confidentiality.

Second, interactions between patients and healthcare systems are often influenced by implicit assumptions that different social and demographic groups deserve distinct levels, kinds and qualities of care, as illustrated in Case 2. Despite undocumented migrants’ right to be assessed by specialists, the team responsible for prioritising admission to the limited public specialist healthcare services

Case 2. Mr S: Rejected referrals for psychiatric distress of undocumented migrants

Mr S, an Afghan man in his 30s, visited the Health Center for Undocumented Migrants in Oslo, Norway, several times during the previous 6 months. At this visit, he presented with insomnia, lack of appetite and a general sense of worry. He was restless, irritable and tired. The primary care physician asked about his situation and Mr S explained he was unable to sleep, despite taking medication. He lacked energy and felt hopeless. He worried that something bad would happen to him. Mr S saw no future for himself in Afghanistan, yet his future in Norway was also uncertain since his asylum application had been rejected 7 years earlier. The primary care physician referred him to a psychiatrist because his mental health concerns had worsened over the previous months. Knowing that undocumented migrants have the right to be assessed by specialists by Norwegian Law, the physician submitted the appropriate referral documents.

Three weeks later, a rejection letter arrived indicating that the patient's precarious situation as an undocumented migrant would limit the treatment effect and the possibility for improvement. Psychiatric treatment would fail, the letter asserted, because Mr S's life conditions as a migrant would lead to a resurgence of symptoms once the treatment was over. The decision revealed no disagreement over diagnosis, and no arguments related to cost-effectiveness. Rather, it hinged on the view that his life circumstances in Norway as a rejected asylum seeker caused his mental illness—something that the medical system could not, or would not, treat. The rejection letter cited no evidence in evaluating the potential effect of treatment for the patient. The usual medical criteria for psychiatric treatment were suspended, and Mr S was denied care.

decided against Mr S being offered psychiatric care. In the assessment of Mr S' deservingness of treatment, his status as a rejected asylum seeker, rather than his mental health condition, dominated their decision. On a different level, Case 3 demonstrates discrimination that prevented Mr G from receiving standard of care for fixing his molar, where front desk staff and clinicians made assumptions about his health insurance status as well as which treatment would be appropriate for his tooth pain. These assumptions stem from power differentials and sociocultural and economic differences between migrants and clinicians and often yield harmful—and avoidable—consequences.

Third, every clinical interaction involves subtle and often unspoken moral and ethical decisions that influence who does and does not access care. Many factors, from nationality, religion, education, class, ethnicity, gender, accent and sexuality to migration and legal status, can affect assessments of deservingness.²⁰ In some contexts, unauthorised migrants may be perceived as less deserving than refugees.^{21–23} In addition, interpretations of migrant patients' moral character and behaviour can affect their healthcare and health outcomes.⁸ These moral assumptions influencing access to and quality of care compound implicit bias and stereotyping about compliance and adherence, such as in the case of Mr G.

Case 3. Mr G: Anti-Roma racism and dental pain

Mr G, a 23-year-old Romani man from Romania, presented to a charity clinic in Berlin with extreme pain in a lower left molar. As the receptionist handed Mr G's chart to the primary care physician, she rolled her eyes and muttered under her breath about 'another one of these pushy Roma'. Even though he was from Romania, a country within the European Union (EU), Mr G did not have health insurance. While all member countries of the EU are required to provide health insurance coverage for their citizens, there have been systematic obstacles to health insurance registration for mobile EU citizens, including Romani people.³⁴

Examining the man's mouth, the evaluating physician said, 'Nice to meet you. What are you doing here in Berlin?' Mr G explained in basic German that he was working in construction, living with his cousin and three other Romanian men in a one-room apartment. Following the brief examination, the clinician gave him a slip of paper with a list of addresses. The first was a mobile van providing free dental care to the homeless. The clinician emphasised that he should not go there, repeating this instruction twice to make sure he understood. 'They won't take you because you are from Romania.' This statement is layered with implications. First, the mobile van had a new policy to prioritise Germans rather than foreigners in order to preserve scarce resources. However, it also reveals the widespread assumption that Romani people are 'traditionally' mobile, and thus do not fit the category of housing instability (and thus are not deserving of free treatment³⁵). Instead, the clinician pointed to the list of private dentists further down the page, who had agreed to lower their rates for self-pay referrals from the non-profit clinic.

Mr G immediately took the subway to the first private dentist, where the receptionist told him the office was too busy and could not see him. At the next office, he faced a locked door because it was closed on Fridays. Finally, the third office on the list agreed to see him 3 days later, telling him to bring €100. Mr G returned to relieve the now-excruciating molar ache. The dental clinic staff extracted the tooth because a root canal procedure was assumed to be too costly for Mr G. Dental treatment at the usual standard of care—root canal for someone in his age category—was considered too expensive for this patient, based on his migration history and ethnic standing as a Romani man. The new gap in his smile joined those from other teeth that had been pulled over the course of his 23 years.

Fourth, assessments of certain populations as undeserving can exacerbate systemic inequities. Structural, institutional and interpersonal racism plays a role in the distribution and quality of healthcare,²⁴ as highlighted during the COVID-19 pandemic.²⁵ These inequalities are perpetuated in part by legal definitions and institutional practices that categorise migrants into groups with different legal rights and entitlements. Yet, each health professional—from front desk staff to infectious disease specialist developing triage protocols in times of pandemic—routinely exercises discretion in relation to the access and quality of care patients receive. Migrants who have experiences of being treated as undeserving of care may be less willing to engage with the healthcare system, with potentially serious consequences. For all these reasons, considering and confronting these multiple levels through which migrants face evaluations of deservingness is

imperative for individual and collective global health and healthcare.

DESERVINGNESS: IMPLICATIONS FOR GLOBAL HEALTH CLINICIANS, SYSTEMS AND POLICIES

Global health clinicians and systems must recognise that implicit assumptions about patient deservingness influence healthcare access and quality, as well as health outcomes. Such assumptions, and the decisions they inform, can be a matter of sickness or health—even life or death. Such assumptions can be contradictory to core clinical values and professional ethics. In addition, the organisation of healthcare and dominant attitudes towards migrants in a given society limit or foster the latitude health professionals have in addressing the health of migrants. With all of this in mind, clinicians, health system planners and policymakers must reflect critically on and confront their own assessments of deservingness. We suggest four steps.

- ▶ First, *clinicians must examine their assumptions of deservingness*. We suggest clinicians ask ourselves: Would some service providers (including me) assume that this patient deserves less than the scope and quality of care I would expect for myself or my family members? Are stereotypes or negative judgements about a patient's appearance, ethnicity, gender, sexuality, migration status language, accent, etiquette, addiction status, personality or behaviours adversely affecting their care?¹⁹
- ▶ Second, *health professional education must include training in social medicine frameworks* such as structural competency and cultural humility in order to produce new generations of clinicians with tools to critically engage assessments of deservingness and their important health implications. Structural competency is a recent framework aimed at training clinicians to perceive and respond to the political, social and economic structures influencing health and healthcare^{26 27} and specific training modules have been developed for health education.²⁸ Cultural humility pushes clinicians and health systems to avoid ethnocentrism and stereotyping forms of racism by asking patients about themselves, their beliefs, values and priorities.²⁹ Together, these frameworks provide a strong background for health professionals to provide effective, respectful care for migrants.
- ▶ Third, *health professionals and health systems must prioritise the clinical vocation, supporting initiatives to secure the rights of patients and make the health system equitable for migrants*. According to the World Medical Association, 'Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.'³⁰ For instance, health professionals and policymakers could advocate for programmes to provide health coverage for all patients, including migrants. Health professionals

and policymakers could also push hospitals and health systems to avoid collaborating with migration policing, as in the recent successful case in the UK.³¹ Without these policy-level changes, clinicians may experience significant limits on their ability to provide effective healthcare for migrants.

- ▶ Fourth, *health professionals, health policymakers and health systems can lend support to migrant communities organising against portrayals of undeservingness* and unequal policies. During the COVID-19 pandemic, for example, groups of migrant workers have appealed for protection while performing 'essential' labour such as planting and harvesting food.³² These groups have criticized the irony of being called 'essential workers' without being provided the means to protect themselves against the pandemic. Clinicians and health systems can support these migrant efforts to be portrayed fairly in ways that could help protect their health and well-being. These portrayals, in turn, are likely to influence policies and health system changes that will enable clinicians to provide effective and equitable care.

A critical lens on deservingness can help global health professionals, systems and policymakers confront and change entrenched patterns of unequal access to and differential quality of care for migrant patients. Health professionals can lend their support to migrant communities by working towards more effective, equitable and fair health systems for all.

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Acknowledgements The authors wish to acknowledge the Institute for European Studies (UC Berkeley), the Walsh School (Georgetown University), Nate Krall, Miriam Magaña Lopez, and the Migration and Health in Social Context Working Group for support making the discussions leading to this article possible. The authors are grateful to Eugene Richardson for helpful comments and suggestions in the drafting and revising of the article, especially in relation to coloniality. And the authors thank the anonymous peer reviewers from the BMJ for their helpful insights and suggestions to improve the article.

Collaborators The Migration and Health in Social Context Working Group, including the co-authors and: Lauren Carruth, American University; Shahanoor Akter Chowdhury, NextSkills Consulting, Dhaka, Bangladesh; Hansjörg Dilger, Freie Universität Berlin; Katharine M. Donato, Walsh School of Foreign Service, Georgetown University; Miriam Magaña Lopez, University of California Berkeley;

Carlos Martinez, University of California Berkeley; Emily Mendenhall, Walsh School of Foreign Service, Georgetown University; Carlos Piñones-Rivera, Universidad Arturo Prat; James Quesada, San Francisco State University; Nasima Selim, Freie Universität Berlin; Lahra Smith, Walsh School of Foreign Service, Georgetown University; Sarah S. Willen, University of Connecticut.

Contributors All authors contributed to and approved the submission of this manuscript.

Funding The writing of this article was funded by the Deutscher Akademischer Austauschdienst (DAAD), the Global Futures Initiative (Georgetown University), the Berkeley Center for Social Medicine (UC Berkeley), the Peder Sather Center for Advanced Study, and the Paoli Calmettes Institute Chair IMéRA Mediterranean Institute for Advanced Study.

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement All data relevant to the study are included in the article.

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REFERENCES

- 1 Spiegel JM, Breilh J, Yassi A. Why language matters: insights and challenges in applying a social determination of health approach in a north-south Collaborative research program. *Global Health* 2015;11:9.
- 2 Douglas M, Katikireddi SV, Taulbut M. Mitigating the wider health effects of COVID-19 pandemic response. *BMJ* 2020;369:m1557.
- 3 Spitzer DL, Torres S, Zwi AB, et al. Towards inclusive migrant healthcare. *BMJ* 2019;366:l4256.
- 4 Nelson. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C: National Academy Press, 2003.
- 5 Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. *Drug Alcohol Depend* 2007;88:188–96.
- 6 Knight KR, Duncan LG, Szilvasi M, et al. Reproductive (In)justice - Two Patients with Avoidable Poor Reproductive Outcomes. *N Engl J Med* 2019;381:593–6.
- 7 Playdon Z. Unequal treatment of transgender people. *BMJ* 2016;353:i2329.
- 8 Willen SS, Cook J. Health-related deservingness. In: Thomas F, ed. *Handbook of migration and health*. Cheltenham: Edward Elgar Publishing, 2016: 95–118.
- 9 Willen SS. Migration, "illegality," and health: mapping embodied vulnerability and debating health-related deservingness. *Soc Sci Med* 2012;74:805–11.
- 10 Crépeau F, Hastie B. The Case for 'Firewall' Protections for Irregular Migrants: Safeguarding Fundamental Rights. *Euro J Migr Law* 2015;17:157–83.
- 11 Berlin A, Koski-Karell V, Page KR, et al. The Right and Left Hands of the State - Two Patients at Risk of Deportation. *N Engl J Med* 2019;381:197–201.
- 12 International organisation for migration. world migration report 2018, 2018. Available: https://publications.iom.int/fr/system/files/pdf/wmr_2018_en.pdf [Accessed 14 May 2020].
- 13 Castañeda E, Shemesh A. Overselling globalization: the misleading Conflation of economic globalization and immigration, and the subsequent backlash. *Soc Sci* 2020;9:61.
- 14 Abubakar I, Aldridge RW, Devakumar D, et al. The UCL-Lancet Commission on migration and health: the health of a world on the move. *Lancet* 2018;392:2606–54.
- 15 Spitzer DL, Torres S, Zwi AB, et al. Towards inclusive Migrant healthcare. *BMJ* 2019;366:l4256.
- 16 Wickramage K, Simpson PJ, Abbasi K. Improving the health of migrants. *BMJ* 2019;366:l5324.
- 17 Lee S, Waters SF. Asians and Asian Americans' experiences of racial discrimination during the COVID-19 pandemic: Impacts on health outcomes and the buffering role of social support. *Stigma Health* 2020.
- 18 Madaras L, Stonington S, Seda CH, et al. Social Distance and Mobility - A 39-Year-Old Pregnant Migrant Farmworker. *N Engl J Med* 2019;380:1093–6.
- 19 Bourgois P, Holmes SM, Sue K, et al. Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Acad Med* 2017;92:299–307.
- 20 Kapilashrami A, Hankivsky O. Intersectionality and why it matters to global health. *Lancet* 2018;391:2589–91.
- 21 Holmes SM, Castaneda H. Representing the European refugee crisis in Germany and beyond: difference, Deservingness, life and death. *American Ethnologist* 2016;43:1–13.
- 22 Geeraert J. Healthcare Reforms and the Creation of Ex-/Included Categories of Patients - "Irregular Migrants" and the "Undesirable" in the French Healthcare System. *Int Migr* 2018;56:68–81.
- 23 Yarris K, Castañeda H. Special Issue Discourses of Displacement and Deservingness: Interrogating Distinctions between "Economic" and "Forced" Migration. *Int Migr* 2015;53:64–9.
- 24 Kendi IX. All policies, even the most trivial, are either racist or anti-racist, — they support equity, or they don't. *Lancet Digital Health* 2019;1:e375.
- 25 Bhala N, Curry G, Martineau AR. Sharpening the global focus on ethnicity and race in the time of COVID-19. *Lancet*.
- 26 Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med* 2014;103:126–33.
- 27 Harvey M, Neff J, Knight KR, et al. Structural competency and global health education. *Glob Public Health* 2020;22:1–22.
- 28 Neff J, Holmes SM, Knight K, et al. "Structural Competency: Interprofessional Medical Education Responding to the Needs of Structurally Vulnerable Populations." *MedEdPortal* 2020.
- 29 Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved* 1998;9:117–25.
- 30 World Medical Association. Wma Declaration of Lisbon on the rights of the patient, 2018. Available: <https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/> [Accessed 14 May 2020].
- 31 Saadi A, McKee M. Hospitals as places of sanctuary. *BMJ* 2018;361:k2178.
- 32 Chang VL, Holmes SM. Us food workers are in danger. that threatens all of us. *The Guardian* 2020 <https://www.theguardian.com/commentisfree/2020/apr/14/will-we-have-food-coronavirus-pandemic>
- 33 Richardson ET. *Epidemic illusions: on the coloniality of global public health*. Boston: MIT Press, 2020.
- 34 Matache M. Biased elites, unfit policies: reflections on the lacunae of Roma integration strategies. *European Review* 2017;25:588–607.
- 35 Bhabha J, Andrzej M, Margareta M. *Realizing Roma rights*. Philadelphia: University of Pennsylvania Press, 2017.