

THE POLITICISED BIOLOGY OF IRREGULAR MIGRANTS: *Micropractices of control, tactics of everyday life and access to healthcare*

Abstract

Norway provides limited healthcare for irregular migrants, partly to make the country an unattractive option for 'would-be refugees'. Drawing on fieldwork and interviews, this article discusses the use of healthcare to regulate migration and how irregular migrants make use of different tactics (creative access, self-care, ignoring symptoms and *raison d'être*) to gain access to healthcare despite legal restrictions. The migrants' tactics are adaptations to the micropractices of control and are about a diseased and politicised biology. They illuminate ways to care or not care for the body from a marginal position. This research, then, highlights how migrants work to restore a political life against the sovereign construction of them as mere biology. While some of these tactics are ways in which migrants can survive without healthcare rights in the short run, other tactics may contest and disrupt how the government is defining and treating irregular migrants in the longer run.

Keywords

Politicised biology • Health • Irregular migrants • Micropractices • Tactics

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Introduction

Farid¹ is from the Middle East. He is in his 40s and has lived in Norway for 12 years without the legally required right of residence. During our interview, he told me about an incident at the National Police Immigration Service. He had gone there to discuss his case with the officer in charge. The officer had said: 'You know that you are illegal here?', and 'You have to go home.' Farid had told her that he could not go home and that he was too afraid to contact his embassy. He had told the police officer: 'If you send me to [country], you are not thinking about me and what will happen to me. I'm a sick man. I need treatment. And there I cannot have it without money. You need to help me. Don't just say that I have to leave the country'. The officer had replied: 'You are ill; I would help you, but there is the law.'

Farid's encounter with the police shows the intertwining of legal residence, healthcare and migration management. Farid's marginalised inclusion in the Norwegian society – he is included in being provided with a minimum level of healthcare – suggests that human life is defined by legal residence and citizenship. Norway, similar to other European countries, has limited social support and health services for irregular migrants, partly to encourage the perception among 'would-be refugees' that the country is an unattractive option. What are the consequences of such policies, regulations and discourses in terms of irregular migrants' everyday

lives? Drawing on fieldwork and interviews with irregular migrants in Norway (2011–2014), this article suggests that healthcare rights in Norway create everyday border practices, and that irregular migrants respond to the lack of healthcare rights through the use of various 'tactics' (de Certeau 1984). The focus here is on migrants in Norway whose asylum applications have been rejected. In practice, access to healthcare is not merely an issue of legal regulation but also concerns migrants' experiences of their rights and their capacity to manoeuvre – through the use of various tactics – in spaces that are bounded by sovereign power. These tactics are produced and performed within the space defined by the Norwegian government's policies and politics, technologies of control and processes of 'illegalisation'.

The past decade has seen an increase in research on irregular migrants and access to healthcare in Europe and the USA (Biswas *et al.* 2011; Castañeda 2013; Hjelde 2010; Miklavcic 2011; Søvig 2011; Woodward, Howard & Wolffers 2014), but more is needed. For countries of the European Union (EU), such research shows that legal entitlement does not necessarily result in access (Platform for International Cooperation on Undocumented Migrants [PICUM] 2010; Woodward, Howard & Wolffers 2014). Key access barriers include arbitrariness in healthcare professionals' attitudes (Biswas *et al.* 2011), fear of being reported to authorities, lack of awareness of healthcare rights and financial obstacles (Bendixsen 2015; Biswas *et al.* 2011; PICUM 2010). In Denmark, Biswas *et al.* (2011) found that

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difficulties in accessing healthcare brought about alternative health-seeking strategies, including self-medication, communicating with doctors in home countries and borrowing others' health insurance cards. Many of my findings resonate with this precedent work. Such previous studies, however, do not discuss migrant manoeuvres to achieve access to healthcare in terms of 'tactics'. I do so here in order to explore both how obstacles to healthcare have become part of the management of migration, and how irregular migrants' health practices operate within the very system of power against which these practices are devised. Yet, these practices can be effective in interrupting the effects of the micromanagement of control and, thus, in generating a space of resistance.²

This article briefly discusses the role of street-level bureaucrats (Lipsky 1980) in the micropractices of borders and de Certeau's (1984) understanding of tactics. It then suggests that healthcare has become a micropractice of border control in Norway. I explore how irregular migrants experience technologies of control in their encounters with healthcare personnel, and finally, I suggest that irregular migrants respond to these micropractices of control through the use of various tactics. While these tactics facilitate access to healthcare in some cases, they produce ill health in others.

Micropractices of borders, governmentality and tactics

Balibar (2003) postulates that borders no longer exist only at the external territorial borders of nation-states or regions, if they ever did; instead, they are spread throughout the territory and materialise wherever mobility happens and is controlled. Borders follow people as they seek to access welfare benefits, health, legal labour and labour protections, civil associations and justice (Balibar 2003; refer also Anderson, Gibney & Paoletti 2011). Everyday border practices, such as encounters with welfare state actors, contribute to multiple (Balibar 2003) and merging forms of border controls.

The production of illegality is defined and structured by law (de Genova 2002), and it is also constructed by individuals working in street-level bureaucracies whose everyday work includes the determination of the rights that should be provided to the person in front of them. Street-level bureaucrats are individuals working in public services, such as doctors, social workers, police and legal services offices (Lipsky 1980). In their translation of laws, norms and bureaucratic procedures, individual street-level bureaucrats interact with and have discretion over the allocation of public benefits. In encounters with street-level bureaucracies, citizens and non-citizens experience the government of the nation-state in which they are living. Individual authorities and street-level bureaucrats pursue micropractices of citizenship as 'subjectification' and, in their encounters with citizens or non-citizens, translate 'the problematics of government into everyday operations' (Ong 2003: 17).

By exploring irregular migrants' everyday experiences of encounters with healthcare workers and their ways of responding to being sick, the present research demonstrates that irregular migrants use creative practices or 'tactics' in their effort to master everyday life. Sager (2018) views everyday strategies as a part of surviving, as a part of migrant struggles. I argue that these tactics suggest that the undesirable non-citizen becomes part of the micropractices of control that shape both how they think of themselves and their actions, as well as their capacity to act creatively. These practices are not the same as activist practices against border controls, such as the 'No Border' mobilisations, hunger strikes and demonstrations

pursued by both irregular migrants and citizens (Bendixsen 2017; Nicholls 2016; Pellander & Horsti 2017). I explore those practices of irregular migrants that seek to interrupt the exclusionary effects of border controls.

To demonstrate these creative actions while recognising the field of power in which their capacity lies, I draw on de Certeau's distinction between strategy and tactic. In de Certeau's words (1984: 29), 'strategies produce, tabulate, and impose these spaces whereas tactics can only use, manipulate, and divert these spaces'.

Against what forms of power are tactics an effective strategy? To answer this, we need to differentiate between sovereign power and disciplinary power, as outlined by Foucault. Foucault (1991) considers sovereign power as taking place in those instances when law or rights have been violated and sovereign power acts to punish or restrain that violation. Disciplinary power is a normalising practice that shapes how subjects become, speak, think and act; 'it is the specific technique of power that regards individuals both as objects and as instruments of its exercise' (Foucault 1991: 170). As I discuss later, tactics may both contest and strengthen sovereign power: while they may challenge *how* power strategies are exercised by the sovereign, they do not necessarily challenge its right to carry out such a strategy. Instead, tactics' potentiality lies in manipulating the mechanisms of power relations, and thus they may counter disciplinary power (de Certeau 1984; Gill *et al.* 2014). Tactics, therefore, operate within the system of power against which they are arraigned but can be effective in creating 'victories of the "weak" over the "strong"' (de Certeau 1984: xix). Tactics produce space by constant manoeuvring, transforming spaces into chances or opportunities. In daily social situations, people can (re)claim autonomy by using tactics that contest oppressive forces, such as othering processes.

Method and data

The data for this article has been collected through fieldwork and interviews with irregular migrants in Oslo and Bergen in the period 2011–2013. Estimates suggest that there were ~18,000 irregular migrants in Norway before the so-called migrant crisis of 2015 (Oslo Economics 2014). The majority of those interviewed for this study were former asylum seekers who had had their application denied and had overstayed their date of exit. I contacted irregular migrants through Oslo's Health Centre for Undocumented Immigrants (HCU; *Helsesenteret for papirløse migranter*), where I was allowed to approach migrants in the waiting room. I explained my project before asking whether they would agree to be interviewed. Consequent interviews would take place outside the centre. In addition, I recruited informants through public events organised during the fieldwork period by irregular migrants. In Bergen, I made contact with irregular migrants through reception centres.³

During my fieldwork, I interviewed 50 irregular migrants and talked with >100. Interviews lasted between 1 and 3 hours, and I met some people several times. The use of a translator was only necessary in a few cases. A majority were men between 20 and 35 years of age; however, I also interviewed women, as well as men of different ages. On the whole, interviewees had lived as irregular migrants in Norway for 2–10 years, although some had lived here for >12 years.

Conducting fieldwork with irregular migrants who are living in a precarious situation requires sustained reflection on the ethical aspects of one's research. Anticipations, voiced and unvoiced,

of the researcher's commitment to transform (positively) their life situation can create false expectations. Further, research information concerning how migrants pursue their everyday life can be misused by various governmental and private bodies. Yet, research about irregular migrants' lives is also important in order to cast light on the politics of which they are a part, its consequences on their lives and the proliferation of nation-state's management. Many of them valued that someone cared about and listened to what they had to say.

Micropractices of control: healthcare mediators

The Norwegian welfare society is characterised by a comprehensive welfare state model: its residents' welfare needs are dealt with through public arrangements financed through taxation. The right to welfare is based on residence and legal status (as a permanent or temporary resident), rather than employment, income or previous contributions to the welfare system. The 'Nordic welfare model' is thus characterised by public funding of the health sector and represents an area of comprehensive control management by the government. In cases in which there are fees (with the exception for children under the age of 16 years), these are quite low, and specialised healthcare providers do not charge at the point of use (Søvig 2011).

The welfare system has played a considerable role in the government's work to include migrants and refugees (Brochmann & Hagelund 2010; Olwig 2011). Asylum seekers, refugees and people arriving on family immigration permits automatically receive rights under the National Insurance Scheme upon registration. If an asylum seeker is rejected, however, and does not leave the country by the stated date of exit, his or her stay in Norway becomes defined as 'illegal' and his or her rights to social welfare and healthcare change. While irregular migrants are currently still included in some instances (i.e. under the 1992 Child Welfare Act, the 1998 Education Act and the 2009 Act on Crisis Shelters), their access to services has increasingly been circumvented by regulations and circulars issued by state departments redefining the scope of the law to mean only 'legal residents' (Søvig 2013). One outcome of a review of existing legislation, which was initiated by the Norwegian Ministry of Health and Care Services because of 'continuing doubt and varying practices', was a healthcare regulation (July 2011) that restricted irregular migrants' access to healthcare to emergency care that could not be delayed 'without danger of imminent death, permanent and seriously reduced functionality, serious injury, or severe pain' (Healthcare Regulation 2011).⁴

Irregular migrants may undergo an assessment of somatic and psychological health within primary and specialist healthcare services. They also have quite extensive rights under the 1994 Act on Infectious Diseases (Søvig 2011), as is the case in several other European countries. However, these rights are not necessarily tied to concern for the irregular migrant patient as much as they are intended to address Norwegian citizens' health concerns. Health personnel whom I interviewed considered the practice of testing irregular migrants and all asylum seekers for tuberculosis and human immunodeficiency virus (HIV) to be part of the government's effort to control infectious disease in the wider population. However, irregular migrants do not have the right to specialised healthcare (Søvig 2011) and their rights do not necessarily include free treatment: 'an irregular migrant given emergency healthcare may be presented with an invoice upon leaving the hospital' (Søvig 2011).⁵

Politically, there is reluctance to grant irregular migrants more generous rights to healthcare in order to appear 'tough on migration'

(Bergens Tidende 2010; NRK 2011). Politicians fear that being 'too generous' will attract care-needing migrants from all over the world. In practice – particularly because 'emergency care' opens up grey zones in which an interpretation both of the law and of the patient's condition is required – the gatekeeper to healthcare access becomes the public service provider, including the emergency ward or clinic receptionist, the nurse and the doctor (refer also Pellander 2018). Thus, their work activities become part of everyday border practices, with the result that 'the border' permeates spaces *within* the territorially defined nation-state. Simultaneously, by constructing migrants as 'productive', 'harmless', 'unproductive' or 'problematic', government policies produce an increasingly controlled environment for irregular migrants who are subject to criminalisation discourses. It appears to be the case that precisely because the welfare system is so generous, the state borders must be regulated and guarded.

Voluntary organisations have largely taken over responsibility for irregular migrants' health needs, and their activities are, paradoxically, partly funded by the Norwegian government. The HCUI was set up by the Red Cross and the City Church Mission (*Kirkens Bymisjon*) in autumn 2009. While this centre is crucial for migrants' physical and psychological health, it demonstrates that irregular migrants' bodies are dealt with at the margins of the state, by parallel institutions situated at unofficial secret addresses, staffed by volunteers. Its existence is legitimised through humanitarian-framed discourse, and its functions are dependent upon the goodwill of public hospitals for the treatment of serious illness.

The government's increased marginalisation of irregular migrants includes decreasing economic support for rejected asylum seekers. Healthcare personnel from Norwegian People's Aid (*Norsk Folkehjelp*) warned in the media that lower benefit payments would lead to hunger and sickness at reception centres (Bergens Tidende 2010). Pål Lønseth (Labour Party), the Secretary of State for the Ministry of Justice and Public Security, argued that it was not the government's 'intention to make people starve'. He added that it would be wrong for asylum seekers remaining illegally in Norway to receive the same as those with pending asylum applications, stating that if they received the same rights, it would not show that they have a 'duty to return' (Norwegian Broadcasting Corporation [NRK] 2011). Irregular migrants are further stigmatised among the public as undeserving of social rights and healthcare by tying their vulnerability to their 'refusal' to return to their country of origin. Their social and health situation is thus constructed as a consequence of their own actions, or lack thereof.

Excluding irregular migrants from public services can be considered part of migration management and a discouragement policy that seeks to 'convince' or 'encourage' rejected asylum seekers 'to return', while also discouraging new asylum seekers from arriving. Deteriorating living conditions for irregular migrants – through reduced healthcare benefits, increased control of workplaces, minimised cash allowances at reception centres, suggestion to illegalise offering irregular migrants accommodation and use of forced returns seek to make 'return' or 'voluntary return' (with money allowances) the only viable option when applications are rejected (Bendixsen 2017).

Norway thus follows a trend among EU state efforts to control legal and illegal migration by means of internal controls and rights exclusions (van der Leun 2006). Restraining irregular migrants' access to public services is a frequent practice in several countries with broad welfare systems (van der Leun 2006). Health and social workers in advanced welfare states have increasingly been given responsibility for distinguishing between nation-state members and non-members. In Norway, however, this role for health and social

workers is not new because they have always acted as gatekeepers for the nation-state in regard to its citizens (Ryymin & Ludvigsen 2013).

Some healthcare workers contest their role as gatekeepers through providing healthcare to irregular migrants without regard to their lack of rights, as in the case of Farid. A few use a 'Don't Ask, Don't Tell' tactic, in which they provide healthcare services without knowing the patient's legal status (refer also Castañeda 2013; Karlsen 2015; Miklavcic 2011). Others volunteer at the HCUI, where they provide their services outside the public healthcare system. For some, volunteering was an essential means by which to address what they experienced as an inhuman system in conflict with their ethical obligation to help people in need.

The fact that irregular migrants have the right to emergency care reflects the ambivalent relation between the state and the rejected asylum seeker: the latter is an undesirable subject that the nation-state seeks to be rid of but will not kill. International conventions (e.g. the European Convention on Human Rights) tie the state to a minimum of care – it cannot let the body die as a result of medical neglect on its territory (Fassin 2009).

Capacities to act: the use of tactics

Given this political and social situation, what happens when irregular migrants feel ill or seek healthcare? In practice, in Norway, if a general practitioner (GP) is unavailable (i.e. when a health-related issue arises outside office hours), people visit the Emergency Care Unit. Here, patients provide their personal number and a name and address matching computerised data, or they show an EU insurance card. Lacking these means of identification, irregular migrants are mostly asked questions concerning their legal status; the intention is to establish whether a given person has a right to public healthcare. The risk is that migrants may be refused assistance. Through this practice, the database becomes a technology of control to distinguish between deserving and undeserving subjects of 'universal' public healthcare: this constitutes a micropractice of border control.

I found that migrants frequently viewed their encounters with street-level bureaucrats as uncomfortable, risky and potentially humiliating. Many irregular migrants talked about receiving negative looks and being asked 'too many questions concerning their identity' when they visited the Emergency Care Unit or other public medical centres. Ali, a Palestinian man in his 20s, argued: 'If I go to the doctor now [before being legalised], the doctor will only believe that I am making up something to get something else.' Ali was disappointed in how he had been treated in the reception centre. He had difficulties in sleeping, but did not visit a GP because he had lost faith that he would be treated as a patient in Norway and not merely as an irregular migrant.

There was a general feeling of being rejected by healthcare workers, which appeared to come both from personal experience and from rumours about other migrants' encounters with street-level bureaucrats. Many expressed that they felt mistrusted in general and believed they would not be seen as a patient, but foremost as a rejected asylum seeker, or as an 'illegal'. Ali told me: 'You always have to convince people that you are not lying when you are an asylum seeker. Even if you are sick, you have to convince them that you really are sick.' Such remarks suggest that the encounter between irregular migrants and street-level bureaucrats has become part of a social construction or verification of some people as being 'illegal' in Norway. Ali's reflection intimates that, independent of

'having' legal rights, people do not necessarily 'activate' their rights. Ali's impression that the doctor would assume that he had made up a story of illness for asylum purposes also draws attention to asylum seekers' and irregular migrants' experiences of being mistrusted: their narratives of flight and reasons for staying are scrutinised by the government and often discredited (Knudsen 1995).

The experience of being mistrusted shapes irregular migrants' decisions not to visit doctors or access other healthcare services. For example, Arzad, an irregular migrant from Iraqi Kurdistan, recalled that he had not returned to the Emergency Care Unit to have his stitches removed because when he had visited the ward with his hand bleeding, the healthcare personnel had asked several questions concerning his identity. 'If they asked all those questions when I was bleeding,' Arzad said, 'what then when I am not bleeding?' Instead, he had found instructions on YouTube for how to remove stitches and had done it himself.

Another migrant, Endale, who had lived as an irregular migrant in Norway for >3 years, no longer went to the emergency unit because of former humiliating and insulting experiences. He recollected his last experience with the receptionist at the Emergency Care Unit, who, Endale said, had looked at him with a 'bad eye, not [a] good eye'. He believed that the receptionist considered he had no right to healthcare and did not even provide an assessment of whether he needed medical care because he lacked identification papers. Endale and his friend had argued with her for a long time but eventually left the emergency room. His recollection of these events visibly affected his mood and frame of mind: Endale's body quivered and the otherwise-calm, balanced 40-year-old man was clearly angry. He emphasised that the incident had made him feel more ill.

Everyday practices by welfare state bureaucrats are experienced as boundary marking – between inside and outside, between deserving and non-deserving and between citizen/legal resident and illegal migrant. In this process, subjects may act as undeserving and illegal, as well as avoid seeking certain rights, although they might be legally entitled to such rights. In such ways, the border landscape becomes experienced or materialised through the body, which enacts 'illegality' in a process through which the border is internalised. It might be observed, then, that the irregular migrant embodies the border. Such practices of control have consequences for how irregular migrants position themselves in Norwegian society, what they do if they feel ill and how they understand their scope of action.

During fieldwork, I found four distinct ways in which irregular migrants responded to their (sick) bodies, which I outline here in relation to their use of specific *tactics*. These tactics, as further explained later, were creative access, self-care, ignoring symptoms and *raison d'être* – in which the sick body become the main purpose in life.

Tactic 1: creative access

During fieldwork, I witnessed creative ways of manoeuvring for entrance into the healthcare system, including the use of a legal resident's medical appointment by an irregular migrant. For example, Ahmed was an Iranian migrant who had lived >5 years in Norway. He was politically engaged and had a rather well-functioning social network. For a long time, he had felt dizzy and, finally, a friend who was living legally in Oslo took him to her medical appointment, asking the doctor (who was also Iranian) to examine him instead of her, telling me: 'A friend of mine gave me her medical appointment!' While

Ahmed might have hesitated to visit a GP also when living in Iran, he specifically explained that his reason for not doing so in Norway was the lack of money and difficult personal access to the healthcare system.

Using the HCUI can also be seen as a tactic through which irregular migrants access Norway's healthcare system. Some frequented the HCUI even when they had no symptoms. The healthcare volunteers considered that this was connected to a fear of becoming ill. Other migrants said that they organised healthcare through friends, some of whom also helped when payment was required. On one occasion, I went with two activists and two irregular migrants to the Emergency Unit: one of the latter had been feeling ill. This man registered using the ID of a person who had a resident permit in Norway – and was thus given access to a doctor.

These ways of accessing healthcare circumvent the rules and regulations and facilitate migrants in attaining healthcare, which most view as part of their human rights. However, these practices do not contest the government's policy of denying them this right. Additionally, such practices can also be detrimental to their own (and others') health, because using other people's ID for medical appointments risks the result that the two people's biomedical data may be assembled into one non-existent biological person.

Tactic 2: self-care

Some of the irregular migrants I interviewed took care of their health by exercising, taking vitamins and taking fluoride tablets to improve dental health. Ways of dealing with a sick body included visiting the church to pray and to be prayed for, or visiting friends. Several spent time with friends in order to forget physical pain resulting from illness. One young Somali man emphasised that he was seldom ill, and that he was concerned not to get cold. 'It is important in this situation, because one cannot live at people's places when one is sick', he stated. 'Thus, it is important to drink a lot of hot tea'. Another man, from Sri Lanka, said that he was afraid of going to the emergency unit – so he tried to keep himself healthy.

Self-care or preventive actions were sometimes entangled with 'traditional' advice from countries of origin about how to deal with sickness and the body. For example, Endale told me what he would do if he suddenly became ill:

First I treat myself; for example, in my pocket I always have aspirin, yeah, two headache aspirins.⁶ Sometimes I have gastric problems, so I drink milk to feel a little better. Sometimes I first buy just normal tablets in the pharmacy. After, if there is no solution, then maybe emergency care, maybe. First thing is to help myself And sometimes I use white onion [garlic], when I have headache problems In villages, we use this white onion.

Endale no longer used public healthcare because he had experienced humiliating situations that had angered him. Instead, he used self-medication, including traditional remedies from his village. His use of aspirin was a practice among most of the irregular migrants. Some migrants expressed that it was pointless to visit a doctor because they would 'only receive aspirin anyway', which seemed to be understood as a disparagement of the very idea that they were ill.

Citizens may also subsume to the practice of carrying painkillers in their pocket and become disappointed in GPs who only prescribe painkillers instead of looking at the cause of the problem. Thus, whether or not irregular migrants would experience that doctors

treated them differently if they became citizens is not certain. Yet, at this moment in their lives, the fact that they are not examined properly made them feel both not recognised and as if their sickness is not acknowledged. Furthermore, while pursuing self-care in relation to health can be considered as a disciplinary practice (Rose 1999) pursued by people independent of their legal status, in Endale's situation, self-care seemed to be more a last resort because he did not feel he was recognised as a potential patient. This suggests that how one responds to one's sick body is also a construction that takes place in relation to healthcare regulations and practices. Avoiding the healthcare system may become a way to avoid the risk of humiliation and medical bills, as well as avoiding being constructed as undeserving.

Tactic 3: ignoring symptoms

Several of the irregular migrants I interviewed were explicitly ignoring symptoms that could have been related to illness. During fieldwork, I stayed for some weeks with some Palestinian irregular migrants who demonstrated from a tent camp they had set up next to St. Jacob's Church in downtown Oslo (2011–2012) (Bendixsen 2017). Even when the young men described symptoms that could indicate illness, they did not want to visit a doctor or the HCUI. One young man had been to the health centre three times, but 'The second time I only went because a Norwegian woman insisted'. When I asked them why they did not visit a doctor or the HCUI, a majority said that their 'illness was of no importance', and that their status as irregular was a more pressing issue than their clinical status. They would go, most argued, when their asylum cases were settled. Until then, 'their health could wait'.

Importantly, as with the majority of the irregular migrants I spoke with, these were young males who might not have been eager in the past to visit the doctor back in their home country. Yet, they explained their reasons for not visiting healthcare institutions as being tied up to their irregular status and consequent precarious situation. Thus, while many of the young men might have (sometimes) ignored symptoms also in their country of citizenship, the reasons given for doing so in Norway were explicitly tied up to the government's treatment of them.

The tactic of ignoring symptoms of illness was also used by other irregular migrants who were not actively engaged in public protests. Attempts to ignore symptoms were frequently tied to their work situation: several, both male and female, migrants asserted that they could not be absent from their (informal) work. Zer, a 42-year-old Ethiopian, said: 'You just cannot become too sick'. Without a family in Norway, Zer was trying to make ends meet with the help of friends. For him, being ill was not an option, because in order to survive he needed to be able to work. As an irregular migrant, Zer could not work legally, so the only work available to him was in the informal labour market. Here, he had no rights to sick leave, and without the money he earned, he would not be able to buy food. Because there is no structure, socially or institutionally, that will care for irregular migrants if they become ill, a sick body creates an impossible situation: the non-citizen without any social rights must be capable of working to survive.

Why might we consider ignoring symptoms to be a tactic rather than submission to oppressive external realities? I view the act of ignoring symptoms as a practice through which irregular migrants reject the Norwegian State's act of denying them their rights. These acts are a form of response: 'I do not need what you are not giving to me, although it should be my right to have it'. In this way, irregular

migrants recapture some measure of control – that is, the situation becomes theirs to reject. This response also highlights the injustice done to them by rejecting their need for the healthcare that is not accessible to them. Thus, such tactics have the potential to challenge sovereign power, because they challenge the right of the state to exercise its power through not providing healthcare. I consider this as a tactic because it has an effect on the irregular migrant's understanding of his or her position in the world, but only potentially on the sovereign.

Tactic 4: contestations and the sick body as the *raison d'être*

Sometimes, the suffering or sick body becomes the basis for seeking asylum. Some migrants I met during fieldwork sought to change the negative result of their asylum application based on their child's, or their own, health condition.

The story of Farid – whose experience at the police station opened this article – exemplifies how the sick body can become the focus of attention for irregular migrants. When I met Farid at the HCU in Oslo, he had lived in Norway for 12 years and had not seen his family for 17 years. He had received several rejections of his asylum application but had not given up trying to obtain residence. He had collected medical papers from the healthcare centre, which confirmed his medical situation; he had letters supporting his application for residence based on his medical condition from his designated GP, who continued to see him even though he had no legal right to access healthcare.

During our interview, Farid focussed on his diabetes, which had become an increasingly important part of his everyday life. He believed that he had ended up with diabetes because of his life as an irregular migrant in Norway: 'The problem is if you don't live good, you are stressed all the time, you think all the time about family, you think all the time about everything. And you feel that you have lost everything when you arrived here'. Over recent years, his diabetes had become chronic, which required more complicated medication and increased self-care in terms of diet and control of his sugar levels. He believed that his diabetes had become chronic because he: 'could not live well. You have to treat the diabetes well, and I couldn't do that, so it got worse and worse'.

Farid often lived with friends, who also offered him dinners. While he appreciated his friends' kindness, it also meant difficulties with regard to his diet: 'I cannot decide what food to eat. What they have, I eat.'

Farid's case suggests that the reason for an initial asylum application can be very different from the reason for not wishing to return to the country of origin. While his health was not his reason for leaving his country, it is now Farid's main reason not to return. Farid believes that he can access better healthcare as an irregular migrant in Norway compared to what he can obtain in his country of citizenship. Thus, Farid's experience highlights how living conditions for irregular migrants can shape people's experience of future options, such as returning home. It also illustrates that irregular migrants' health situations are shaped not only by a lack of access to healthcare (because Farid had always had, or actively sought, access to healthcare). His ill health is shaped by more than the formal healthcare system: his accommodation, nutrition and psychological health were all interlinked with his (il)legal status.

Having or not having asylum rights was something that Farid carried on his body – which I call a diseased and politicised biology

because it remains outside the juridical possibility for requesting legal permit in Norway. In Farid's narrative, his sick body was 'upgraded' to being his *raison d'être*: it was the centre of his existence. Rather than neglecting or ignoring symptoms, they were the focus of his attention, and while seeking recognition for the sick body, it was transformed into a political body in three interrelated ways. Firstly, it became the focus for his legal status: the claim that he is not 'illegal' in Norway. Farid denied any characterisation of himself as 'illegal', by highlighting his receipt of medical treatment and because he had documented where he was living to the Norwegian police, in contrast to what he viewed as a popular image of 'illegal' migrants hiding to avoid the authorities. Secondly, Farid's sick body was the focus of attention during social encounters. He referred to his sick body during an argument with the police to retrieve his expired ID card from a policewoman: he explained the need for the Norwegian government to be able to document him in case he should fall ill on the street. Thirdly, Farid's sick body became the focus of his political claims: that he should be given refugee status. In his fight for regularisation, his sickness had become the defining basis of his asylum claim. Vulnerability, then, had become a 'resource' on which a 'legal' identification could be constructed. The identities typically assigned to the irregular migrant (victim, vulnerable and refugee) may be transformed in this process to an identity by which the individual can demand political recognition.⁷

The tactic of Farid is in direct contrast to the tactic of self-exclusion from healthcare (by pursuing self-care or ignoring symptoms). His engagement with the healthcare system is based on the privileging of the suffering subjectivity over political agency. While in France, irregular migrants can apply for a residence permit under an 'illness clause' (Ticktin 2006), in Norway, there is political reluctance to grant residence for health reasons, mostly because of the fear that it would encourage 'health tourism' or 'health migration'. Ticktin (2006) has showed how, in France, migrants stop taking their HIV medicines to avoid getting better, because their legal permits in France are tied up to pathologies of life-threatening consequence. The logic behind the law was humanitarian; if deportation had consequences of extraordinary gravity, such as death, the French state would not deport people. The humanitarian clause in France means that there are possibly more irregular migrants whose sick body becomes the reason for being in France compared to the situation in Norway. While I did not meet many irregular migrants pursuing this tactic in Norway, Farid's case remains relevant as an important instance of how the body is made political by and for the irregular migrant.

Conclusion

In the encounter between irregular migrants and healthcare institutions, the provision of healthcare has become entangled with migration policies, the construction of difference as well as the construction and microcontrol of 'illegalised' bodies. Through various means, including laws that limit healthcare rights, the Norwegian government seeks to prevent 'bogus' asylum seekers from arriving in Norway and encourages rejected asylum seekers to leave Norway as soon as possible. However, rather than leaving, the people I met during fieldwork sought various ways by which to remain in Norway and, ultimately, to gain a legal right to remain.

Governmental practices, regulations and public discourses that construct irregular migrants as undeserving subjects, potential criminals and non-tax contributors shape how irregular migrants experience encounters with governmental institutions, such as the

healthcare system, and consequently their choices and actions when they are ill. Subtle and un/conscious practices, which are experienced as humiliating for irregular migrants, may further constrain perceived options in contexts wherein issues of morality and legality are often entangled. Through such experiences, irregular migrants may become accustomed to the notion that their status as an 'illegal' migrant overrides their status and needs as a patient.

As a consequence, while some use creative tactics to gain access to healthcare, others avoid clinics and doctors and instead use tactics that confirm their lack of rights and position as 'illegal' (creative access and pursuing self-care). In this sense, irregular migrants take part in their own subjectification as 'illegal' bodies without rights in Norway. Ignoring symptoms is another tactic that can be a way to contest the right of the state to exercise its power through not providing healthcare.

This research, then, highlights some ways in which experiences of 'illegality' are constituted, and how micropractices of control shape the health and well-being also of those who are not members of the welfare state. Some of the responses to the micropractices of control contribute to self-exclusion from the healthcare system. Irregular migrants' responses risk the border being enacted on their bodies, through the boundary marking of their illegalisation, which is thus produced and performed by both the welfare state and themselves. In such instances, the migrants' tactics comply with disciplinary power – embodying the 'illegal' stigma of their subject position as produced by the government.

Yet, other responses to the micromanagement have the potential to refute sovereign power. Sovereign power claims the monopoly to violently repress certain forms of behaviour. Resistance against sovereign power is thus about breaking commands of repression or circumventing the sovereignty of power centres. Both the tactics of creative access and the body as *raison d'être* can be understood as undermining sovereignty because these practices refuse the sovereign categorising of them according to the binary logic of citizen/'illegal', and they refuse the sovereign construction of reducing their life into mere biology. Both tactics may contribute to restoring a political life.

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All the mentioned tactics constitutes a diseased and politicised biology insofar as the practices that I have discussed on accessing healthcare ultimately concerns the biological functions and illnesses of the body and ways to care or not care for the body. These are means of resistance, contestations and practices of everyday survival. While some of these tactics are ways to get along without (much) rights to healthcare, some of these tactics contest and might disrupt how irregular migrants are defined and treated by the government in the longer run.

Notes

1. All names have been anonymised.
2. Other studies have used the notion of tactics, for instance, in relation to Chinese migrants working as prostitutes in Paris (Lévy & Lieber 2008) and in exploring how irregular migrants use tactics to counter migration control in the UK (Allsopp, Chase & Mitchell 2014; Gill et al. 2014).
3. In Norway, refused asylum seekers are allowed to continue living in reception centres and will receive a limited sum of economic benefits.
4. Children, pregnant women, prisoners and persons with communicable diseases are granted some additional rights.
5. Children under the age of 18 years and pregnant women who do not have right of residence have some additional rights granted by the authorities, who – in this regard – refer to the Convention on the Rights of the Child (CRC) and the practice of Committee on the Rights of the Child (Søvig 2011).
6. Aspirin is normally used for the relief of headaches and other minor aches and pains.
7. Another identity typically assigned to the irregular migrant is that of 'criminal'.

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