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Introduction to *A Research Agenda for Migration and Health*

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Over the past few decades, the number of immigrants and migrants has grown, with the proportion of people living outside of their country of birth rising from 2.8 per cent in 2000 to 3.3 per cent in 2015 (UN DESA, 2016). Major sending regions include North Africa, Asia and Latin America, while both the developing world and developed world are important destinations. This growth in the number of migrants can be explained by a number of factors, including the neoliberal globalization of trade, finance, production and culture; the emergence of new transportation and communication technologies that have eased communication and reduced the cost of travel; the existence of inequalities in people's lives and opportunities; and local or regional conflicts that have resulted in massive forced population displacement, with the United Nations High Commission for Refugees (UNHCR) estimating some 68.5 million people are forcibly displaced worldwide, including 25.4 million refugees, 40 million internally displaced persons (IDPs) and 3.1 million asylum seekers as of 2017. South Sudan, Afghanistan and Syria were the top three sources for refugees during the same period.

At a global scale, population migration is at the highest levels ever recorded, making immigrant and refugee movement one of the most pressing social, economic and humanitarian issues faced by countries around the globe. Fundamentally, migration includes both forced and voluntary movement. In the latter case, individuals commonly move for economic reasons, including employment, better pay and related economic opportunities, while persecution, violence and, increasingly, environmental reasons are forcing relocation across space. While such population movement raises a number of questions, including access to food, security, shelter and legal status, the concept of 'immigrant health', or the health of immigrants, has received increased attention from academics and policy makers alike. Such interest is hardly surprising given the greater attention associated with immigration in general, including immigration policy along with acculturation and settlement issues, but also due to events such as Europe's 2015 refugee crisis, moves by the United States (USA) to deny access for individuals coming from selected Muslim countries, and talk about undocumented migrants and building border walls. For receiving countries, questions around the quantity of health care consumed, the type of health care consumed, barriers to accessing health care, use of preventative services, mental health, increased refugee flows (and the perceived greater

vulnerability of refugees) and other questions drive research to consider health within the immigrant populations.

Migration and health: a research trajectory

'Space and place affect people's health, well-being, and access to and experiences of health care' (Crooks et al., 2018, p.1). In many ways, this quote succinctly draws the connections between migration and health. Not unexpectedly, migration and human mobility impact health through physical means, including access or use of health services, as well as impacts on mental health, particularly when migrations are forced or made under stressful situations. In addition, population movement has implications for both the sending and receiving societies. For receiving countries, immigrants may embody different levels and perceptions of health, as exemplified in the healthy immigrant effect. For the sending societies, the literature has often documented that it is the healthier and younger population that moves, while an older and less healthy population is left behind.

While it is difficult to adequately or fully summarize the state of knowledge related to migration and health (with a large probability that we will invariably miss something or someone), there is a long- and well-established interest in the relationship between migration and health. Indeed, as Darlington-Pollock et al. (2018, p.59) point out, 'population movements have long been associated with the spread of disease' and 'this fear of diseased migrant bodies persists today'. Darlington-Pollock et al. go on to argue that this history of research has implications for research that is conducted today.

Echoing broader trends in health geography (see Andrews et al., 2012; Elliott, 1999; Kearns, 1993; Kearns and Collins, 2010; Kearns and Moon, 2002) and other disciplines, early research into immigrant health often considered broad patterns to describe use of the health care system by immigrants, their changing health needs and the barriers to care. Early work was often grounded in positivistic thinking that explored health-service use and access to care. While finding broad similarities across space, such studies were more often than not based upon evidence collected in the developed world. For example, early immigrant health research often relied on large, representative data files and focused on the health of the immigrant population after arrival in the destination country (see Dunn and Dyck, 2000; Fennelly, 2007; Globerman, 1998; Gotsens et al., 2015; Jasso et al., 2003; McDonald and Kennedy, 2004; Newbold, 2005). Commonly referred to as the 'healthy immigrant effect', the literature suggests that immigrants – at least in the developed world – are typically healthier and are less likely to report chronic conditions or impairments than individuals born in the destination country (De Maio and Kemp, 2010), a pattern that most likely represents their age (immigrants and migrants are typically young adults and in good health), along with health screening by the destination countries. However, the health of these new arrivals is typically observed to decline rapidly after arrival (Farré, 2016; McDonald and Kennedy, 2004).

Despite ongoing debates within the literature over whether the healthy immigrant effect is real or not (Barcellos et al., 2012), it has been observed across a number of immigrant groups (including refugees), in a variety of countries and for a range of health outcomes, including mortality, chronic conditions, self-assessed health and mental health (Farré, 2016; Ng, 2011; Stafford et al., 2011; Trovato, 2003; Vang et al., 2015).

Beyond changing health status, researchers have also explored health relative to the broader determinants of health, and issues including access to and use of health care, mortality and survival (see, for example, the edited volume by Trovato, 2017), public policy (Raphael, 2016), reproductive health, and gender and health, amongst other research questions while continuing to use large data files. For instance, barriers such as language, insurance, transportation, cultural roles and system knowledge have frequently been identified as significant barriers to individuals and their health (Asanin and Wilson, 2008; Winn et al., 2018). Other work has documented significant differences in health, health perspectives and health/health care experiences by gender (Llácer et al., 2007; Vahabi and Wong, 2017), including reproductive health care issues amongst immigrants.

With time, research questions have gradually shifted to consider a number of different themes and methodologies within the broader context of immigrant health. Within geography, the research agenda has turned away from a bio-medical framework and towards a more richly informed theoretical socio-environmental perspective that emphasizes social theory and the role of place (Kearns, 1993), transforming medical geography to health geography (Crooks et al., 2018). At the same time, a greater emphasis on the social determinants of health, including perceptions of the quality of life of newcomers, entered the discussion (Williams et al., 2015), the relationship between neighbourhoods and health (see Asanin and Wilson, 2008), and transnational health care seeking and behaviour (Wang and Kwak, 2015). Concurrent with the changing focus of research questions was the greater use of qualitative methods to better understand the processes that were shaping health, providing more detailed and nuanced understandings.

Still, much of the research into the immigrant experience has been conducted in the developed world, and it is only much more recently that researchers have turned their attention to the experiences of immigrants in the less developed world. Such a move on the part of researchers is an important step given that many immigrants and refugees either originate or settle in the less developed world. In particular, low- and middle-income countries host 84 per cent (22 million) of all refugees and asylum-seekers globally (UN DESA, 2016).

Chapter overview

In many situations, the health of an immigrant or refugee reflects an observation at a particular point in time. The challenge for researchers, however, is to recognize that

health is an evolving concept, and one that is shaped by their experiences in their origin countries, the immigrant journey and, ultimately, their experiences in their country of residence, increasing the complexity of the task of identifying health issues.

Given that we live in the 'Age of Migration' (Castles et al., 2013), the need to understand the health of immigrants grows stronger. The following chapters seek to explore the next generation of questions that health and immigration scholars could address. Researchers have, for example, largely explored the concept of barriers to health and health care. But how, for example, do we move beyond and overcome these barriers? Are there best-practice examples and what are they? How can they be applied in different settings? These are just some examples of how researchers can move the agenda forward with respect to immigration and health research.

The following chapters are organized around multiple non-exclusive themes. Several chapters, including Chouinard (Chapter 2), Stelfox and Newbold (Chapter 7) and Hennebry and Walton-Roberts (Chapter 6), take a gendered look at immigration issues. While much of the established research focuses on the developed world, chapters by Wang (Chapter 3), Osei-Twum, Pulfer and Banerjee (Chapter 9) and Chouinard include discussions of immigration relative to the Global South. Each chapter provides an overview of particular research areas, before presenting agendas for further research.

Many nations, including developed nations, receive large numbers of care workers through targeted migration schemes. While the gain of human capital is seen as beneficial for receiving countries, what are the implications for sending countries? It is easy to imagine that the loss of human capital – a 'brain drain' – means that nations losing skilled workers, including health care workers, will be disadvantaged, with their own citizens placed at risk. Chouinard's chapter explores the linkages between migration, health and disability in the Global South through a case study of the outmigration of skilled health professionals from Guyana, along with the consequences for disabled individuals who are left behind.

Wang's chapter on health care access among immigrants and transnational migrants takes a somewhat different perspective on the relationship between north and south or developed and developing countries. By drawing on the concept of transnationalism, Wang considers three broad themes, including the culturally diverse health care workforce, transnational health care seeking among migrants, and aging and health care access in the context of transnationalism and globalization. The implications of each are drawn out in her discussion.

Hunter and Simon (Chapter 4) maintain the focus on less developed nations through their chapter, which unpacks the relationship between climate change, migration and health. While there is significant discussion within the literature that climate change will unleash a flood of internal and international migrations, Hunter and Simon argue that the relationship between climate change and the

decision to migrate is a much more complicated one than is often portrayed based on work that looks at migration between Mexico and the USA. Moreover, the 'healthy immigrant effect' may be less important in cases where social ties and networks reduce the costs of migration, meaning good health is less relevant to the migration decision. Consequently, Hunter and Simon argue that the relation between migration, health and climate requires further research in order to inform policy and programmes that are intended to respond to climate change.

Of course, not all migrants come to stay, with many individuals migrating for shorter periods of time either by necessity or by choice. Amongst those workers who enter a country for a short period of time to work, there is an important linkage between health and the labour and living conditions that they are faced with. The chapter by Hanley, Park, Gravel, Koo, Malhaire and Gal (Chapter 5) focuses on temporary foreign workers (TFW) and their access to health care, recognizing the importance of agency, as well as their strategies to increase access to health and well-being.

While migration and immigration flows have typically been male dominant, they have become increasingly feminized given women's roles in the health care and service sectors. Continuing the notion of agency, and using a gendered lens, Hennebry and Walton-Roberts examine the balance between women's economic contributions and their experienced health impacts, focusing on how their transnational status challenges their ability to access health services and exercise their rights to social protection, with particular attention to sexual and reproductive rights, mental health issues, and specialized supports and health care for women who are often engaged in precarious roles.

Stelfox and Newbold explore the concept of cultural food security amongst immigrants and how it can best be addressed. After arrival in the reception country, immigrants are faced with numerous challenges, including access to food. Indeed, food is not only relevant for health, but is also a critical component of culture and emotional well-being. Yet, many immigrants and refugees are vulnerable to a decline in nutrition, health and overall well-being after arrival.

Although there is a strong and growing literature associated with immigrant health, Kobayashi and Deng (Chapter 8) note that it is often uneven, leaving multiple areas for further research. For example, given the over-representation of Asians within existing work, there remains a need for comparative research that includes non-Asian immigrants. Additionally, Kobayashi and Deng call for further research on the relationship between racialization and health.

The ethnic and cultural diversity of immigrant populations in many countries raises questions on how best to provide health care. Within the literature, concepts such as 'cultural competence' or 'cultural awareness' have been proposed as ways to reduce barriers to health care and improve satisfaction with the health care experience. The final chapter by Osei-Twum, Pulfer and Banerjee unpacks the various ideas of culture, cultural awareness, cultural sensitivity, cultural competency,

cultural humility and cultural safety. The latter concept – cultural safety – is one that originated from indigenous peoples' experiences, with the authors arguing that cultural safety can inform health research with immigrant groups by creating opportunities for health and well-being.

What next? Additional research questions and needs for the next generation of research

In considering these potential research questions, it is important to remember that they are just that – potential research questions that could (and should) be pursued. These chapters provide our readers with a list of contemporary and important research questions that must be asked if the area of migration and health is to be advanced. The reader should be cautioned, however, that the questions posed in this book do not limit the areas of exploration, with new research directions and questions regularly appearing. At the time of writing this book, for example, the Trump administration in the USA had taken to separating children from parents as they tried to cross the border into the USA from Mexico. Many of these children would be detained for months without knowledge of where their parents were or what their status within the USA would be. Indeed, some of the children detained by US officials were too young to verbalize their fears. Instead, images and sounds of children crying for their parents could be seen and heard. For researchers, the pressing questions that come out of this reality are, unfortunately, plentiful. What will be the long-term implications of this forced separation? How will children develop and adapt in the coming years? What are the impacts on their mental health and resiliency?

Similarly, the Trump administration has also provided rich research questions in multiple other areas related to immigrant health. Take, for instance, the administration's move to end temporary protected status (TPS) for Nicaraguans, Haitians, Salvadorans and others. Individuals resident in the USA under the TPS programme faced a deadline to either leave the country or seek lawful residence in the USA. In the interim (and given that their future legal status in the USA was far from certain), the termination of the programme creates individual and societal impacts for individuals now faced with the prospect of return and whose future is now far less certain as lives, relationships, careers and futures are placed in jeopardy. At the societal level, ending TPS is also problematic for their home countries, as they may not be able to absorb returnees. At the same time, many of the countries that individuals with TPS status arrived from are heavily dependent on remittances that are sent home to help support extended families, with the World Bank estimating that Haiti received US\$2.359 billion in 2016 alone. Opportunities for researchers in the mental and physical health of these individuals, as well as their ability to reintegrate into their home economies and culture, abound.

But it is not only the USA that provides researchers with case studies and examples. Recent events in Europe, including the European refugee crisis of 2015 as well

as more recent events and changes in European politics, also provide opportunities for research, including consideration of how immigration policy is framed in a multinational environment, the adjustment of refugees into a society that has shifted sharply right on the political spectrum, and other questions. Elsewhere, the plight of Rohingya refugees (Muslims forced to relocate out of Myanmar and into Bangladesh), and other refugee groups including Syrians, Afghans and others, create opportunities for research. While many such research avenues could explore relatively short-term agendas, others will (and should) consider the longer-term implications of these events and on the individuals and families that experience them. More broadly, therefore, additional research attention must be placed on refugee health given their already vulnerable and precarious health situation and the challenges they face. In particular, studies exploring mental and physical health issues within refugee camps are needed, given implications for resource availability and delivery, public health, and the short- and long-term health of refugees settled in these locations. In this way, the importance and role of place, including transit route, refugee camps and settlement, in health outcomes is prioritized. Clearly, research in refugee camps will be challenging, but will also be rewarding as new insights are gained.

The health of refugees is also exceedingly complex, reflecting what Newbold and McKeary (2018) defined as their ‘journey to health’ as they travel from home through refugee camps and other tenuous situations to their (hopefully) final destination. Although civil war, violence and persecution are often identified as the primary causes of refugee movement, climate change is increasingly implicated in population displacement. The concept of ‘environmental refugees’, or people who have been physically displaced from their homes and livelihoods by the effects of climate change, is a relatively new one that is not currently recognized under the 1951 United Nations Convention Relating to the Status of Refugees, and the 1967 Protocol Relating to the Status of Refugees. As such, people displaced due to climate change are not counted in the official refugee numbers, but can be found in places where the environment has been degraded due to changing precipitation patterns and increased drought, rising sea levels and increased frequency of severe weather. It is argued that such events may ultimately generate tens of thousands of environmental refugees.

There are multiple examples that highlight the relationship between climate change and refugee flows. In Africa, it is expected that reduced precipitation will result in increased desertification of large portions of the continent, leading to the displacement of some 135 million people based on projections by the United Nations Food and Agricultural Organization. Likewise, the Fourth Assessment Report of the Intergovernmental Panel on Climate Change (IPCC, 2007) predicted the displacement of hundreds of millions of people due to climate change by 2080. The resulting movement of environmental refugees into neighbouring countries will strain existing infrastructures and social relations. Recent work by Missirian and Schlenker (2017) reinforces this linkage, finding that weather conditions – hotter than normal temperatures and drought – were directly associated with

refugee flows into Europe. Missirian and Schlenker further argue that the number of refugees will increase as climate change changes weather patterns and global temperatures in the coming years. Of course, many of those displaced due to climate change will never actually leave their home country. Instead, they will be displaced within their country (so-called internal displacement), which brings with it its own concerns. Again, opportunities for researchers to explore the health implications of their forced displacement will add to the literature.

Finally, new research methods, theories, data and collaborative interdisciplinary work will enhance our understandings. That is, the research agenda requires health geographers, sociologists, anthropologists, economists and others to work together to explore and understand these pressing questions. Researchers should also frame their work within the diverse set of theories including (but not limited to) feminist, social or Marxist theories, or new frameworks such as intersectionalism. A critical piece that is only indirectly raised in the subsequent chapters is the importance of data and the types of data that can underlie research. Large, representative data sets will always have a place in the research agenda, providing the power of numbers and generalizable results. Concurrently, qualitative data and methods will provide detailed and nuanced understandings by focusing on the lived experiences and outcomes of immigrants and refugees. But, something as simple as defining who a migrant is becomes critical, as we must consider the timing of the migration, the distance involved, whether it is permanent or temporary, forced or voluntary, as well as other contextual information. Additionally, there is the need for comparable definitions to be used if one of our ultimate goals is to build a richer understanding. In particular, longitudinal or cohort data (as compared to cross-sectional data) offer far greater opportunities of the relationship between migration and health over time, enabling researchers to focus on health over the life-course and places/times where health is most vulnerable to disruption (Vang et al., 2015).

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