Introduction

Nadia El-Shaarawi and Stéphanie Larchanché

Migration is one of the defining issues of our time. The beginning of the twenty-first century has been characterized by a consistent increase in the number of people on the move and it seems that in nearly every year in recent memory, the United Nations reports a record increase in global migration. In 2020, for example, the UN reported that an estimated 281 million people around the world are international migrants (International Organization for Migration 2022). Yet such numbers do not provide us with the full scale of human mobility; excluded from this number are the hundreds of millions of people who migrate without crossing state borders, for reasons that include mobility for work or education, as well as fleeing from conflict, persecution, or environmental degradation, among others (International Organization for Migration 2020). As a dynamic and multifaceted process, migration affects individuals, families, communities, and societies across time and space in myriad ways. In this volume, we bring together anthropological scholarship that addresses one domain of these complex processes: the intersection of migration and health. In doing so, we seek to consider both migration and health from an inclusive, holistic, and critical perspective, undoing conventional ideas of the connection between these two vital topics and questioning some of the usual borders that are applied to both scholarly and public conversations on the topic. We ask: how is migration a health issue, and vice versa, how is health impacted by migration?

This edited volume explores, and challenges, the various borders of health and healthcare as they appear in the context of migration, while also unsettling some of the boundaries that structure conversations about human mobility and movement. The motif of challenging borders appears as powerfully evocative of contemporary migrants' experiences (Agier 2016), and we use it as a thread to help think through the challenges migrants face in attaining health and accessing healthcare as well as their efforts to transcend such boundaries. While readily construed as geographical and physical, borders can also be social, economic, political, historical, discursive, ideological, and disciplinary. These less visible borders may act more insidiously, as they constrain our thinking and inform scholarly policy and discursive responses to migration and migrants at different scales.

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Despite the proliferation of scholarship on this topic, thematic, regional and sub-disciplinary boundaries have limited the extent to which the diverse anthropological perspectives on migration and health have come into conversation with one another. We argue that transcending such boundaries allows for a fruitful and more critical understanding of the intersections of migration and health, one which offers new ways of reckoning these two crucial topics both within, and beyond, academia. While the contributors to this book are all anthropologists, their work crosses subfields and addresses topics often not brought together. The work in this volume shares some anthropological hallmarks that we believe contribute to a rich understanding of the stakes of migration and health: long-term ethnographic fieldwork, locally situated analyses, and attention to the understandings and theorizations of our interlocutors, whether they are people on the move or health care providers. The contributors to this volume also draw on and contribute to what must, by definition, be a multidisciplinary conversation, as investigations of both migration and health draw on the expertise and experiences of scholars and practitioners in a wide range of fields. We hope this volume will be of interest not only to anthropologists, but to anyone interested in understanding the relationships between these two domains that are so vital to human life and its ability to flourish.

In this introduction, we begin by laying out our two key domains of interest, migration and health. Then we survey the landscape of contemporary global migration by describing current migration statistics and trends. We next discuss and, in the spirit of this volume, challenge the various categories used to describe migration and people who move. We complicate each of these categories, briefly discussing what they offer but also what they obscure. Next, we briefly survey the existing literature on the health effects of migration. We then turn to the larger theoretical motif of the volume, challenging borders. Finally, we describe the organization of the volume and review the contributions.

Thinking with Migration

As suggested by the subtitle of this book, our view of migration is expansive and transcends boundaries and categories that are often kept separate in scholarship, policy, and public debate. Indeed, there is no single, agreed-upon definition of the term "migration" or consensus about who is included in the category "migrant." Instead we see a proliferation of categories and terms used to define and describe people on the move; these terms structure how people are treated, often in violent and exclusionary ways. They also structure the terms of academic and public debates, which frequently end up mirroring and replicating these categories. To provide just one prominent example, despite the widely accepted critique that the separation between "refugees" and "migrants" does not represent the actual experiences and motivations of the people these categories describe, refugee studies and migration studies are often held apart as distinct fields, each with its own journals, conferences, and conversations. We argue that bringing together areas that are often kept siloed from one another creates fruitful possibilities for understanding the interlocking health effects of migra-

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tion while also rendering visible significant differences that occur as a result of legal status, class, racialization, national identity, gender and sexual orientation, ability, and age, among others.

Counting and Classifying Migration

In order to trouble them later, we begin by sketching some of the existing ways of classifying and discussing migration. Broadly, migration refers to the movement of people from at least one place to another. But this general category encompasses a great diversity of experiences, practices, actors, institutions, and policies, each with different implications for questions of health and well-being. For example, the temporality of migration is one important dimension of comparison. People may move from one location to another and plan to stay permanently, or move for a temporary period, or travel seasonally between one or several locations, often for work. Journeys may take hours or years and may include multiple legs of travel as well as periods of waiting or transit that themselves can last years in some cases. The directionality of mobility is also variable. We often imagine migration to be linear and move in one direction, but it can also be circuitous, circular, or bi-directional. People may cross state borders, but, as mentioned above, most migration occurs within the borders of states. Who travels also varies: individuals, families of various configurations, and larger collectivities all migrate. The term "migrant" is sometimes applied to people who do not actually migrate, for example the children of immigrants or stateless populations who have been denied the rights and recognition associated with citizenship.

In this introduction, we use the term "migrant" in an inclusive way, irrespective of legal or social status. While recognizing its limitations, we have chosen this term partly because it is the most expansive term available, able to encompass a range of legal statuses and experiences, and partly because we seek to contribute to its destigmatization. At times, when describing particular policies, and especially in this section, we refer to the legal and political categories by which migrants are categorized. Doing so creates a tension: we acknowledge how these categories are used to govern and divide migrants, positioning some as deserving (Willen 2012) while irregularizing or illegalizing others (Jansen, Celikates, and Bloois 2015; Coutin 2003; Ngai 2014). At the same time, the policies and categories, themselves historically and politically constituted (Hathaway 2007), come to shape the subjective experiences and social and political positioning of migrants, with important implications for their well-being. If we take the structural determinants of health into account, one might argue that migration policy is always already policy that affects health and well-being. Anthropological research has been instrumental in documenting how processes of classifying and categorizing migrants themselves can have deleterious effects for mental health and well-being, especially when such processes interpolate migrants as security threats or criminals (Haas 2012). It is therefore important to document, empirically, the role that such categorizations have in creating differential experiences and status for migrants without taking the categories as natural or given.

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Mindful of this variation and complexity, we begin this section with a brief snapshot of global migration trends, while also introducing some of the principal challenges of counting and classifying human mobility. Human migration is an age-old phenomenon that stretches back to the earliest periods of history, but its scale and its impact have changed with globalization, especially the proliferation of technology that renders migration more accessible (and at times is weaponized to make it more difficult) and global inequities that alternately make migration more necessary and difficult for some and easier for others.

Today, we are also able to access more information on migration and displacement. It must be stated, however, that there are challenges to collecting data on global migration, and therefore these figures must be viewed with caution. For a number of reasons, statistics do not always accurately reflect migration, either at a global, national or local scale. First, a person's immigration status can be fluid and change quickly, depending on the circumstances and local legal/policy settings. For example, many international migrants who may be described as "undocumented" or "irregular" enter countries on valid visas and then stay in contravention of one or more visa conditions. Second, in contexts where migration is criminalized, people have incentives, often existential ones, to avoid being enumerated, since to be counted might put them at risk of deportation, detention, or other punishment. Third, there is tremendous variation in terms of which agencies or institutions are responsible for migration. States and international organizations have different immigration policies, definitions, and ways of collecting data on migration, all of which makes it difficult to establish a harmonized approach to documenting migration globally. At times, the under- or overestimation of migration is part of a political strategy on the part of politicians or governments.

With these cautions in mind, certain empirical trends provide a general picture of contemporary global migration. The population of international migrants—people who cross at least one state border regardless of the cause of their mobility—has increased but remains relatively stable as a proportion of the world's population, approximately one in every thirty people (International Organization for Migration 2020). Close to half are women (48 percent), and 14 percent are children, 164 million are classified as migrant workers, 25.9 million are refugees, 41.3 million are internally displaced persons, and 3.9 million are stateless persons (International Organization for Migration 2020). Most international migrants (74 percent) are of working age (twenty to sixty-four years old). Europe and Asia currently host the largest number of international migrants, followed by North America and Africa. The impact of international migration on population change varies from one region to another. For example, in Europe, where the rate of proportional population change is the slowest, international migrants can be said to have mitigated decreasing populations in many European countries where birth rates are declining. Meanwhile, in Africa, steady population growth was reduced by emigration from the continent to other countries.

In international and much national law, refugees, as a particular category of cross-border forced migrant, are classified separately from other international mi-

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grants. Under the 1951 Refugee Convention and its 1967 Protocol, refugees are people who have crossed international borders seeking protection because of persecution on the basis of either race, religion, nationality, political opinion, or their membership in a particular social group. In both Africa and Latin America, regional conventions have broadened the definition of a refugee to include people fleeing war or generalized violence. In all cases though, a person's ability to claim protection and legal status is dependent on the non-voluntary nature of their displacement. As people understood as outside of the territorial bounds of the nation-state, and therefore unable to make political claims on the state (Malkki 1992), they lack what Hannah Arendt has referred to as "the right to have rights" (Arendt 1986). While the Refugee Convention sought to address this imbalance and ideally provide temporary protection with the goal of eventual reincorporation of the refugee within a national community, in practice contemporary asylum falls seriously short of this ideal.

Internal migration or displacement, as mentioned above, occurs within state borders and accounts for the majority of global migration although it is usually less regulated and harder to quantify. While we do not often think of internal migration as involving border-crossing, it is important to recall the history of control and criminalization of migration within particular states, including in apartheid South Africa or the Soviet Union, for example (Light 2012). Rural to urban migration makes up the majority of internal migration and is also frequently for work and study. Indeed, many of the early anthropological studies of migration focused on exactly this kind of mobility (e.g., Feldman 1975; Mangin 1970). However, internal migration can also take place from urban to rural or suburban locations. Internal displacement occurs when people are forced to flee as a result of conflict, disasters, environmental degradation, or development projects, among other causes. The Internal Displacement Monitoring Centre estimated that, at the end of 2019, 50.8 million people were internally displaced. Most of these people (45.7 million) were displaced as a result of conflict, although a sizeable number (5.1 million) were displaced as a result of disasters (Internal Displacement Monitoring Centre 2020).

Of course, internal and international migrants are not discrete, separate categories of people and the internal-international dichotomy is one of the borders that this volume seeks to unsettle. People often become internally displaced before becoming refugees or after they attempt to return to the country from which they fled. Secondary migration—when immigrants or refugees voluntarily move from one location to another within a country—is also common. For example, when refugees are resettled to the United States, they are initially assigned to specific locations but then often move on to other cities and towns where they find greater economic opportunities, more affordable cost of living, or to join family or community (Besteman 2016; Ott 2011).

Statelessness represents another set of conditions and experiences that is not well-addressed by existing structures, policies, and institutions. By definition, stateless people are in a vulnerable situation, as they are not recognized as nationals by any state. Whether the condition occurs as a result of gaps in citizenship laws, the

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creation of new states, or systematic and violent mass denationalization of particular groups of people, stateless persons face obstacles in accessing basic services—such as education, employment, or health care—and can suffer discrimination, abuse, and marginalization. While stateless persons are not necessarily migrants, their vulnerability and lack of rights may lead them to migrate, internally or across borders, and often irregularly, given the significant obstacles they can face in accessing travel documents and regular migration pathways. As part of its statelessness mandate, the United Nations High Commissioner for Refugees (UNCHR) reported 4.2 million stateless persons globally in 2019 (UNHCR 2020), however, this number is likely to be a significant underestimate because fewer than half of all states report statelessness, including some of the countries known to have the largest stateless populations. A pressing example of a population facing contemporary statelessness is the situation of the Rohingya, many of whom are internally displaced within Rakhine State in Myanmar or have sought safety in Bangladesh. Bangladesh and Myanmar were the countries with the first and third largest populations of stateless persons, respectively, in 2018 (around 906,000 stateless persons in Bangladesh and 620,000 in Myanmar) (UNHCR 2019). The combined burdens of statelessness and displacement have significant impacts on the health of Rohingya people as well as their ability to access health care (Ahmed et al. 2018).

Shared Stakes, Divergent Experiences

The discursive framings of migration, especially how people on the move are categorized as deserving or undeserving of international protection, inclusion, and rights, shape how states and other actors respond and have significant effects for migrants' lived experiences (Holmes and Castañeda 2016; Yarris and Castañeda 2015). Migration that is variously described as illegal, undocumented, unauthorized, irregular, or even "mixed" is often, if not always, discursively positioned as "undeserving" of rights and assistance (Willen 2012). Yet even those people who are categorized as refugees or (especially) asylum-seekers are not immune from being understood as undeserving (Fassin 2005), untrustworthy (Daniel and Knudsen 1995), or threatening (Papastergiadis 2006).

Perhaps one of the most powerful—and troubling—categorizations shaping the politics of deservingness in migration links assumptions about choice and agency to questions of migrant deservingness. This distinction is enshrined in international law and reflected in much of the policy and public discourse surrounding migration. According to this categorization, forced migrants (refugees) are compelled to seek protection by violence and persecution, while "economic" migrants choose to move in pursuit of better livelihoods. In this volume, we follow Kristin Yarris and Heide Castañeda's (2015) powerful challenge to the dichotomy between "forced" and "voluntary" migration. Although they are often treated as such, neither of these categories can be cleanly mapped onto distinct populations, as Elizabeth Marino and Heather Lazrus illustrate in their chapter in this volume. The categories themselves emerge from particular legal, political, and economic histories and their application to specific populations changes over time and are often more reflective of contempo-

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rary geopolitics than they are to the actual lives of the people they describe (Coutin 2011; Horton 2004).

Migration is a result of a complex interplay of acute events and longstanding global processes, personal and familial aspirations, and structural inequalities. For example, protracted and new conflicts have led to record levels of displacement, both in terms of the number of refugees and asylum-seekers and internally displaced persons. The total number of persons internally displaced by conflict and violence has almost doubled since 2000 and has risen sharply since 2010. But it is climate and weather-related disasters that triggered the vast majority of all new displacements, such as storms, floods, and droughts. Climate change must thus be taken into account as a central factor in contemporary migrations (Faas et al. 2019; Hastrup and Olwig 2012), and it will continue to trigger major changes for human organization at large (Oliver-Smith and Hoffman 2019). Climate change and environmental disasters are not, as anthropologists have noted, exclusively natural phenomenon, but are shaped and exacerbated by human action and inaction. Vulnerable and marginalized populations typically bear the brunt of dispossession associated with environmental catastrophes and climate change. Underlying more acute causes, globally ever-deepening socioeconomic inequalities and environmental destruction associated with structural forces of neoliberal capitalism and imperialism underpin much of the impetus for migration.

Given the role of broad structural inequities in shaping migration, and its current prominence in local, national, and global politics, it seems clear that migration, if differentially experienced, is part of our shared human condition. This shared quality of migration remains true even though the majority of the world's population remains either unable or unwilling to migrate. However, debates about migration tend to tacitly assume that migration policy only affects people who move. In her recent book on mixed-status families in the United States, Heide Castañeda illustrates how the precarity and illegalization of one undocumented family member comes to have powerful effects on the lives of other relatives, including those who are citizens and permanent residents (Castañeda 2019). On a population level, migration affects all our lives, even those of people who "stay home": perhaps someone in their family migrates, or the food they eat is picked and packaged by migrant workers, or they join a solidarity initiative providing assistance to refugees, or they are affected by a virus that travels alongside business people from one side of the globe to another. To provide one example of the broader social and economic impacts of migration, consider how remittances—transfers of resources from migrants back to kin or home communities—not only affect the livelihoods of migrants' families but are a major source of global capital flow, infusing community and national economies (Cohen 2011). More negatively, we see how discrimination and criminalization of migrants does not only end up affecting migrants but bleeds over into other groups who are perceived to be associated with them (Ngai 2014). For example, the stigma that is levied on undocumented immigrants in the United States is not only applied to them but becomes part of the lived experience of Latinx people regardless of legal status (Chavez 2003, 2013; Willen 2007). One of our key claims in this volume is that

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migration and health cannot be separated from the health of broader publics more generally. Migration affects us all.

The shared stakes of migration are often obscured by the ways that migration is depicted as a "crisis." Crisis narratives are applied to migration more generally (De Genova 2017; Holmes and Castañeda 2016; Cabot 2015) but are often especially present in discussions of migration and health. Framing migration in terms of crisis portrays mobility as a problem and obscures historical continuities through an insistent focus on an urgent present. But migration is not new. People have always moved; in some ways it is a fundamental human experience. And yet, at different moments, in different places, and for different people, movement is experienced, understood, and governed in radically diverse ways. Paying attention to local variations, and the ways they articulate with transnational links, connections, and collaborations, help us to make sense of current processes of migration and their implications for health and well-being. And putting contemporary migration into historical perspective helps to provide context and grounding for understanding the present as well as to critically interrogate growing xenophobic rhetoric that seeks to stoke fears of "migrant invasion." Crisis discourse also obscures the transnational connections, many of them emerging from histories of colonization, conflict, and exploitation, that precipitate and shape much migration (Danewid 2017; Mayblin 2017).

Governing Migration

Contemporary migration politics and policies also often obscure the common stakes of migration in ways that muddy, not clarify, our understanding. For example, although countries in the Global South host the vast majority of people on the move, immigration and asylum policies in Europe and North America have grown increasingly restrictive. These restrictions have included the proliferation, offshoring, and militarization of borders, the erosion of international and national protections for asylum-seekers and refugees, increased migrant detention, the intensification of deportation and push backs, and the rolling back of entitlements and assistance even to migrants who have been granted legal status. In the United States, for example—which for decades remained the top refugee resettlement country—there was a significant decline in the number of refugees resettled in the country due to the Trump administration's efforts to virtually eliminate resettlement by substantially lowering the annual refugee admission numbers and implementing enhanced security screening for refugees from "high-risk" countries. In fact, since 2001, there have been several legal immigration reforms that represented migrants as potential "terrorists," just one especially troubling dimension of an overall shift in focus from human rights to security in the treatment of asylum seekers in the United States as well as in Europe (Abbas 2018; Boyle and Busse 2006; Watters 2007).

These restrictions have typically been accompanied by nationalist, xenophobic, and racist rhetoric that treats migrants with suspicion, if not as an outright threat. What Nicholas De Genova has described as the "deportation regime" does not just exclude people through processes of illegalization. Instead, it includes migrants in selective conditions of precarity that maintain their role as excludable, and therefore

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vulnerable, subjects (De Genova 2002). Such exclusionary responses also have their precedents in older policies and attitudes about migration, many of which, like xenophobic rhetoric today, conflate mobility with a range of threats, including the specter of disease. In the United States, historical examples include the Chinese Exclusion Acts of the 1880s and the mid twentieth-century internment of Japanese Americans. Many of these punitive policies, both historical and present day, have clear and documented health effects (W. D. Lopez et al. 2017). Even after return or deportation, migrants continue to experience ongoing health consequences of discrimination and criminalizing policy and practice. Whitney Duncan terms such cross-border, long-term health effects "transnational disorders" (Duncan 2015). The health effects, while clearly borne most directly by migrants, do not only affect the health and well-being of migrants but also larger communities. For example, during the COVID-19 pandemic, immigration raids violated quarantine orders, placing larger populations at risk (M. M. Lopez and Holmes 2020), while the deportation of migrants who were COVID-19 positive (many of whom were likely infected in immigration detention facilities) from the United States to other countries may have led to the additional, unnecessary spread of the disease (Kassie and Marcolini 2020).

Contrary to what media coverage may convey (Holmes and Castañeda 2016), not everyone wants or is able to come to Europe, North America, or Australia. Overall, South to South migration is just as common as migration between the Global South and the Global North. For example, the vast majority of refugees, around 85 percent, have sought refuge in lower- to middle-income countries (UNHCR 2020) and the same is true for most internally displaced persons (Internal Displacement Monitoring Centre 2020). Why some migratory movements are politicized and rise to the level of "global crisis" while others are relatively ignored is itself an empirical and political question anthropologists and other scholars might consider (Peutz 2019).

It is not hard to imagine that the co-occurrence of record migration numbers alongside the erosion of protections and rights for people on the move poses immense challenges. In 2018, the United Nations launched The Global Compact for Migration and The Global Compact on Refugees. Both non-binding compacts emerged from the New York Declaration for Refugees and Migrants, the outcome of a United Nations General Assembly-led Summit largely in response to the mass movements of people fleeing Syria and other countries and traveling to Europe in 2015–16. The Compact for Migration is the first such comprehensive document that aims to address a range of different kinds of migration in one international agreement. Its stated goals include encouraging international cooperation on migration, as well as the collection of migration data, so that migration trends and patterns may be better understood. Among its 23 objectives, the Compact intends "to mitigate the adverse drivers and structural factors that hinder people from building and maintaining sustainable livelihoods in their countries of origin" as well as to "reduce the risks and vulnerabilities migrants face at different stages of migration" (Global Compact for Migration 2018). The Compact on Refugees' stated objectives are to (1) ease the pressure on host countries; (2) enhance refugee self-reliance; (3) expand access to third-country solutions; (4) support conditions in countries of

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origin for return in safety and dignity. The Compacts aim to offer new global frameworks and relationships for governing migration. Some scholars see the Compact as a strong foundation from which to support migrant health and well-being (Devakumar et al. 2019). However, the Compacts have also been criticized by scholars and activists for failing to more clearly lay out state responsibilities, significantly center migrants' rights—especially the right to health—and thereby more strongly protect the health and well-being of people on the move (Bozorgmehr and Biddle 2018; Chimni 2018; Gunst et al. 2019).

Health and Well-Being in the Context of Migration

If migration is a challenge to define, health is similarly broad, potentially encompassing a wide range of states of being, practices, individuals, and institutions. Medical anthropology's general concerns with the social and cultural dimensions of health, illness, and healing systems can all be applied to the subject of migration. Perhaps the most obvious place to begin is with the effects of migration for the health of people who move. Such effects are not inherent to mobility but emerge in relation to the conditions in which people move, especially the structural vulnerabilities and violence people face both in transit and at their destinations.

The Health Effects of Migration

While some studies suggest that migrants may be healthier than non-migrants, possibly because those who are less healthy tend not to migrate (Wingate and Alexander 2006), the literature generally demonstrates that migrants experience poorer mental and physical health (self-reported and clinically documented) than non-migrants. Clearly, migrant populations are diverse, and the immigration journey, immigration status, and life conditions in host societies altogether have significant implications for migrants' health and access to health services.

Recent scholarship in medical anthropology has documented how the greatest challenges to migrants' health and well-being are most often determined by precarious social and economic conditions and an overall political context that casts them as outsiders, illegitimate, or threatening (see, for example Castañeda 2019; Chavez 2013; Larchanché 2020; Kline 2019; Willen 2019). For those who flee violence or persecution, their psychological or physical health may be threatened even before they leave home. Along the way, stricter and more militarized border controls, including in transit countries and destination points, have not reduced immigration flows, but instead created longer and more perilous migration routes, placing migrants at greater risk for ill health or even death (Albahari 2015; De León 2015). Those who end up stuck at borders, or who spend time in camps, or are imprisoned in detention centers are even more exposed to health risk (Griffiths 2013; Carney 2017; Steel et al. 2006; Werthern et al. 2018; Eonomopoulou et al. 2017). Even once, or if, migrants reach their destination, they frequently face obstacles, including stigma and racism, which may also have effects over their life course and into subsequent generations. On the other hand, migration can be salutary, allowing people opportunities to in-

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crease their standard of living, access needed medical care, healthier food, and other determinants of health for themselves and their children. More privileged migrants, with access to structural advantages, capital, and privileged documents, travel with less effort and enjoy easier integration at their destination points. Yet even in difficult migration circumstances, including experiences of conflict and displacement, people demonstrate tremendous strength, hope, and resilience (Panter-Brick 2014; Panter-Brick and Eggerman 2012).

Most significantly, anthropological studies of migrant health reveal the importance of the social, political, and economic production of distress and disease (Farmer 2004; Kleinman, Das, and Lock 1997; Singer and Baer 1995), as well as the structures and dynamics that produce particular patterns of access to health services and the quality of those services (Castañeda et al. 2015; Willen et al. 2017). These cumulative conditions of adversity that produce ill health among migrants are referred to as "structural violence" (Farmer 2004). From that perspective, it can be said that migrants are structurally vulnerable to ill health (Quesada, Hart, and Bourgois 2011). For example, the COVID-19 pandemic highlighted how migrants suffered from a host of adverse conditions that limited their ability to quarantine and made them particularly at risk for exposure to the virus, such as lack of insurance (Duncan and Horton 2020), precarious housing conditions in social housing or shelters (Du Loû 2020), or lack of basic hygiene in encampments and detention centers (Agier et al. 2020). There has also been an increase in racial discrimination and hate crimes against Chinese and other Asian migrants identified as "vectors" for the virus (Tisserand and Wang 2020; Huang and Liu 2020).

A central issue debated in the literature is the notion of the "right to health," which is related to the concept of deservingness that we discussed earlier in this introduction (Willen 2011; 2012; and Willen and Cook, chapter 1 of this volume). Indeed, the social construction of distinct migrant groups by dominant groups in receiving societies impacts both migrant health and management by local public health institutions (Briggs and Mantini-Briggs 2003; Chavez 2013; Quesada et al. 2011). Public discourse in receiving countries often emphasizes the drain on national resources (whether in the medical sector or other social services) generated by migrants (Goldade 2009; Ormond and Nah 2019 and see Nolan Kline's contribution, chapter 7 of this volume). Paradoxically, ill health has become one of the few legitimate paths to legal status, leading migrants to rely on their "suffering body" to make claims on the state (Ticktin 2011). For example, Didier Fassin and Estelle d'Halluin (2007) documented how asylum policies in France intrumentalize asylum seekers' body as their main evidence for testimonial truth.

More recent ethnographies have taken a critical look that brings attention to how both the lived experience and social context of migrants also shape chronic disease or work-related injuries (Mendenhall 2016; Flynn 2018; Quesada et al. 2011). In the context of migrant labor more specifically, ethnographies thus reveal a conceptualization of migrants as "disposable" (Stuesse 2016), as well as economic and legal systems that not only enforce but normalize such vulnerability (Benson 2011; De Genova 2002; Holmes 2013; Horton 2016). In addition, the mental health of mi-

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grants has drawn significant attention in anthropological research. Specific challenges experienced by migrants include communication difficulties because of language and cultural differences, acculturative stress, and obstacles related to employment, social status and integration. In the context of mental healthcare provision, challenges may be related to the cultural formulation of symptoms and diagnostic categories that negatively impact diagnosis and treatment. Recent ethnographies have particularly shed light on the mental health impacts of asylum policies (El-Shaarawi 2015; Haas 2017) and have been critical of the popularization of the PTSD category as individualizing trauma, narrowly focusing on pre-migration events, as well as downplaying or ignoring cultural, linguistic or sociopolitical contexts (Fassin and Rechtman 2009; Kirmayer, Kienzler et al. 2010; Young 1997).

Migration and Care

In addition to health status, migration raises complex and challenging questions of care and policy. Beyond moving across geographical borders, migrants also move across medical systems. Significant changes in risks to health and therapeutic options thus accompany migration, but vary in relation to features of migrant populations such as gender, ethnicity, class, and legal status (Sargent and Larchanché 2009: 346). Although access to health care is only one, if important, determinant of health, migration and health care also exist in multiple, complex relationships. Take, on the one hand, how states increasingly exclude migrants from health care policies and programs as part of a larger strategy of excluding migrants more generally. But on the other hand, medical tourism remains an important way that people with means travel, seeking better or experimental treatment. And, as Rania Sweis shows (chapter 6, this volume), sometimes it is the medical professionals themselves who travel. Although clearly patterned along lines of race, gender, nationality, and class, the relationships between migration and health cannot be assumed and require empirical investigation.

As highlighted above, the multiple forms of social inequalities that migrants must face create a risk environment that is rarely taken into account in public health and medicine (Castañeda et al. 2015). Rather, anthropologists have documented how clinicians often emphasize individual behavior and intrinsic characteristics that are imbued by the collective narrative on migrants as radically Other or as a risk group. For example, anthropologists have critically assessed the use of the concept of "culture" in relation to healthcare policy and provision, in the context of mental health in particular (Carpenter-Song, Schwallie, and Longhofer 2007). Notable critiques focus on the patient-therapist interaction, marginalizing of non-biomedical representations of mental health suffering, and methods of assessment that potentially lead to unnecessary clinical referrals and may impact therapeutic outcomes (Good et al. 2011; Larchanché 2020). As a response, some anthropologists engaged with mental health issues affecting migrant populations have proposed clinically relevant recommendations (Carpenter-Song et al. 2007; Kirmayer, Guzder, and Rousseau 2013; Kleinman and Benson 2006; Larchanché 2020), including a "structural competency" approach that engages medicine with stigma and inequality (Metzl and Hansen 2014).

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Politics and Policies of Migration and Health

Finally, intersecting with both health status and care, policy has important implications for health. Most obviously this relates to questions of health policy directed specifically at migrants, such as whether or not immigrants have access to national health care services or the funding and implementation of health care initiatives in contexts of mass displacement. Such policies can positively or negatively affect the health not only of migrants but also of larger populations. For example, in the coronavirus pandemic, policies that restrict undocumented immigrants' access to health care potentially create pockets of infection that harm immigrant communities but also increase the risk of the spread of the virus to the population as a whole (Duncan and Horton 2020). But policies intended to govern migration can themselves have both intended and unintended health consequences. As Jason De León (2015) has illustrated on the US southwest border, policies ostensibly intended to deter migration by making travel dangerous and even deadly have instead led to increased illness, injury, and death. Similar trends have been documented in the Mediterranean, where Europe's efforts to dissuade migrants from making dangerous sea journeys only make those journeys more deadly (Andersson 2014a, 2014b; Albahari 2015).

Thus, many health challenges are also a function of policies, political discourse, and public attitudes toward migrants (Carballo and Mourtala 2005; Willen 2011). In that context, migration has often elicited discourses of illegitimacy (Fassin 2004), suspicion (Haas and Shuman 2019) or fear associated with migrants in relation to specific disease categories or social issues that produce anxiety and mistrust (Chavez 2013; Larchanché 2020). One realm in which migrants may be cast as threatening to the nation is reproductive health. Migrant fertility specifically is frequently contested in narratives of the nation-state (Chavez 2017; Goldade 2009; Sargent 2007; Castañeda 2008).

Among the threats identified in the public imagination, the most prominent appear related to infectious diseases, leading to the characterization of migrants in general as a "risk group." These generalizations about the prevalence of diseases such as tuberculosis or HIV/AIDS often ignore that the communities migrants are coming from, or settling in, are characterized by structural disadvantages such as poor nutrition, inadequate housing or overcrowding, low education levels, and limited access to health services, which facilitate the spread of infectious disease. Instead, discourses of blame rely on anthropological notions of culture that place responsibility for an epidemic onto victims, such as in the case of cholera in Venezuela (Briggs and Mantini-Briggs 2003). Ultimately, both geographical and symbolic border practices themselves create conditions of pathogenic communicability (Chuengsatiansup and Limsawart 2019; Mason 2012).

Challenging Borders

The study of migration and health has been constrained by what we term "epistemic borders"—boundaries that challenge our abilities to speak to one another across sub-

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fields and disciplines. Among the most central, and problematic, of these epistemic borders are distinctions between "deserving" and "undeserving" migrants that continue to pervade conversations about migration. Even our vocabulary and the ways that we classify people on the move legally and politically constrain us within these borders. Take, for example, the distinction between refugee and migrant, which we will return to below. While these terms themselves have and can be fruitful objects of study, and while they come to have significant meaning for the people to whom they are ascribed, they nonetheless have been subject to important critique (Yarris and Castañeda 2015; Casas-Cortes et al. 2015). This epistemic border then reflects the extent to which the literatures in refugee studies and migration studies often do not seem to speak to one another, despite having significant common interests. Other epistemic borders that this volume seeks to challenge include dichotomies between health and mental health/well-being as well as those that emerge between more experience-near approaches and those that focus on structural violence. Not only does this volume seek to document some experiences faced by those who cross borders and those who offer them care or seek to classify, document, and understand them, but we also hope to challenge the epistemic borders that may limit wide-ranging, holistic analyses of the health and well-being of people on the move. If the defining feature of borders is the way that they are selectively permeable, it is our goal to use this metaphor to exceed the limits of the categorical containers we have been offered by academic and policy debates to consider what might be possible if we transgress and transcend these borders. Among the questions asked by this volume are: How does migration affect health status? What do practices of migrant health care look like, and how are they implicated in regimes of control or practices of solidarity?

The anthropological study of borders and boundaries, an area of recent growth within the discipline, addresses the ways that borders and boundaries are implicated in our understanding of subjectivity, migration, nationalism, and state-making, as well as cross-ethnic or cross-national conflict and cooperation. Increasingly, border studies' contributions have not been limited to what happens at, across, and around borders themselves, but have importantly provided a lens into major global political, economic, and cultural changes. This increased attention emerges in a time when, far from receding in the face of globalization, borders have proliferated (Ticktin 2011). Not all migrants cross state borders, of course, and borders affect not only those who cross them but also populations who live around them, who themselves shape borders (Cole and Wolf 1974; Lauth Bacas and Kavanagh 2013; Reeves 2014). But people on the move are the populations who most challenge and cross borders, whether they are material, bureaucratic, or metaphorical. Fredrik Barth's (1969) observation that boundaries, not only that which they contain, should be of interest to anthropologists because of the different ways in which they are expressed, maintained, and validated by the people who move between and across them, laid a foundation for thinking about boundaries and borders as being important to the self-conceptualizations of people and communities. Borders, then, and the people who contest them, provide a lens for looking at some fundamental questions: How is inclusion and exclusion negotiated and challenged? What relationships exist between territory, mobility,

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state power, inclusion/exclusion, and health and well-being? What happens when we transgress the tightly guarded boundaries around our concepts and ideas?

In times of fear, uncertainty, and anxiety, such as those that characterize the contemporary world for many people (Larchanché 2020), borders between those who belong and those who do not often harden (Castañeda 2019; Willen 2019). If this is a dynamic that we see repeated across many different settings, people in each nation or group draw those lines differently and reflect their own histories and ideologies in the process. Race, ethnicity, and religion are common markers of difference, and social representations that have evolved around these categories—while shaped by historical context—often travel across time. Anxieties that stem from fear in the face of social change or difference are culturally shaped, and almost without us realizing it, they recurrently crystallize around people who are considered "other"—migrants and their children.

These invisible borders, as Gloria Anzaldúa writes, include not only the borders that define us and them, but also creates a borderland, "a vague and undetermined place, created by the emotional residue of an unnatural boundary" (Anzaldúa 1987: 3). It is in this space that those who do not hold power and do not fit the dominant mold—migrants, of course, but according to Anzaldúa, also racialized people, LGBTQ+ people, disabled people, and indigenous people—have learned to navigate multiple worlds, to travel across the open wound "where the Third world grates against the First and bleeds" (Anzaldúa 1987: 3). The concept of *borderland* also draws our attention to the ways that borders can no longer be conceptualized solely in terms of state politics or imagined as the archetypical line that bisects sovereign territories (Alvarez 2012). For the "wound that bleeds" may be found on the bodies of those who feel they do not belong, based on imposed boundaries that separate them from broader communities of inclusion.

Recent ethnographic scholarship has focused on borders as a project, practice, and process as opposed to as an object. Bordering is a "technique that classifies and reclassifies both places and persons and their relations" (Green 2013: 350). An approach that looks at borders as a process allows for the possibility of people engaging strategically with borders and being both displaced and emplaced. It also renders visible borders that occur within, not between, the territory of states. Wendy Vogt (2018), for example, describes "arterial borders" as the ways that states patrol, police, and surveil migrants within national territories. Another important strand of recent border scholarship focuses on borderlands and non-territorial borders, such as maritime borders and boundaries (Ballinger 2003; Albahari 2015; Klepp 2010), and has laid the groundwork for a more dynamic and varied understanding of borders. This has also involved more analytical attention to the meaning of borders themselves, as the changes in the form and functions of borders may be leading to, or stemming from, changes in the notions of what constitutes a border. Scholarship on borderlands recognizes that we do not sit on the frontier of a border line, but instead "we are situated increasingly in the midst of a ubiquitous and multiple border, which establishes unmediated contacts with virtually 'all parts' of the world" (Balibar 2004: 1–2). Borders then become not only places, but also practices.

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Many of the contributions in this volume aim at revealing such intangible borders, how they shape common sense narratives on migration in various contexts, and how they impact various stakeholders—from politicians to community representatives and leaders, health professionals, and migrants themselves. When resorting to the analytic of the border, we were careful to reflect power relations while not reducing the reality of immigration to a narrative between oppressors and victims, and several contributions that document migrants' experience specifically upset this category of victimhood (see Walker and Oliveira, chapter 2, and Yarris chapter 8). Instead, we take inspiration from our interlocutors and aim to think and discuss across legal categories, domains of interest, and geographical space.

Organization of the Volume:

Part I: Challenging the Borders of Belonging travels through various national and cultural contexts to identify these less visible borders of belonging and exclusion, how they define healthcare legitimacy, and assess how the political affects the biological, and vice versa. Sarah Willen and Jennifer Cook's introductory chapter unveils how such intangible borders are construed around the notion of *deservingness*, which they operationalize in relation to health. They provide a framework of analysis that identifies the various stakeholders, contextual variables, and evaluative criteria undergirding conceptions of health-related deservingness. In doing so, they help unveil the moral assumptions and "taken-for-granted truths" that constitute a collective "common sense" and that orient responses to such questions as "Who has access to healthcare coverage?" or "Who can benefit from specialty medicine?" Willen and Cook engage this framework of analysis through three case studies in three different contexts, which powerfully illustrate the situationally specific and context-dependent determinants that define the borders of belonging, and hence health-related deservingness. Ultimately, the authors call for investigations of how migrants themselves conceptualize their own deservingness and identify, resist or challenge the borders of belonging in the community(ies) they live in. What are the health implications of these borders for migrants and their families?

This is precisely what Rebecca Walker and Elsa Oliveira explore in their ethnography of cross-border migrant women in Johannesburg, South Africa. Drawing on an arts-based creative story project, Walker and Oliveira share the experiences of women—almost all of them asylum seekers and single parents—and their sense of well-being. The authors come to the concept of well-being from a holistic perspective, that is, one that encompasses community and social well-being, physical well-being, and access to healthcare, career well-being, and financial well-being. They also challenge the traditional focus on migration and health that highlights vulnerability—especially in light of pre-migration experiences, and instead unveil the more insidious structural determinants that negatively impact women's attempt to "keep well" in their host society. Doing so, Walker and Oliveira reveal how women struggle to find a sense of belonging in a context where the collective narrative blames foreign-born nationals for the country's social ills. Such a public

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narrative translates into concrete forms of discrimination and abuse, leading women to struggle to "be seen"—that is, treated with dignity and respect. This is even true of the healthcare domain, which in theory these women should be able to access: there again, the collective common sense negatively imbues healthcare professionals' judgment, leading them to see migrant women as malingerers or as contagious bodies, undeserving of medical care. Despite multiple layers of adversity, migrant women find energy to challenge the borders of belonging, by resisting gendered and cultural norms in particular.

If the women Walker and Oliveira describe challenge categories of belonging and exclusion in their everyday lives and in the sphere of health care, Elizabeth Marino and Heather Lazrus's chapter powerfully illustrates another way that the concepts and categories we commonly use to describe migration can fail to capture the empirical realities of human mobility. Marino and Lazrus's chapter draws on fieldwork conducted in Shishmaref, Alaska, and Nanumea, Tuvalu. Both of these communities are among the first to be identified as future "climate refugees" because their homes are threatened by environmental disaster, specifically flooding. However, the risk of a devastating major flood turns out to be only one of the migratory pressures people in both Shishmaref and Nanumea must reckon with. As a result, migration cannot be easily separated between forced displacement and voluntary migration as risks, pressures, and opportunities intersect and interact on the ground. Marino and Lazrus demonstrate how, rather than being separable into discrete categories, migration represents complex decisions made by individuals, families, and communities as they navigate risk of environmental disaster, deteriorating infrastructure, and other economic and social pressures. They argue that, in order for responses to climate change, environmental disaster, and climate-induced migration to be successful, they must take the lived experiences of the people most vulnerable to environmental disaster and degradation, including how people themselves relate to their environments, the constraints and pressures that lead to displacement, and the choices people make about their residences, livelihoods, and mobilities.

The second part, *Challenging the Borders of Care*, looks at how migrants' health status and needs challenge the borders of biomedical care, and argues for global perspectives on health that link the biological to the social, the political, and the personal. It gathers various experiences that have crossed the aforementioned borders to propose disciplinary articulations between field data and health settings. In her chapter on the development and practice of ethnopsychiatry in Italy, Cristiana Giordano describes how a local intellectual tradition of analyzing the relationship between hegemonic and subaltern cultures has opened a space for political action that would involve subalterns. In the context of psychiatric care, this implied denouncing institutional, normative psychiatry, to bring the focus back onto patients' experience and needs. In the context of migration, this meant allowing for "alternative modalities of healing and suffering" in the clinical context. Ethnopsychiatrists thus accept negotiating the traditional borders of psychiatric care as they integrate patients' own interpretations and worldviews and they see this confrontation of explanatory models as constitutive of the act of care, rather than the strict labeling of symptoms. Mean-

while, this form of therapeutic process challenges the dynamics of othering that otherwise actively marginalizes migrants in the host society.

Interestingly, in France, where in theory access to healthcare is universal—and as such "presents no borders to the sick," a combination of economic precarity, legal challenges, and language obstacles in practice challenge this access for vulnerable migrants in many ways. In that context, Carolyn Sargent, Laurent Zelek, and Anne Festa look at the importance of local associations in offering advice and assistance to those needing treatment for serious chronic conditions such as cancer and diabetes. They focus on one such association, AC Santé, located in Seine-Saint-Denis—considered the most structurally vulnerable department in the Paris metropolitan area. They describe the association professionals' efforts to create health paths that trigger the intervention and collaboration of professionals from different categories to address vulnerable migrant patients' health needs. Through the creation of innovative tools such as the "social dialogue meeting" or the EPICES score, the association specifically addresses the social dimensions of illness that typically elude traditional health institutions. By anticipating the needs of patients at the intersection of the biological and the social, they challenge the traditional borders of biomedical care. Sargent, Zelek, and Festa illustrate the impact of these efforts at providing holistic care through two poignant vignettes. The authors' pluridisciplinary collaboration also highlights the combined relevance of anthropological research and associative field actors to better inform health professionals on vulnerable migrant patients' needs and on the necessary adjustments for their treatment.

Rania Sweis provides an original contribution on how the act of caring itself may be driven by a sense of national belonging in the context of humanitarian aid, specifically the provision of health care to refugees and other populations affected by war. By documenting the experience of Syrian-American doctors' intervention during the Syrian Civil War, she challenges the notion that it is primarily white American or European aid workers who do humanitarian work, unsettling the imaginary of humanitarian care that often dominates the literature and the media. In doing so, she also disturbs the traditional East-West or North-South border divide that typically defines the context of humanitarian aid and creates a hierarchy of humanitarians, beyond hierarchies of care. Sweis thus shows how, in Syria, it is in fact local doctors and Arab emigrants—not foreign doctors—who provide most humanitarian aid to Syrians. While these doctors place their universal, professional ethics of beneficence and medical neutrality first, they reveal that both their cultural knowledge and attachment to the place of conflict undergirds their commitment to intervening in the context of war. In conclusion, Sweis contends that identity strongly matters in shaping global humanitarianism and that documenting the "reasonings" of humanitarian workers in war-devastated zones such as Syrian is paramount to obtaining "new insights into the nature of violence and its effects on human lives."

Finally, in the third part, *Challenging Policy Borders*, we gather perspectives on how various types of policies act as borders that directly and indirectly impact migrant health and their access to health care. Nolan Kline looks at the United States and examines how both the healthcare and immigration systems have become in-

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creasingly financialized. Based on a rhetoric that conflates both economic concerns and racial difference, vulnerable immigrants such as undocumented individuals or refugees are considered a "public charge" burdening the nation. More disturbingly, this "public charge" rhetoric has recently translated into policies that challenge immigrants' access to residency and citizenship. As a result, it creates a climate of fear among immigrants themselves who refrain from applying for benefits such as food or healthcare assistance. The enforcement of immigration laws through the militarization of borders or through detention also has negative health consequences for immigrants. While benefiting the security businesses or private prison companies who are profiting from aggressive immigration laws, detention conditions are abusive and traumatizing for migrants. In particular, the strategic use of family separation creates inhumane situations for families, with long-lasting mental health consequences. This is also true of detained undocumented migrants who identify as LGBTQ+, who suffer mistreatment and harassment from staff and other detainees. As Kline contends, crime and punishment were established to control and deter the presence of economically and racially undesirable immigrants. Under the Trump administration, policy measures such as the "remain in Mexico policy" or the announced end of the temporary protected status (TPS) for those fleeing civil conflict or natural disaster legitimate these violent control practices. Conversely, Kline shows, legal residency and citizenship have become easily accessible for wealthy individuals who wish to invest in the US economy. There is a commodification of citizenship statuses which reinforces global inequalities. Altogether, the financialization of immigration and related healthcare conditions in the US are part of a neoliberal agenda that serves to create a "political economy of belonging."

From Kline's account, we may be tempted to conclude that anti-immigrant policies erect borders that further victimize migrants and deny them any form of agency as political subjects, leading to deteriorated health status. But as Kristin Yarris skillfully shows in her chapter, the lived experience of migrants in response to aggressive policies may be more complex—or at least it may take different shapes depending on the local context. In the US state of Oregon, where Yarris carries out ongoing ethnography on migration and policy responses,—specifically on the state's "Sanctuary" law—advocates mobilized state law to protect immigrant community members from the federal Immigration and Customs Enforcement (ICE) measures. In fact, when this state law was challenged during the 2018 general elections, on account of the same rhetoric described earlier by Kline and others in this volume—migrants are a public charge and that their presence leads to increased crime and insecurity—community members testifying against the violation of the state law were able to reassert their right to belonging. Interestingly, Yarris shows, they did so by positioning themselves as victims of ICE family separation interventions and using this narrative positionality as a way to assert their political agency. Through her retranscription of the poignant testimonies, Yarris describes how the public context of hearings makes violence visible, and formally acknowledges speakers' political subjectivity. Therefore, it legitimates the lived experience of state violence, as well as the experience of trauma. Indeed, the trauma of family separation is no longer abstract nor is it restricted to an event (that of detention and deportation) or to an individual. Rather, this trauma is

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shown to have long-lasting effects on subsequent generations and impacts the immigrant community as a whole. Yarris thus concludes that, while this narrative strategy could have been seen as reinforcing migrants' victimhood, ultimately it emphasized migrants' political subjectivity and their right to belong.

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