


# Theoretical perspectives on health and migration: social determinants, transnationalism, and structural vulnerability<sup>1</sup>


## Perspectivas teóricas sobre salud y migración: determinantes sociales, transnacionalismo y vulnerabilidad estructural

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### Abstract

This article critically analyzes the three major contemporary theoretical approaches in addressing health and migration: the social determinants of health approach of the World Health Organization; studies on transnationalism and health; and current proposals on structural vulnerability. To this end, the core ideas that characterize each of these approaches and the main criticisms made are presented. Given that most of the current literature is being published in English, this article summarizes some of the main contributions in the field for the Spanish-speaking public, constituting the first work of this type to include the structural vulnerability approach. The analysis was carried out with CAQDAS Nvivo, using summarizing, structuring, and explanatory content analysis. The article emphasizes the importance of the processes of structural determination of the health of migrants and concludes by advocating an analysis of the scientific conventions present in the theoretical perspectives, insofar as these have a concrete impact on the health of migrants, as policy's foundations and as raw material for common sense.

**Keywords:** Vulnerability in Health; Social Health; Immigration; Social Determinants of Health.

<sup>1</sup> This article is the result of the Fondecyt Postdoctoral project no. 3180173, "Itinerarios terapéuticos transfronterizos", of which Dr. Piñones Rivera is the main researcher

## Resumen

El artículo analiza críticamente las tres aproximaciones teóricas contemporáneas más importantes en el abordaje del binomio salud-migración: el enfoque de determinantes sociales de la Organización Mundial de la Salud; los estudios sobre transnacionalismo y salud; y las propuestas sobre vulnerabilidad estructural. Se exponen las ideas centrales que les caracterizan y se presentan las principales críticas realizadas. Dado que la mayor parte de la literatura actual está siendo publicada en inglés, el artículo acerca de manera sintética algunas de las principales contribuciones en la materia al público hispanohablante, siendo el primer trabajo de este tipo que incluye la aproximación de la vulnerabilidad estructural. El análisis se apoyó en el software CAQDAS Nvivo, utilizando análisis de contenido sumariante, estructurante y explicativo. El trabajo enfatiza la importancia de los procesos de determinación estructural de la salud de los migrantes, y concluye abogando por un análisis de las convenciones científicas presentes en las perspectivas teóricas, en tanto estas tienen un impacto concreto en la salud de los migrantes, como fundamentos de políticas y como materia prima para el sentido común.

**Palabras clave:** Vulnerabilidad en Salud; Medicina Social; Inmigración; Determinantes Sociales de la Salud.

## Introduction

The first publications in the U.S. scientific literature addressing the problem of the relationship between health and migration appear in 1912. As has been a historical constant (Abel, 2003), such works establish a relationship between the migrant and infectious diseases, showing “that there is a link between imagining disease and imagining foreignness” (Sontag, 2003, p. 64). Based on Sontag’s warning, we ask ourselves: How is the relationship between migration and health being thought nowadays? The question is eminently practical and results in the emergence of policies, programs, projects, diagnoses and care practices aimed at the health of migrants. We do not intend to undertake a systematic review of the literature, since efforts in this direction have already been made (Castañeda et al., 2015; Villa-Torres et al., 2017; Viruell-Fuentes; Miranda; Abdulrahim, 2012). Our contribution focuses on a critical analysis of what we consider to be the 3 main approaches from which migrants’ health is currently considered: the social determinants of health (SDOH), the perspective of transnationalism applied to health, and critical approaches, among which the structural vulnerability focus stands out. After analyzing the first two approaches, the objective is to present, in detail, the contributions of the latter perspective to health and migration studies.

For this purpose, we conducted a literature review on health and migration in English and Spanish. The publications reflecting the chosen perspectives were submitted to the CAQDAS Nvivo, used to perform a qualitative content analysis integrating the three techniques defined by Mayring (2004): by means of summarizing content analysis, we codify the material in order to reduce it to a manageable short text, which preserves its essential content for our issue. Using a structuring content analysis, we searched for formal structures considering the dimensions of the health/illness/care process that was addressed, emphasized and ignored in a relatively systematic way. Finally, by means of explicating content analysis, we sought to construct a coherent analysis of the material, involving narrow and broad context material. This analysis led us

to identify these three approaches as the most significant ones in the contemporary debate on the health-migration binomial.

Given that much of the literature analyzed is written in English, one contribution of this manuscript is to bring some of this literature to the Spanish-speaking community. Moreover, we want to contribute to the progressive strengthening of approaches based on social medicine, as it seems necessary at a time when both neoliberal multiculturalism and anti-immigrant racism are gaining strength by producing pathogenic socio-political environments in general and specifically for migrants.

## Social determinants of health (SDOH)

The SDOH perspective is probably the one with the broadest consensus among the approaches to the health and migration binomial. Part of this consensus is because it is presented in opposition to the reductionist biologicistic perspectives, so that its approaches can reflect very diverse methods that emphasize psychosocial and cultural aspects or even, as the critical perspectives do, the processes of economic and political determination.

Since 2009, the social determinants perspective has been at the heart of the proposals established by the World Health Organization (WHO). However, its history goes back much further and is mixed, in a specific sense, with some of the proposals developed in the 1970s in the heat of the Alma Ata discussions, but in a broader sense, with the discussions and proposals that have emerged from the long tradition of social medicine (Solar; Irwin, 2006).

The traditional definition of social determinants conceptualizes them as

the circumstances in which people are born, grow, live, work and age, including the health system. These circumstances are the result of the distribution of money, power and resources at the global, national and local levels, which in turn depends on the policies adopted. (OMS, 2018, our translation)

In WHO's current approach to migrant health, the social determinants model is one of the key

elements, along with a "migration cycle" model. Thus, the panorama includes vulnerabilities and resilience arising from social determinants over the entire migration cycle (origin, transit, destination and return) in a framework of actions that contribute to the United Nations 2030 Agenda (WHO, 2017). As can be seen, the model presents a fairly broad and complex picture of the factors at play and includes both disease-producing and protective elements.

However, this apparently neutral and encompassing definition does not look so when viewed in the light of the history of the discussion in the field of social medicine. In it, the processes of struggle against the commodification of health and the destruction inherent to capitalist accumulation led to the development of a critical view of the clinical approach as a way to improve the health of collectives, since it makes invisible "the relations of determination generated by the economic system of capital accumulation, the relations of inequality that reproduce it and the destruction of nature" (Breilh, 2013, p. 14, our translation).

The hegemonic development of SDOH concept is the result of a partial institutionalization of this critical conception within the WHO, which is correlated with the progressive influence of the World Bank in the WHO domains of competence (Irwin; Scali, 2007). In this institutionalization, the criticism of the role of the capitalist mode of production is expressed in a non-specific allusion to power, reflected in the following lines: "These circumstances are the result of the distribution of money, power and resources at the global, national and local levels, which in turn depends on the policies adopted" (OMS, 2018, our translation).

A good example of how the spirit of counter-hegemonic health initiatives can be distorted is the Chilean version of the SDOH. It states that

the social determinants of health are understood as the social conditions in which people live and work, which have an impact on health [...] The social determinants that are the object of public policies are those that can be modified through effective interventions. (Chile, 2019, our translation)

As can be seen, both the criticism of the economic system of capital accumulation, the relations of inequality that reproduce it and the destruction of nature disappear from the Chilean definition, or are translated by means of the innocuous qualification “social” (Piñones-Rivera; Mansilla Agüero; Arancibia Campos, 2017).

Another paradigmatic example of the use of SDOH are the reports made by the Báltica Cabieses team (Cabieses; Bernales; McIntyre, 2017; Cabieses et al., 2016; Cabieses et al., 2017), among which is the analysis of the social vulnerability of the migrant population in the commune of Iquique (Tarapacá, Chile) in terms of the “social conditions of health”: poverty, housing, crime (IFV), urban quality of life, drug micro-trafficking, delinquency and prostitution.

Although this approach seems to be a good remedy against the reductionism of biomedical biologicism, the way the data is presented reinforce racist elements present in the Chilean imaginary (Tijoux; Córdova, 2015; Tijoux; Palominos, 2015). For example, when analyzing the housing situation and, in particular, overcrowding and poor housing conditions, Cabieses team (Cabieses; Bernales; McIntyre, 2017) does not relate such conditions to the dynamics of racial segregation that Contreras Gatica, Ala-Louko and Labbé (2015) called “exclusionary and racist access to housing,” which pushes migrants to neighborhoods where such conditions prevail. Even less is shown how overcrowding, pressure for occupations and, in general, life in “bad conditions” are related to the neoliberal commodification of the right to housing (Imilan, 2016).

In the example, it is clear that when neoliberal policy and the socioeconomic production of the social reality of migrants in Chile are not analyzed, what appears as a desirable “objective” description of the “social vulnerability” of migrants offers objectified elements that reinforce existing racist prejudices, as well as the idea that

poverty, overcrowding, delinquency and drugs constitute the social place typical of migrants.<sup>2</sup> An issue denounced by Eduardo Bonilla-Silva: “This is the central way in which contemporary scholars contribute to the propagation of racist interpretations of racial inequality. By failing to highlight the social dynamics that produce these racial differences, these scholars help reinforce the racial order” (Bonilla-Silva, 2006, p. 8).

The SDOH approach brings together very dissimilar processes with respect to the negative impact on health, such as overcrowding, environmental health problems, multidimensional poverty and biological processes, integrating them into a framework that assumes that there is no structuring order in the multiplicity of causes (Breilh, 2013; Krieger, 1994). This is just the opposite of the initial effort behind the discussion on social determination processes and **subsumption** (Breilh, 1994, 2013; Franco et al., 1991). Indeed, a comparison of Latin American and Anglo-Saxon social epidemiology points out:

The SDOH-a [Anglo-Saxon] understands that health outcomes are related to a social context where the social position of the individual generates differential exposure and vulnerability that explains the distribution of health inequities, but makes invisible the forces in tension and power relations in society. The SDOH-b [Latin American] emphasizes power relations and highlights the dynamics of capital accumulation as essential to understand the social determination of the health-disease processes that determine work and consumption patterns, the failures of social supports and the forms of culture that lead to unhealthy ways of life and lead individuals to suffer from disease in a differential manner, according to social class, gender or ethnicity. (Morales-Borrero et al., 2013, p. 800-801, our translation)

2 An interesting element is that, in general, these analyses do not highlight the social determinants that may play in favor of migrants' health, nor their contribution to the health of the destination countries, either through the self-care knowledge they disseminate, or through the health specialists of hegemonic or subalternized knowledge (PIÑONES-RIVERA, C.; MUÑOZ HENRÍQUEZ, W.; LIBERONA CONCHA, N. Te mueves o te mueres: la movilidad del saber médico andino en la triple frontera Bolivia, Chile y Perú. In: FERRARI, M. et al. *Fronteira, território e ambiente: diálogos entre América Latina e Europa*. Cascavel: Edunioeste. In the press).

## Transnationalism and health

The second approach chosen is transnationalism, which we can characterize, although at the risk of simplifying it, as a theoretical perspective that seeks to overcome the linearity and unidirectionality of previous migration studies, whose analyses were centered on the concepts of assimilation and acculturation, as well as affected by “methodological nationalism” (Glick Schiller, 2009; Wimmer; Glick Schiller, 2002, 2003). To this end, it considers the relationships, ties and social, cultural, economic and political interactions that are established across borders, showing that migrants not only do not leave their culture behind, but also help to transform the places of origin and destination, by virtue of the cross-border relationships and dynamics they establish. In this way, transnationalism has shown the emergence of “transnational social spaces” (Villa-Torres et al., 2017).

The transnationalism perspective has recently been applied to health research. At the international level, authors as Baldassar (2014), Grineski (2011), Horton (2013), Madden (2015) and Villa-Torres et al. (2017) have studied it. However, there is an extensive literature on medical tourism (Connell, 2015; Crush; Chikanda, 2014; Ormond; Sulianti, 2017), which can also be used for thinking about transnational relations in health, as well as the already classic works of Connell (2015) and Bell et al. (2015). In Chile, Liberona Concha, Tapia Ladino and Contreras (2017) have examined cross-border health mobility between Arica and Tacna from a critical analysis of the concept of medical tourism, considering the commodification of health systems.

Some of the important findings that have been established in the field of transnationalism and health are (Villa-Torres et al., 2017):

- Health and related behaviors are influenced by transnationalism, and there is a need to systematically investigate how migrants' health practices are integrated into the process of transnational migration.
- In spatial terms, the existence of “transnational therapeutic landscapes” has been reported. In other words, the

therapeutic process is developed in space through the negotiation between territorial, individual and social factors, emphasizing the transnational character, showing how such landscapes transcend national borders, drawing new functional territorial units.

- Migrants have been valued as holders of “transnational cultural capital” (Grineski, 2011), which has an impact on health. This includes knowledge about paperwork to cross borders, information, referrals, tele-diagnosis, access to medicines (from places of origin and destination), access to traditional healers and use of formal and informal health services in the countries of origin and destination.

To the above we could add the important contributions of Thomas Faist on the institutional conditions for the integration of migrants in welfare states (Dörr; Faist, 1997), as well as his recent work on transnational informal social protection, in which makes visible the contribution that informal strategies make to confronting the risks associated with production (for example, work) and reproduction (for example, care) (Faist et al., 2015) while problematizing the production and reproduction of social inequity that takes place through these strategies. Finally, Faist provided a new definition of transnationality as a marker of heterogeneity, at the crossroads of the transnational approach and the intersectionality approach, which no longer defines it as a dichotomous characteristic but as a variable (Faist et al., 2015).

Of the many aspects that we could analyze of this approach, we would like to focus on the use of the concept “cultural capital.” This concept is based on Bourdieu's work to overcome a sociological approach that was restrictively focused on economic capital. It is thus defined as:

a unique type of cultural capital that gives one power to achieve ends across borders. As opposed to being inculcated into one culture (for example, American or Mexican), TCC [Transnational Cultural Capital] is the power to acquire what one perceives to be best in a health-care field that spans borders. (Grineski, 2011, p. 258)

How does it apply in practice to the understanding of the health-migration binomial? For our critical analysis we will take the example of Grineski who establishes that for parents seeking medical care for their asthmatic children in Phoenix (Arizona) key advantages of transnational cultural capital were: “speaking English, working in the health-care field, having a college degree, and being born in the United States” (Grineski, 2011, p. 258).

The assumption that the standard of “advantageous cultural capital” to address health problems coincides with the standard of assimilation (to U.S. biomedical knowledge, language, schooling and nationality standards of the United States) is striking. In the same theoretical vein, other authors have studied the patient-physician encounter and found that healthcare relationships are most successful when both patients and physicians adopt a set of cultural skills that include verbal and nonverbal competencies, interaction styles, and attitudes, called by Shim (2010) “healthcare cultural capital.”

We would like to stop and reflect: what kind of senses this approach can articulate? what kind of skills or cultural capital are the authors thinking about? Grineski (2011, p. 258) highlights:

Those of the lower social class, and specifically immigrants, were less likely to possess these cultural resources, making it more difficult for them to successfully manage their child’s asthma; while they attempted to deploy social capital to compensate for their lack of economic and cultural capital, it was not as useful in the health-care field.

In other words, the maintenance of one’s own cultural knowledge is interpreted as a source of difficulties. Based on the assumption of the supremacy of biomedical knowledge, it is presumed that the key to addressing health problems lies in assimilation with biomedical knowledge, ignoring that the universe of “cultural capital” is a much broader set, in which, with good reason, indigenous knowledge can be included in the approach to health, or forms of spiritual healing typical of the multiple Christian denominations, to mention some of the most relevant in intercultural

health studies with indigenous populations. Here we note an important difference with the tradition of Latin American Critical Medical Anthropology, which since the 1970s has emphasized the importance of medical pluralism as a way of making visible the coexistence of medical knowledge, denaturalizing the hegemony of biomedical culture.

Transnationalism has constituted an important contribution to the approach to migrant health, being recently identified as one of the main contributions of social theory for public health decision-making regarding migrants (Cabieses; Galvez; Ajraz, 2018). Then, we share one of the main criticisms that has been made to the studies of transnationalism and health, in confluence with what we have problematized in the approach of SDOH:

At the structural level, the ability to enact this transnationality and move and mobilize resources across borders, requires an analysis of the intersecting policies associated with health policies, such as immigration, labor and social welfare policies [...]. Ultimately, what we observed with this review, is that many transnational health practices are not addressing the fundamental causes of health inequities, but rather circumventing the lack of transnational social protections. (Villa-Torres et al., 2017, p. 77)

This difficulty in addressing the structural has already been raised by other authors not only in relation to the field of health, but also in the understanding of migration processes in general. Thus, Márquez Covarrubias (2012, p. 318-319, our translation) points out:

The central point for this perspective is the connection of socio-cultural relationships that migrants and their families have with each other, which makes it possible to link places of destination and origin [...]. In the same context, they emphasize the organization of migrants, which includes the social union of migrations, social networks, migrant groups and their links with their places of origin. By promoting the organization, it loses the

structural and strategic dimension, the political and institutional dimension where political power, represented by the State, and economic power, represented by capital, coexist.

## Critical approaches: structural vulnerability

One of the most vigorous contemporary approaches in addressing the health-migration binomial is the structural vulnerability. The notion is borrowed from Mexican anthropologist Daniel Hernández Rosete (Piñones-Rivera; Quesada; Holmes, 2019), but it emerged as a concept in 2011 in texts written by Quesada, Hart and Bourgois (2011) and Holmes (2011). In it, one can see the confluence of a number of critical approaches in the field of Critical Medical Anthropology, Social Medicine, Critical Epidemiology or Public Health, which have shown how the social structure (Stonington et al., 2018) imposes specific risks and constrictions on individual and collective health. In contrast to previous approaches, this perspective emphatically points out that the problem of migrants' health must be addressed by first considering the problem of the economic and political structure, or the mode of production.<sup>3</sup>

In this field, an important contribution from the Anglo-Saxon Social Sciences has come from the concept of structural violence. As early conceptualized by Galtung, it is that type of violence that does not allow identifying an agent directly, since violence is integrated in the structure of society and in the existence of hierarchical positions. From this matrix emerges the concept of structural vulnerability as a tool to understand how the mechanisms of structural violence affect the body, health, illness and interfere in care, crystallizing specific vulnerabilities (Holmes, 2013b). In this view, it is emphasized that socioeconomic and political

structures produce and organize risks, harm and suffering (Holmes, 2011), as these are determined by the position that a person occupies in the hierarchical order (Quesada; Hart; Bourgois, 2011). This position is the one that defines life choices (Holmes, 2011) and is where different forms of oppression operate in conjunction: class, race/ethnicity, gender, immigration status, nationality, among the most important ones (Bourgois, 1988).

## The place of migration in the capitalist economic structure and its impact on the health of migrants

Based on Burawoy (1976), Holmes (2013a) shows how migrant labor systems are characterized by establishing a temporal and physical separation between the processes of production and those of reproduction of the labor force. The migrant can survive on low wages only because education, health care and other services are provided in the country of origin. Thus, the "host" country externalizes the cost of such processes. The whole situation involves an economic-political contradiction, for while, on the one hand, the economic situation requires the migrant labor force, on the other hand, the political structure deprives it of the basic rights of citizenship, severely limiting its power to interfere in labor. In this way, the migrant labor system relies on the migrant's difficulty in influencing the institutions and structures that subordinate him or her, thus producing the effect of maximum exploitation of the labor force, with all the suffering and burden of illness that this represents (Holmes, 2013a).

This makes it possible to describe a hierarchy of suffering, since work is segregated according to ethnic-citizen-labor hierarchies, which expose to harm, risks and health resources in a differential way. For example, while perceived indigeneity defines the occupation, the position

<sup>3</sup> It is no secret that this approach draws extensively on the contributions of Latin American Social Medicine/Collective Health. Cfr. Piñones-Rivera, Quesada and Holmes (2019).

held in the job will depend heavily on immigration status and citizenship (Holmes, 2013a). The conjugated oppression of this and other processes of determination make migrants probably the most vulnerable in the hierarchical structure. This vulnerability is functional to the capitalist production system to the extent that it ensures greater stability in the provision of labor force, greater exploitation-productivity- and guarantees a reduction, to a minimum, of the ability to influence the conditions of their work (Holmes, 2007, p. 48-49).<sup>4</sup>

## How social hierarchies are naturalized by means of symbolic violence

Another significant aspect is the naturalization processes that are at the basis of both the reproduction of social hierarchies and the lack of understanding of migrants' suffering by society in general and by health care workers. For this, authors have resorted to Bourdieu's concept of symbolic violence, according to which the acceptance of domination, with all the violence it implies, occurs because "each group understands not only itself but also the other to belong naturally in their positions in the social hierarchy" (Holmes, 2016, p. 75). In other words, there is a foundational misrecognition of both the hierarchical nature of social functioning and the role we play in the process of its reproduction.

Thus, it has been shown how naturalization affects the health of migrants through different ways:

- a. The naturalization of labor exploitation: Holmes (2016, p. 217) shows how the place of indigenous Mexican migrants in the social hierarchy and the type of exploitation they suffer is naturalized through certain expressions such as "Oaxacans like to work bent over." From ignorance about the social reality and the conditions that lead them to work in such contexts, the correlation between ethnically defined social position and the type of work is wrongly attributed to physical characteristics: "the O'xacans are too short to reach the apples, they're too slow... They have to use ladders a lot more than some of the other guys." (Holmes, 2016, p. 217). Perceptions, as well as the associated meanings, constitute the forms through which symbolic violence is materialized, fixing the migrant in a social position in which he or she supposedly deserves to be, establishing a relationship of self-evidence between the migrants' bodies and the kind of work they do (Holmes, 2016).
- b. The naturalization of social position by internalization: Given that symbolic violence organizes the perceptions and practices of both the dominant and the dominated, the aim is to understand the different identity negotiations. On the one hand, it shows how they identify themselves in conflict with some stigmas associated with migration (Organista et al., 2013; Quesada, 2011; Quesada et al., 2014). On the other hand, they also show the more subtle process whereby they cultivate an identity pride that helps them to cope with extreme working conditions: "pesticides affect only white Americans [gabachos] because your bodies are delicate and weak [...] we Triquis are strong and *aguantamos* [hold out, bear, endure]" (Holmes, 2016, p. 220). However, at the same time, by relying on the distinctions inherent to the game of symbolic violence, it reflects the internalization of social hierarchies and ends up reinforcing the exploitation they are subjected to. The biomedical doctor, whose position in the social hierarchy is

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<sup>4</sup> Something similar can be found in Fassin (1999, 2000), who analyzes the disparities in the access to health of immigrants and foreigners, considering that their health exists in the relationship historically constructed by social actors, raising the problems of inequity as a function of social hierarchies resulting from the colonial condition (Fassin, 2004).



incomparable to that of the migrant worker, is also affected by the ubiquity of structural violence, as reflected in the double bind to which the health professional is subjected in capitalist contexts. On the one hand, this professional must fulfill bureaucratic and statistical tasks, on the other hand, must examine, interview and organize a plan of care in time, and all in 15 minutes (Holmes, 2016).

- c. The naturalization of diseases attributed to individual carelessness (biomedical individualism): due to the biologicist ideology and individualism characteristic of the medical viewpoint, it almost inevitably identifies the place of responsibility for the disease in the patient, blaming the victim (Ryan, 1976). When to biomedical individualism is added the culturalist assumption that it is by virtue of certain cultural characteristics that patients become ill, a new form of racism is created, that of cultural competencies (Pon, 2009).

These processes of naturalization are part of the symbolic violence against migrants and have important effects on their health. Structural vulnerability makes it possible to understand why the inequities described remain unquestioned and unchallenged, both by the migrants themselves and by health personnel and society in general.

### **How structural racism affects the health of migrants**

Finally, this approach incorporates the displacement that has occurred in the approach to racism, from individual or interactional racism, to institutional (Krieger, 2014), systemic (Castle, 2019; Feagin, 2006; Feagin; Bennefield, 2014) or more properly structural one. In this move, the focus draws on approaches to public health based

on critical race theory (Airhihenbuwa; Ford, 2018; Ford; Airhihenbuwa, 2010a, 2010b; Hicken et al., 2018; Madden, 2015; Metz; Roberts, 2014).

Structural racism is defined as “the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups” (Gee; Ford, 2011, p. 3). The concept emphasizes the most influential socioecological levels at which racism can affect racial and ethnic health inequalities. It clarifies that structural mechanisms do not require the actions or intentions of individuals, since as fundamental causes (Phelan; Link, 2015) are constantly reconstituting the necessary conditions to guarantee their perpetuation. To the extent that, if interpersonal discrimination were completely eliminated, racial inequalities would probably remain unchanged, due to the persistence of structural racism (Gee; Ford, 2011).

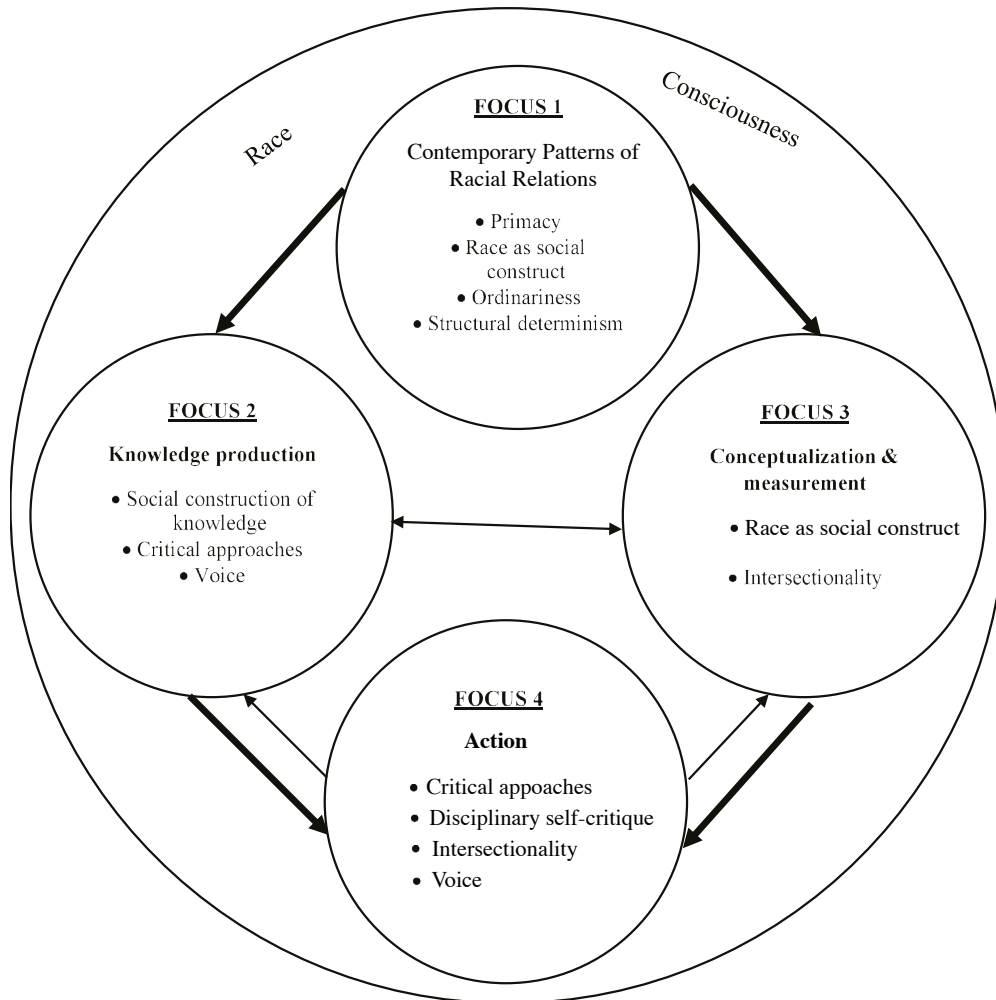
It is then this racism, with all its subtleties, operating in the most dissimilar spaces and with its deep historical roots, that is placed as a focus of analysis in relation to the processes of determining the suffering of migrants. While previous literature states that racism is a factor that affects health, constituting a barrier to care, structural racism focuses on the impact on health of immigration policies, public policies in general, residential segregation processes (Williams; Collins, 2001), ethnic segregation of workplaces, but also the theoretical models from which health problems are thought of or the production of scientific knowledge when it operates in a racialized logic.<sup>5</sup>

In an effort to systematize a public health approach capable to transform the praxis and research from which racism in health is discussed, specific approaches have been developed, highlighting those of Ford and Airhihenbuwa (2010a, 2010b). Their work defined 4 areas of intervention focus (Figure 1) and 10 constituent principles of any research based on critical race theory (Table 1).

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<sup>5</sup> A similar approach is found in Fassin (2004, p. 295), who from a “political anthropology of health” calls for a necessary revision of the “political morality” of the countries of destination. To this end, he associates public health issues with those of immigration policies by highlighting aspects such as the construction of difference in the field of health and the question of migrants’ access to citizenship. (Fassin, 2000).

**Figure 1 – Race consciousness, the four focuses and ten affiliated principles**



Source: Ford and Airhihenbuwa (2010b, p. 1391)

**Table 1 – PHCR principles and affiliated focuses**

Principle	Affiliated focus(es)	Definition	Conventional approach	PHCR approach
1. Race consciousness	All	Deep awareness of one's racial position; awareness of racial stratification processes operating in colorblind contexts.	Colorblindness-belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors (e.g., SES)	A researcher clarifies her racial biases before beginning research within a diverse community
2. Primacy of racialization	Contemporary racialization	The fundamental contribution of racial stratification to societal problems; the central focus of CRT scholarship on explaining racial phenomena	Tendency to attribute effects to race rather than to racialization or racism	A study of neighborhood characteristics includes factors hypothesized to reflect structural racism

continue...

**Tabela 1 – Continuation**

Principle	Affiliated focus(es)	Definition	Conventional approach	PHCR approach
3. Race as social construct	Contemporary racialization Conceptualization & measurements	Significance that derives from social, political and historical forces	Biological determinism – the belief that race is meaningful because it provides insights about one’s biology and propensities	A study assesses race not as a risk factor but to identify a population at risk for specific racism exposures
4. Ordinarity of racism	Contemporary racialization	Racism is embedded in the social fabric of society.	Racial exceptionalism – defines racism as rare, discrete and overtly egregious incidents	A study on racism and health operationalizes racism as routine exposures (e.g., being followed while shopping)
5. Structural determinism	Contemporary racialization	The fundamental role of macro-level forces in driving and sustaining inequities across time and contexts; the tendency of dominant group members and institutions to make decisions or take actions that preserve existing power hierarchies	Emphasizes individual or interpersonal factors	A multilevel study considers policy factors that may promote residential segregation
6. Social construction of knowledge	Knowledge production	The claim that established knowledge within a discipline can be re-evaluated using antiracism modes of analysis	The belief that empirical research carried out properly is impermeable to social influences	A disparities-related literature review compares articles published in minority vs. majority journals
7. Critical approaches	Knowledge Production Action	To dig beneath the surface; to develop a comprehensive understanding of one’s biases	To accept phenomena or explanations at face value	A researcher considers alternative explanations for findings than those previously posited
8. Intersectionality	Conceptualization & measurement Action	The interlocking nature of co-occurring social categories (e.g., race and gender) and the forms of social stratification that maintain them	Additive model of co-occurring social categories (e.g., race and gender).	Efforts to reduce HIV risk behaviors among diverse men who have sex with men address racial stereotypes

continue...

**Tabela 1 – Continuation**

Principle	Affiliated focus(es)	Definition	Conventional approach	PHCR approach
9. Disciplinary self-critique	Action	The systematic examination by members of a discipline of its conventions and impacts on the broader society	Limited critical examination of how a discipline's norms might influence the knowledge on a topic	Researchers examine implications for research of using "health inequities" vs. "health disparities" vs. "health inequalities"
10. Voice	Knowledge Production Action	Prioritizing the perspectives of marginalized persons; privileging the experiential knowledge of outsiders within	Routine privileging of majority perspectives	Responses of skepticism or anger when outsiders within speak truth to power

Source: Ford and Airhihenbuwa (2010b, p. 1394)

We cannot thoroughly examine them, but we would like to highlight two aspects of the structural dimension of racism that have been studied in depth and seem to us important, both for the value they have and for the decisiveness with which they are approached in these studies.

The first refers to how administrative irregularity impacts health by exposing it to all kinds of abuse. In this regard, Castañeda (2017) shows how migration status affects in multiple dimensions: by fear, stress, establishing differential access to resources, experiences of prejudice and violence, family separations, as well as work and safe housing. Moreover, she concludes that public policies such as the Affordable Care Act (ACA) increased the symbolic and social exclusion of immigrants by producing a new boundary that separated unauthorized immigrants more strongly and clearly from the rest of the political body (Castañeda, 2017).<sup>6</sup>

Thus, the cumulative effect of all these instances leads to an experience of tension and dissatisfaction that cannot be easily overcome, which constitutes an extra burden due exclusively

to the vulnerability of their position in society (Quesada et al., 2014). To all this must be added the risk of deportation (Quesada, 2011) and the generalized fear of institutions, which is behind the delay in seeking care, even when the care does not ask for immigration status, and when there is a clear and extreme need for care (Quesada, 2011, p. 391).

Migrants find themselves in a racialized social status (Asad; Clair, 2018), in a discredited social position based on a legal classification that is apparently neutral. This disproportionately affects ethno-racial minority groups, exerting a disparate burden on them through the restriction of social and political rights, and stigmatization processes that negatively affect psychosocial stress and their coping responses (Asad; Clair, 2018).

The second aspect refers to how policies aimed at migrants directly impact health by producing a pathogenic socio-political environment (Castañeda et al., 2015; Gee; Ford, 2011; Gee et al., 2016; Morey, 2018). In line with what Castañeda has already analyzed regarding the ACA, Morey (2018) shows

<sup>6</sup> Another type of frontier is revealed by Fassin (2003) when analyzing the humanitarian policies that facilitate migratory regularization for severe illnesses in France. The critique is situated in the "political uses of the body" (Fassin, 2003, p. 49) of immigrants, who must expose their suffering and illness in order to obtain -as sick people- the previously denied regularization. Fassin describes as "biogitimacy" or the politics of recognition of the suffering being and the sick body (Fassin, 2004) this form of government of the "illegitimate ones" (Fassin, 2003), which fosters inequality.

that all undocumented people were ineligible for any plan or subsidy, and that, in addition, workers were rarely qualified for indigent programs, making the cost of health care one of the main problems they face. Thus, as Castañeda (2017) emphasized, social policy not only constitutes a way of producing new social relations, modes of governance and experiences of care, but in itself can have pathogenic effects. One way to understand this is to assume that an anti-immigrant socio-political context is a social determinant of health, which primarily affects ethnic communities, whether migrant or non-migrant (Morey, 2018).

Morey (2018, p. 461) points out:

Stress caused by the threat of a socio-political environment that specifically aims to exclude and disenfranchise entire population groups can accumulate over time to cause greater “wear and tear” on their bodies, leading to higher levels of chronic disease, risky health behaviors, and premature mortality.

## Final remarks

At the end of this critical review of the three main approaches to the migration-health binomial, we can see that all the perspectives reviewed shed light on aspects and introduce nuances in the reflection on this relationship. The review has enabled us to outline a comprehensive view that, although not exhaustive, has revealed some of the cleavage sites that distinguish one perspective from another.

The SDOH perspective emphasizes sociocultural conditions from a classic epidemiological model, which lacks a theoretical foundation that would allow it to recognize a structuring order in the multiplicity of causes. This makes it not very suitable for analyzing power relations and the relationship between the dynamics of capital accumulation and the health/disease/care process. Indeed, we have shown how, even when certain material aspects are considered (the “social conditions of health”), the dehistoricized and

depoliticized analysis results in an objectification that reinforces the relationship that racist common sense establishes between migrants and poverty, delinquency, drugs, violence, etc.

In the case of transnationalism, we have seen how its systematic questioning of methodological nationalism allowed the development of a series of theoretical-methodological approaches that have broadened the understanding about migration and mobility processes in their relationship with health. Thus, it has shown the relationship of health practices with transnational processes, the importance of transnational territoriality in the search for health care, the value of informal social protection structures for migrants, as well as the importance of transnational cultural capital. Our analysis of this perspective focused on showing how an uncritical use of the latter concept can convey hegemonic ideals regarding the medical knowledge of migrants that ignore the value of medical pluralism while culturalizing the problem of access to health care, ignoring the fundamental causes of health inequalities (Villa-Torres et al., 2017).

In contrast to the two previous perspectives, the proposal of structural vulnerability was developed by resolutely assuming the centrality of the structural in the health of migrants, gathering the critical tradition of social medicine. We showed how, starting from the impact of structural violence on bodies, this perspective analyzes the place of migration in the capitalist economic structure; the symbolic violence present in the naturalization of social hierarchies; and structural racism, materialized in the processes of administrative irregularization and the production of pathogenic socio-political environments.

Beyond the theoretical interest that this overview may have, we understand that it has several practical aspects. First, because it constitutes the technical-ideological background of the policies, programs, projects, diagnoses and care practices aimed at migrant health care. Thus, clarity with respect to the main theoretical coordinates also makes it possible to visualize the

scope of the concrete proposals for addressing the causes of the inequity that affects the health of migrants. Second, because in light of the criticisms reviewed of the naturalization of social hierarchies, as well as the reproduction of structural racism by scientific knowledge, it seems necessary to problematize to what extent these theoretical perspectives contribute to the reproduction of the symbolic violence exercised against migrants in the space of science.

To this end, it is necessary, as proposed by critical race theory, to carry out a systematic examination by members of scientific disciplines, of their conventions and impacts on society in general, based on the assumption of the ideological production of knowledge, since racism is also reproduced in the daily life of scientific discourses, analyses, programs and projects. This reproduction is not reduced to a question of more or less conscious wills, but responds to the processes of social production of knowledge, which are always ideological processes, permeable to influences, interests, economic pressures, in short, to the games of power.

Of course, reality is not transformed only by operating at the theoretical level, but we consider it important to problematize the reproduction present in the academic space, since it is where these readings of reality are sacralized, rising from common sense and returning as a scientific foundation of everyday life politics.

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### **Authors' contribution**

Piñones-Rivera worked on the research, methodology, analysis and writing of the text. Liberona contributed to the research and writing of the final version. Leiva worked on writing the final version of the article.

Received: 08/10/2020

Approved: 09/09/2020