Chapter II

REVIEW OF LITERATURE

Health status of migrants is a significant factor in their successful establishment in the country of origin when they return after a stint in an alien land. However, optimum health and lifestyle have often been challenging for the migrant workers owing to the peculiar political, economic, social, cultural, racial, and work environment in the host country. Yet, researchers paid scant attention to the health status of return emigrants and its socioeconomic consequences for the sending country. The aim of this chapter is to exemplify analytically the scholarly investigations, both theoretical and empirical, on the health of migrants and its determinants, and to make obvious the discernible diversity, if any, between the health status of emigrants and non-emigrants. This chapter has two parts. The first part reviews the substantial investigations related to the health consequences of migration. The second part focuses briefly on the works which examine the issues associated with the emigration of contract workers from Kerala to the Gulf Cooperation Council countries, and the outcomes of their eventual return and resettlement.

Much of the literature on migrants is about immigrants—people settling in a new country—but as all immigrants begin as ‘emigrants’—people who leave the country, (Marks & Michael, 1997) one may take recourse to literature on immigrants’ health in order to get an overview of the health issues of the emigrants, or the return emigrants. This review, therefore, recounts the terms “migrants”, “emigrants”, and “immigrants” interchangeably.

2.1. Health Consequences of Migration

2.1.1. Studies on the health status of immigrants in UK reveal mixed results. An investigation (Balarajan et al., 1984) into the pattern of mortality among migrants to England and Wales from the Indian subcontinent brought to light the fact that these migrants had a higher death rate due to ischemic heart disease and cirrhosis of liver, but had fewer than expected deaths due to lung cancer and chronic bronchitis.

2.1.2. A comprehensive immigrant mortality study (Marmot et al., 1984) of England and Wales from 1970 to 1978 showed that ethnicity, defined as foreign born minority,
influenced mortality independent of social class. The study found that standardized mortality ratio (SMR) from hypertension among West Indians, diabetes in Indians, infections in Irish and Indians, cirrhosis of the liver and accidents among the Irish and complications of pregnancy and child birth among women born in the Indian subcontinent, Africa and the Caribbean, were all larger than the SMR for the most disadvantaged native born social class in England and Wales.

2.1.3. Incidence of heart disease has been shown to be higher among people of Indian descent in England and Wales (Pedoe et al., 1975), S. Africa (Walker, 1980), and Fiji (Sorokin, 1973). Some other studies indicate lower mortality due to cancer, and higher prevalence of diabetes (Cruickshank et al., 1980) among immigrant population.

2.1.4. In Germany, Razum et al. (1998) conducted a comparative study to examine the health status of Turkish minority relative to the German nationals. The study tested the hypothesis that as a minority with lower socioeconomic status, Turkish residents in Germany might experience a higher mortality than Germans. But the study arrived at a quite unexpected result that the overall mortality rate of German males and females were much greater than that of the Turkish nationals residing in Germany. The authors explain their findings in terms of ‘unhealthy re-migration effect.’ According to this explanation, socially successful migrants with lower mortality risk stay in the host country while less successful ones return home even before becoming manifestly ill.

2.1.5. Although France has long been a country of immigration, few studies have been made on migrant health and particularly on the impact of migration on diet and lifestyle related diseases. However, the studies that are available (Bouchardy et al., 1996; Courbage & Khat 1996) also showed a paradox among Mediterranean migrant men in France, i.e., that migration could have a protective effect on mortality and morbidity linked to non-communicable diseases compared with the local born population.

2.1.6. Caroline et al. (2007) studied the effect of migration on overweight and morbidity linked to non communicable diseases among Tunisian migrants in the south of France and the potential influence of socioeconomic and individual lifestyle factors. The study compared a group of Tunisian migrants first with a local born French population living in the same environment and second with a non-migrant Tunisian population. The main
The question addressed was whether Tunisian migrants retain traditional healthy behaviours that could explain the protective effect of migration.

The findings of the study provide evidence that Tunisian migrant men residing in France enjoy better health with respect to overweight and non communicable diseases than local born French. The study thus supported the works that brought to light a ‘Mediterranean migrant paradox’- the remarkable mortality advantage that some Mediterranean migrant groups enjoy in Germany and France. Although several hypotheses have been put forward, the origin of this paradox is still unknown. (Darmon & Khlat, 2001)

2.1.7. Some US studies have shown that some immigrants enjoy better health than people born in the United States notwithstanding their higher poverty rates and limited access to health facilities. Other studies, however, indicated that immigrants have higher rates of disease and poorer health than would be expected.

In 1986, an epidemiological paradox was revealed in USA: Compared with non Hispanic ‘white’ population, the Hispanic population had lower death rates for cancer, cardiovascular diseases, and all cause mortality (Markides & Coreil, 1986). Several hypotheses have been proposed to elucidate this effect, (Khlat & Darmon, 2003) which could be related to the “healthy migrant effect”, i.e., the selection at entry, of applicants for immigration who are healthier than their average compatriots (Abraido-Lanza et al., 1999). The hypotheses affirm that the healthy migrant effect may fade out over time because migrants are exposed to risk factors in the recipient country. Another explanation could be the “Salmon Bias” theory which supposes that the migrants probably migrate back to their home country after the retirement or when they are seriously ill.

2.1.8. Sharma et al. (1990) found that immigrants from Europe, Asia, Africa, and North, South and Central America had higher life expectancy than both the Canadian-born host population, and the native-born in their places of origin. In this case, the immigration process seems to be highly selective in nature with immigrants being healthier.

2.1.9. In Canada, analysis of National Population Health Surveys data found that the prevalence of excess weight among immigrants increased with length of stay in Canada for both males and females. Some researchers examined selected determinants of diabetes
in immigrant and marginalized populations. Pilot interviews conducted with South Asian and Chinese immigrants identified loss of social support, increased work burden and decline in status, as significant contributors to their onset of diabetes. (Young et al., 1999)

2.1.10. Bollini and Siem (1995) argue that the poor health outcomes observed are linked to the lower entitlements for migrants and ethnic groups in the receiving countries. The authors note: “Not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population and which vary in different societies and for different groups.

Language, different concepts of health and disease, and the presence of racism are examples of such barriers.” Of course, migrants do not form a homogeneous group – Bollini and Siem note that the general trend to poor health outcomes may vary from one group of migrants to another and for individuals with in a group – however, the general statement holds true in most parts of the world.

2.1.11. Maria Kristiansen et al. (2007) attempted to find out the factors influencing the health status of citizens with an ethnic minority background in Denmark. They cite migration as one of the factors influencing the health status of these people. The authors conclude that migration may have negative health consequences due to physical and psychosocial strains experienced by migrants throughout the entire migration process. These strains may lead to stress and risk behaviours having a negative effect on the migrants’ somatic and mental health. The migrants’ social resources such as social network, according to the authors, may act as buffers in this process. In the same article, the authors admit that the knowledge about the health status of migrants is limited due to lack of data as migrants are often excluded from surveys.

2.1.12. Many European studies found a negative association between immigration and health status (Carballo et al., 1998). Studies of South Asian migrants in the United Kingdom (Williams et al., 1994; Greenhalgh, 1997) examined changes in the risk factors associated with the development of diabetes and found that diabetes in the group was associated with elevated levels of psychological stress, precipitated by low socioeconomic status and poor living and working conditions.
2.1.13. Thomas S. L. and Thomas S. D. (2004) argue that negative as well as positive changes in migrants’ exposure to risk factors for lifestyle related diseases will occur over a long period of time. Some studies showed that Asian immigrants in the United States reported lower level of health problems than their US born counterparts.

2.1.14. Results based on the analysis by Frisbie et al. (2001) of the 1992 to 1995 National Health Interview Survey showed significant health advantages among Asian immigrants in the US in terms of activity limitation, leave days due to illness and self reported health.

2.1.15. Palloni and Arias (2004) explained that the immigrant health status may appear to improve with duration in cross sectional data if the least healthy die or re-migrate.

2.1.16. The Centers for Disease Control and Prevention reported that between 1999 and 2004 in the Asian American and Pacific Islander population, the suicide rate was 5.4 per 100000, approximately half the US rate of 10.75 per 100000.

2.1.17. Researchers in Israel (Griffin & Solskone, 2003) found a positive association between Psychological distress among immigrant Thai workers and exposure to pesticides.

2.1.18. Jackson (1996) described the experiences of a group of immigrant nurses in Australia. The women in reporting general feelings of displacement, loneliness and stress, described having these same feelings regarding their place at work.

2.1.19. Facey (2003) examined the health effects of taxi driving on visible minority taxi drivers in Toronto. The study reported that the minority taxi drivers in Toronto described the difficulty making decisions between protecting their health at work and the financial security of choosing a less healthy practice.

2.1.20. Research on mortality and morbidity and international migration (Mc Kay et al.) has compared patterns of migrant groups with patterns of native groups, both in the country of origin and in the local population. The study covered mortality and morbidity from a number of causes such as cancer, cardiovascular disease, respiratory or digestive disease, infections and accidents or suicides. Results of the study suggest that changes in migrants’ environment, with the move to the receiving country have profound effects on health.
2.1.21. Shuval (1993) pointed out that while migration may offer economic benefits, physical health problems and psychological distress often result from the social stress involved in moving from one’s country.

2.1.22. Numerous studies have been published on the phenomenon of mental health and mental illness in immigrant groups since the seminal paper of Odegaard (1932), who found elevated rates of schizophrenia in Norwegian immigrants in the United States. The study reported that Migrant Norwegians to the USA had a higher rate of schizophrenia and high rate of mental hospital admissions when compared with Norwegians who had stayed back in Norway.

It is argued that the process of migration, sense of dislocation and alienation must have contributed to the stress on migrants and the stress of living in an alien culture might be more relevant than the stress of migration. Furthermore, the author added, factors such as cultural identity, self esteem, patterns of attachment and prolonged separation from family might have played some role in the genesis of mental disorders.

2.1.23. Ben-Sira (1997) examined the stress and readjustment related to immigration. The study revealed that, although, many immigrants eventually adapt to the new culture, some face difficulties in adapting and social and psychological problems during this process might lead to poor physical and mental health.

2.1.24. Dinesh Bhugra and Peter Jones (2001) pointed out that migration process itself is an etiological factor in the genesis of many mental disorders. They stated that the worse mental health status of migrant population in many countries has been increasing and has become an issue of concern. The risk factors associated with migrations were underlined as the contributory elements towards the worsening of the mental health of many migrants.

2.1.25. In another study, Dinesh Bhugra (2004) emphasized the lack of social support, large geographic distances to members of the social network, and high expectations from relatives as additional stressors leading to mental health problems and risky health behaviour among migrants. Bhugra argued that the effect of the adaptation process on the migrants’ mental health depends on social network, gender, age, language, skills, educational level, religious beliefs, the reasons for migration and the reception upon arrival in the recipient country.
2.1.26. Delroy (1995) investigated the environmental influences on the health of migrants and found higher rates of mental illness in migrants compared to their counterparts who remain at home. The paper, specifically, examined the rates, incidence and prevalence of schizophrenia in Caribbean born immigrants to Britain. It is argued that Afro-Caribbean people in England were over represented in the diagnosis of Schizophrenia.

2.1.27. Sreedhar (1986) analysed the role of genetic and environmental factors in the causation of disease by comparing the prevalence rates of diabetes mellitus among emigrant Indians with the all India reported rates (Zimmet, P. 1982; Ahuja, 1976) of 1.8 per cent to 1.9 per cent. The study arrived at a much higher prevalence rate for emigrant Indians – 4.2 per cent in South Africa (1963), which increased to 10.4 per cent in 1969 and to 11.1 percent in 1985. Similarly, the study reported an increase in the prevalence rate in Fiji Indians from 5.7 per cent (1967) to 12.5 per cent (1984) over a period of 17 years. These results suggested a genetic susceptibility of Indians to diabetes mellitus; as well as environmental factors which act to increase the prevalence of the disease over time, in the presence of a genetic trigger.

The study cited environmental factors – dietary habits, degree of physical activity, possible food toxins, socioeconomic status, psychosocial stress as a result of modernization – that could be contributing to the higher prevalence of diabetes among emigrant Indians compared to the non-emigrants and host population.

2.1.28. Tan (1998) offers the term ‘ethnic distance’ to illustrate the elements of cultural differences and risk inherent in moves from one country to another, even where the same sending and receiving countries are involved. Using an example of two nationals of the Philippines moving to Hong Kong for work purposes, Tan notes that the ethnic distance for a young Filipina from a small village going to work as a domestic helper in Hong Kong is much greater than that for a young Filipino male executive also going to Hong Kong to take up a job with a multinational corporation. In cases where the sending and receiving countries are highly disparate in cultural values, this ethnic distance can be even more substantial.

2.1.29. The health perils of being at the lower end of a work place hierarchy were borne out by a study (The White Hall Study, 2005) of British Government officials, where one indication of stress, the elevation of blood pressure during working hours, was found to be
more pronounced among the low status workers than high status workers. The study also revealed that the lower level workers had higher death rates than higher level workers, even when other variables such as age were taken into account.

2.1.30. A study (Silveira et al., 2002) comparing prevalence of mental, physical and social health problems, rates of hospital admission, and mortality in Swedish and non–Swedish people found that the migrants reported more chronic health problems. Overall, migrants had a poorer perception of their health in all domains except physical functioning. The main findings showed that elderly people in various migrant groups have low levels of life satisfaction, despite the absence of major biological problems such as disability and mortality.

2.1.31. The Secretariat of the World health Organization (WHO, 2008) reported that the migrants’ fundamental health needs are not adequately met, thus raising concerns with regard to equity, social cohesion and inclusiveness. The report accentuated that, for their part, low skilled and seasonal workers are often concentrated in sectors and occupations with high levels of occupational health risks. The report referred to evidences that certain non communicable diseases, diabetes and cancer are an increasing burden on migrants.

2.1.32. Elkeles and Seifert (1996), in a study on unemployment and health risks of labour migrants in Germany, found that unemployed foreigners suffered from more long term or chronic health problems and reported lower satisfaction with their health than did unemployed Germans.

2.1.33. Akhavan et al. (2004), in their study of unemployment and sick leave in Sweden, found that more than half of the immigrant study participants considered their health to be poor, and they experienced various physical and mental disorders. Many of the participants actually attributed their poor health to their unemployment status.

2.1.34. In a paper, Worth et al. (1975) examined the incidence of coronary heart disease and stroke in Japanese men living in Japan, Hawaii, and California. The study found an increase in cardiovascular mortality among Japanese migrants to the US due to gradual change of exposure to different risk factors.

2.1.35. Analyzing the association between migration, socioeconomic status and risk factors for cardiovascular disease, a Swedish study (Pudaric et al., 2000) found that foreign born people of low income had the highest proportion of physically inactive
individuals and the highest proportion of smokers. Low income and foreign born 
individuals showed high ‘body mass index’ in comparison to high income respondents and 
Swedes in general.

2.1.36. Pol and Thomas (1992) pointed out that age at migration is surely relevant as 
health status tends to decline with age; and gender is also relevant as women tend to report 
a poorer health status than do men, presumably for gender related biological reasons

2.1.37. Williams (1999) identified race as central determinant of social identity and 
obligations and an empirically robust predictor of variations in morbidity and mortality.

2.1.38. Bhopal (2004) provides a useful conceptualization of racism and defines it as a 
belief that some races are superior to others, used to devise and justify individual and 
collective actions that create and sustain inequality among racial and ethnic group.

2.1.39. Pardies (2006) pointed out that those who say they have experienced racism are 
more likely to have poor mental health and unhealthy lifestyles and they are also 
somewhat more likely to report poor health status.

2.1.40. In the Czech Republic, a study (Nesvadbova et al., 1997) on the health and social 
situation of migrants focused on sickness and psychological problems. The study found 
that there was significantly more illness among construction workers who had changed 
professions as a result of migration, who were not satisfied with their accommodation, and 
who did weekend work. The main complaints were backache and digestive problems. 
Also, in comparison to Czech men, this group had more emotional and mental health 
problems.

2.1.41. Ahmed et al. (1995) investigated some of the health problems among cement 
workers in the United Arab Emirates (UAE). For the study, they selected cross sectional 
random sample of 304 workers. The main health symptoms reported by the cement 
workers were chronic cough, chronic bronchitis, burning, itching, and runny eyes, head 
ache and fatigue. These symptoms, according to the study, were significantly increased 
with age of workers.

2.2. Gulf Specific Migration Impact on Kerala

The option to go abroad seeking better opportunities has been regarded by many 
generations in Kerala as an economically sensible and socially acceptable life choice. The
largest market abroad for the job seekers from Kerala has been that of the Gulf States. There exists host of studies focusing on the positive and negative impact of emigration to and return from the Gulf States on individuals, households and the Kerala economy in general. That is, the micro and macro aspects of emigration and return have thoroughly been investigated by scholars. A critical review of some important migration studies in Kerala is made in this section to make obvious the gaps in the available literature.

2.2.1. In analyzing the socioeconomic dimensions of emigration, Mathew E. T. and Gopinathan Nair (1978) took into consideration the primary causes, costs and the concerns associated with migration. They conducted their study in a coastal region in Trivandrum district in two Panchayat wards and in the combined sample, 96 percent of the emigrants were in the Gulf region. The study noted that the emigrants invariably returned home in old age or consequent to retirement or disablement.

2.2.2. In a micro level study, Prakash (1978) attempted to examine the impact of Gulf remittances in Kerala. He selected 95 households from Chavakkad village, a Gulf pocket, in Kerala. The study reported that the migrants’ families receiving remittances enjoyed a pretty good consumption levels. Prakash pointed out that the entire income earned by the persons working abroad was either being used for consumption or invested in land and houses.

2.2.3. The work and living conditions of Keralite emigrants attracted the attention of a number of researchers. Gopinathan Nair (1983) reported that that the emigrant workers in the Gulf live in their own social enclaves and have restricted access to social benefits. Not only that Indians live in an enclave social life, it is reported, they have serious complaints of discrimination and contempt as well. Nair opines that the fear of repatriation lurks in the mind of every Indian migrant and they know well that their stay and work in the countries of their employment are purely of a temporary nature and that they hardly expect from the Government of India any protection against mistreatment by the host countries.

2.2.4. Gopinathan Nair (1986) observed that the foreign environment had affected adversely the physical and mental health of about 10 to 20 percent of the emigrants. The study pointed out that the schooling and medical care facilities are highly expensive in the Gulf region and accommodation is costly and very difficult to obtain.
2.2.5. Gopinathan Nair (1988) reported that in the case of some individuals, migration has resulted in higher income and asset levels and more comfortable living conditions for the households concerned, and better health for their members, more and better education to their children and more rational utilisation of resources. He also emphasized that such positive results are seldom found to extend to every migrant or household. For making an assessment of the migrants’ performance – ‘success’ or ‘failure’ – the study looked into changes in income, assets, consumption, housing area, housing quality, intra family relationship and social relationship. The improvement in the economic base was considered an important criterion to categorize a migrant as a success case. But such an absolute reliance on income, without considering the well being of the migrants, narrows the scope of his analytical research work.

2.2.6. In an article, Thomas Isaac (1997) sought to answer questions pertaining to the issues: consequences of outflow of migrant workers on the domestic employment situation, impact of remittances on consumption, savings, investments and state domestic production, problems and prospects of reintegration of returned emigrants and implications for the distributions of assets and income. Isaac argues that it was the Gulf boom of the mid 1970s that catapulted Kerala into becoming a front ranking state in international migration along with Punjab and Goa. Isaac underlines the fact that unlike the migrants to Western countries the Gulf workers neither aspired to become permanent residents in the host country nor was there any possibility of their becoming so; Gulf migration is usually, a purely, temporary migration and workers have time horizons, fixed in their labour contract, within which they attempt to maximize savings and remit them home.

2.2.7. A study (Prakash, 1998) on the economic impact of large scale labour migration from Kerala to the Gulf found that Gulf migration and the migrants’ remittances have been one of the major factors which had greatest impact on Kerala economy since 1970s. Prakash argued that even though gulf migration has helped the migrant households to attain higher levels of income, consumption and acquisition of assets, resulting in overall reduction of poverty in Kerala, it also pushed up the price level including the expenses on health care.
2.2.8. In a comprehensive study that covered the entire state, Zachariah et al. (1999) argued that migration has been the single most dynamic factor in the otherwise dreary development scenario of Kerala in the last quarter of the twentieth century. The study reports that migration has contributed more to poverty alleviation in Kerala than any other factor, including agrarian reforms, trade union activities and social welfare legislation. The principal source of data for their study was a large scale sample survey, conducted during March-December 1998, of 10000 households selected from 200 panchayat/municipal wards composing all the districts and all the taluks of the state. The study analysed the consequences of migration on Kerala economy and society and reports that remittances and their utilisation bring about most of the consequences taking place in the households of migrants and 86 percent of the households mentioned living expenses as the main expenditure met out of remittances. The study speaks about education expenses, repayment of debt, bank deposits and housing expenses and predicts that the number of return emigrants might increase rapidly in the coming years. Nevertheless, the authors did not cite any evidence to support their prediction of a large scale return from the gulf region. The authors suggest that in addition to taking steps to rehabilitate the return emigrants, the optimum utilisation of their expertise should receive appropriate attention.

2.2.9. As a sequel to their earlier study, Zachariah et al. (2000) conducted an in depth investigation on the demographic and socioeconomic consequences of migration in Kerala. The study makes it clear that Kerala is becoming too much dependent on migration for employment, sustenance, housing, household amenities, institution building and many other developmental activities. The paper warns that the inherent danger of such dependence is that that migration could stop abruptly, as was shown by the Kuwait war experience of 1990, with disastrous repercussion for the state. The study examined the link between migration and mortality and finds that behavioural changes lead to decrease in mortality. The logic behind such an argument is that migration brings in remittances, which result in increase in wealth of the family and consequent improvement in education and nutrition of the members of migrant households and greater use of hospital facilities during times of illness of the members of the family. However, the study does not point out the migrants’ health/mortality issues and focuses totally on the issues pertaining to the households. This lacuna of paying scant attention to the migrants’ issues, while
concentrating on migrants’ households is quite evident in a number of other studies as well.

2.2.10. The causes of exodus of emigrants, profile of return emigrants and the current economic status of return emigrants were investigated by Prakash (2000) in a micro level study based on Varkala town in Kerala. The study mentioned, among other things, ill health as a factor contributing to the return of emigrants from the Gulf in recent years. But the study did not get into the specifics of ill health as a causal factor in explaining the exodus emigrants from the Gulf region.

2.2.11. Zachariah et al. (2001) analysed the Gulf emigrants’ demographic, social and economic characteristics before emigration, after emigration, and after return to Kerala. The study found that most of the return was due to involuntary reasons. They cite several explicit reasons for return: some (41 percent) have returned because their contract expired or their employer terminated their job; more than a fifth of the emigrants came back home because they could not stand any longer the difficult working and living conditions in the host country; ill-health, injury and accidents accounted for, according to the study, another one eighth of the return.

2.2.12. Prema Kurien (2002), in her ethnographic research on the factors responsible for the striking differences in the migration patterns of Ezhava Hindu, Mappila Muslim, and Syrian Christian Communities in Kerala, argued that a community specific nexus of religion, gender, and status shaped migration and was, in turn, transformed by it. She found that the rapid enrichment of the lower classes brought about several major changes in the migrant communities. Besides being able to afford a better lifestyle, she noted, migrants and their families also tried to obtain status and recognition in the community commensurate with their newly acquired wealth and used their newly acquired wealth to obtain recognition in their home communities. This observation is worth mentioning since changes in the life style and conspicuous consumption of individuals will have a greater bearing on their health regardless of the quantum of physical wealth they built up.

2.2.13. An online and field survey conducted by Pravasi Bandhu Welfare Trust (2009), a Dubai based non-governmental organization for bettering the lives of Indian workers in GCC countries, found that the majority of Indians working in the Gulf fail to save sufficient money due to low wages and high expenditure on medical treatment.
2.2.14. Zachariah and Irudaya Rajan (2007) look forward with some degree of confidence to an era in which emigrants and return emigrants take leading roles in the developmental activities of Kerala. The study reported that more than a million former emigrants have returned with their accumulated savings, acquired expertise and external contacts with individuals and establishment that matter very much.

2.3. Conclusion

The review of literature in the first part of this chapter suggests that it is not useful to make generalizations about the health of migrants, since mortality and morbidity patterns vary across space, time, age, gender, and type of migration. Much of the research on migration and health addresses long term migration and the effects of enduring transformation on migrants. Relatively less attention has been paid to the health problems of temporary sojourners and/or return emigrants.

The appraisal of literature related to Gulf specific migration reveals that no research in Kerala focused explicitly on the very vital issue of the health consequences of migration that have far reaching impact on individuals, households, society, and the economy at large. This apparent gap in the existing literature warrants an in depth analytical examination of this germane problem. Before embarking on the analysis of the socioeconomic dynamics, and health status of the return emigrants from the Gulf, the next two chapters will discuss the implications of the multifaceted concept of human health, and its measurement norms; the dynamic history of migration through its contemporary relevance, in the Kerala setting, will be examined in the chapter that follows.
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