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ORIGINAL ARTICLE

Bangladeshi immigrants in Detroit: an exploration of residential mobility and its effects on health

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Abstract

Aim The purpose of this study was to identify key research priorities related to the health effects of the settlement process for Bangladeshi communities in the USA, specifically in Detroit.

Subject and method A scoping study, incorporating a literature review and interviews with key Bangladeshi community stakeholders, was completed. Content analysis was used to identify emerging research gaps in Bangladeshi community health to immigration, settlement, and residential mobility.

Results Two major themes identified from the literature review and key informant interviews: *settlement effects on health* and *language and culturally appropriate care*. Additional issues emerged from the interviews with stakeholders, namely *resettlement effects on health* and *physical environment and health*.

Conclusion These key areas will help guide future research to better understand US Bangladeshi community health outcomes, in addition to the importance of community-based understanding and approaches to address immigrant health issues.

Keywords Bangladeshi community · Detroit · Ethnic enclave · Settlement · Immigration · Health

Introduction

Existing research has described some of the stressors faced by US immigrants, including economic instability and poor access to employment (Edberg et al. 2011; Portes and Rumbaut 2014; Schweitzer et al. 2006). Links have also been made to negative health outcomes, citing inaccessible health care due to costs, language, and lack of cultural-specific resources as barriers (Anderson et al. 2003; Edberg et al. 2011; Singh and Miller 2004). While such studies have provided some insight on the process of immigration, settlement, and health, few have focused on specific populations such as the Bangladeshi community, and even fewer have considered the impact of the social and physical context on the settlement process in Detroit.

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Immigrant settlement and health

Much of the immigration health research in the USA describes poor access to health care and health interventions in low socioeconomic immigrants from Asia and Latin America (Anderson et al. 2003; Edberg et al. 2011). Despite the motivation of seeking better economic opportunities, or safety from civil or political turmoil, US immigrants are more likely to have or continue having worse health outcomes than US-born populations over time (Frisbie et al. 2001). This is reflected in studies that show Asian immigrants face higher rates of stomach, liver, and cervical cancer mortality than their US-born counterparts (Singh and Miller 2004), for example. In addition, although less studied, it is important to also consider other complexities faced by immigrants, including exposure to higher health risks due to environmental and social factors because of where they live and higher exposure to toxic pollution, in addition to lower access to resources (Larsen et al. 2014; Schulz et al. 2016).

US Bangladeshi population settlement

Approximately 57,000 Bangladeshis make up the third largest South Asian subgroup in the USA (Bald 2013; Migration

Policy Institute 2014). Most US Bangladeshi immigrants moved recently, in or after the year 2000, largely to New York City, Washington DC, Los Angeles, and Detroit (Danico 2014; Dutta and Jamil 2013; Migration Policy Institute 2014).

Although settlement of Bangladeshis also occurred in the 1930s, it was not until 1971, when Bangladesh became an independent nation, that the first official Bangladeshi immigrants to the USA were recorded (Bald 2013). Prior to that, newcomers from this region were categorized under Indian or Pakistani ethnic groups. The 1970s and 1980s brought a large migration of professional Bangladeshis, while changes to the US Diversity Immigrant Visa Program in the 1990s increased immigration from Bangladesh, bringing in a wave of working-class immigrants (Danico 2014; Migration Policy Institute 2014). Since then, other forms of visas through familial or spousal reconnection, education, and employer sponsorship have contributed to the steady growth of US Bangladeshis (Barnes and Bennett 2002; Migration Policy Institute 2014).

While settlement in some cities such as NYC has been explored (Bald 2013), limited research exists on the Bangladeshi population in Detroit and in particular, Hamtramck, a city located within Detroit, with a separate jurisdiction. Hamtramck has a population of 22,099 of whom 43.6% are foreign-born, including 22.5% who identify as South Asian, predominantly from Bangladesh, India, and Pakistan (US Census Bureau 2010). Moreover, this area accounts for 75% of all of Michigan's Bangladeshis, with the largest growth occurring between 1990 and 2000 during which period Hamtramck experienced a 1000% growth of South Asians (Metzger and Booza 2013). Nearly all of Detroit's Bangladeshis live here. Many hold blue-collar jobs or own small business, catering mostly to their community (Kowalski 2003). This specific development has largely been attributed to a steady influx of Bangladeshi migrants resettling from NYC to Hamtramck (Kershaw 2001; Metzger and Booza 2013).

Bangladeshis and health

Previous studies on the health of Asian immigrants in the USA and Canada provide some insight into potential shared experiences (Edberg et al. 2011; Singh and Miller 2004). Racial and language discrimination are two significant barriers which Asian-Americans face when seeking health care, and have been linked to various negative health outcomes, including an increase in the number of chronic health conditions, after controlling for socio-demographic factors (Gee and Ponce 2010; Yoo et al. 2009). This relation was particularly strong for Asian immigrants residing more than 10 years in the USA (Yoo et al. 2009) However, such studies are not optimal, as the categorization of *Asian/South Asian immigrants* encompasses a largely culturally diverse community, resulting in different perceptions and experiences that are not reflected in research. Therefore, more ethnic-specific research is needed to capture these differences, to facilitate development of more effective and efficient health interventions.

To address such limitations in the research, the purpose of our study is to contextualize and focus on one immigrant population, the Bangladeshi community, in order to identify key research priorities related to the health effects of the settlement process in Hamtramck, Detroit and the USA in general.

Methods

The review was completed using the approach propsed by Arksey and O'Malley (2005) for conducting scoping studies, including both a literature review and key informant interviews (Arksey and O'Malley 2005). This is an appropriate method for exploratory studies in areas with limited evidence, allowing researchers to identify areas of need for further research (Arksey and O'Malley 2005). The scoping review was carried out between January and August 2016. The study protocol and interview guide were approved by the University of Michigan Institutional Review Board.

Phase 1: review of existing research

A literature review was conducted to explore the health effects of the settlement process on US Bangladeshi immigrants. Searches were conducted in the Scopus, PubMed, and Scielo electronic databases. The main keywords guiding our search were: *Bangladesh* immigra*, settle*, United States, health, wellbeing* and *quality of life*.

Inclusion and exclusion criteria

As part of the search parameters, empirical studies published in peer-review journals relevant to the US context and in English, were included. Studies that did not consider health or US Bangladeshis were ruled out from this review. Studies that grouped various countries within the South Asian category were excluded, unless separate data for Bangladeshi immigrants was provided. In cases where the relevance of the study was unclear from the title or abstract, the full manuscript was reviewed to determine inclusion for analysis. An Excel matrix was used to facilitate data extraction of study characteristic inputs [e.g., author, location, year, aim(s), methods, and findings]. To establish

common themes, a narrative approach was used to identify key areas in the information collected for each article.

Phase 2: key informant interviews

Semi-structured interviews were conducted with key informants in the Detroit area. A purposive sampling strategy was used to capture a range of perspectives in the local Bangladeshi community. All participants worked closely with this community either through providing services or civic engagement, and all, except for two health care professionals, were of Bangladeshi origin. To capture a longer-term perspective of the community, respondents must have lived in Michigan for at least 15 years. Recruitment focused on community leaders, health care providers, and City Council members. A diverse group was selected including various faiths and geographic designations, to capture the diversity within the Bangladeshi community. This included recruitment of participants from faith groups including Muslim, Hindu, and Buddhist, and the districts of Sylhet, Chittagong, and Dhaka in Bangladesh. City Council members were selected due to their advocacy and on-the-ground perspective of their constituents. Health care providers (e.g., physicians, nurse practitioners, and mental health providers) were selected according to their familiarity with health challenges.

A research team member conducted the hour-long, semi-structured interviews in English and/or Bangla. With the consent of the participant, interviews were audio-recorded and written notes were taken. An interview guide was used to ensure comprehensiveness and consistency in data collection, as well as to promote emergence of new ideas through the conversational nature of the exercise (Patton 1990; Ulin et al. 2005). Interviewees were asked questions about their personal history of migration to the USA and Detroit, factors that attract immigrants to Detroit, perceived patterns of migration, common health issues, facilitators of or barriers to health care access, and issues that influence resettlement to other areas.

The analysis was an iterative process. Immediately after the interview, the interviewer reviewed the audio recording and completed an interview summary sheet to capture the main points from each question and identified emerging themes. The research team then reviewed the summary sheets to highlight topics of interest to the research purpose, spot patterns in the data, and strategize about further recruiting and ideas to explore in subsequent interviews. The descriptive analysis allowed the team to identify patterns in the topics covered during the interview and to find emerging themes in the data (Braun and Clarke 2006). The findings from the key informant interviews were then triangulated with the information from the literature review.

Results

Results from the scoping review

A total of 21 peer-reviewed articles were investigated based on the inclusion and exclusion criteria and discussing health and some aspect of migration for the Bangladeshi population. Of these, eight were scrutinized using qualitative methods (Amin and Ingman 2014; Chakrabarti 2010; Changrani et al. 2011; Dutta and Jamil 2013; Gany et al. 2013; Karasz et al. 2014; Patel et al. 2014; Riley et al. 2016), ten using quantitative methods (Changrani et al. 2006; Gany et al. 2014; Karasz et al. 2013, 2015; Markova et al. 2007; McLafferty and Grady 2005; McLafferty et al. 2012; Patel et al. 2012; Rianon and Rasu 2010; Sanchalika and Teresa 2015), and three by means of other methods including mixed-methods to collect evidence (Ahmed and Lemkau 2000; Islam et al. 2013; Rianon and Shelton 2003). The majority of the papers were based in NYC including the Bronx and Brooklyn (Chakrabarti 2010; Changrani et al. 2006, 2011; Dutta and Jamil 2013; Gany et al. 2013, 2014; Islam et al. 2013; Karasz et al. 2013, 2014, 2015; McLafferty and Grady 2005; McLafferty et al. 2012; Patel et al. 2012, 2014; Riley et al. 2016), and there was only one from Detroit (Markova et al. 2007).

Results from key-informant interviews

Nine individuals, four women and five men, took part in semi-structured interviews. Four participants were health professionals and five were community leaders, and all had lived or worked in the area for at least 15 years. They described the collective experiences of the Bangladeshi community with regard to immigration to the USA and the Detroit area.

Themes identified

The four major themes that emerged from the scoping review based on both the literature and interviews included: *settlement health effects, resettlement health effects, language and culturally appropriate care*, and *physical environment*.

Settlement health effects

Among participants, there was a consensus that settlement in the Detroit area and the USA is a stressful process due to factors such as difficulties in finding employment or precarious working conditions. This was supported in the literature, with one study showing increased risk for cardiovascular disease in Bangladeshi taxi drivers (Gany et al. 2013), while another highlighted the importance of employment support programs for this community (Amin and Ingman 2014). Education also has impacts on the settlement process, with

one community leader explaining that earlier immigrants were at a disadvantage compared to more recent immigrants:

"Early immigrants came and had to support family back home, and raise family here." The participant goes on to explain that kids back in Bangladesh would now have access to education, "since they were able to access schooling due to financial resources provided by early migrants." This initial support from earlier migrants also benefited new migrants in finding housing and employment opportunities, as pointed out by several participants, including another community leader who stated, "Early migrant knows new migrant will need housing or help enrolling in school; the early migrant will facilitate securing those things". Such preexisting social networks have also had positive health impacts, including prenatal care and mental wellbeing (Chakrabarti 2010; Karasz et al. 2013).

Resettlement health effects

The participants identified two types of resettlement: resettlement from other US cities, and resettlement to suburbs in Detroit and the city of Hamtramck. One participant described his experiences as "no longer able to afford to live in NYC due to the high cost of living". However, upon arrival in Michigan, he, like many other Bangladeshi men, started working in an automotive company with a good salary, permitting a comfortable lifestyle. Reasons for resettling in other Detroit areas included opportunistic home prices, better school districts, and improved social status, where one could serve as a role model for others within the community. However, resettlement appears to be related to age. One councilman describes the situation like this: "For elders, in Hamtramck or Detroit, there are neighbors who are also Bangladeshi; people can walk together, get rides, help each other out, hang out together, go shopping together. Here (in the suburbs) people are farther away". Nonetheless, this residential mobility to the suburbs is noted largely in populations that have lived in Detroit and Hamtramck for some time and who have been successful in education and employment. From the literature, only one study discussed resettlement to an ethnic enclave as a solution to reduce isolation stress for new migrants moving to areas with no preexisting Bangladeshi communities (McLafferty and Grady 2005).

Language and culturally appropriate care

Most articles discussed language or culture as barriers to health care access (Ahmed and Lemkau 2000; Markova et al. 2007). Language was identified by one health professional as: "one of the most important barriers for these (Bangladeshi) people when they migrate". To address language barriers, private doctors are often sought because they speak the language, or, in the case of undocumented individuals, are more likely to not report them to immigration officials, making the care more expensive (Changrani et al. 2011). Language difficulties also prevent patients from understanding test results and adhering to treatment (Dutta and Jamil 2013). In a study on caries prevention in children, reported communication obstacles resulted in lower oral health care compliance for children by their mothers (Karasz et al. 2014).

The lack of culturally appropriate health care is another hindrance to accessing health care affecting mental health and the associated stigma (Karasz et al. 2013, 2015), as is education of women about the importance of breast and cervical screening for cancer prevention (Markova et al. 2007). One community leader mentioned: "(I) would love to see a community health center in a centralized location where everyone can get all needs taken care of, people speak Bangla, or interpreters are on hand to provide service for that need". In the case of the Detroit area, few Bangla-speaking physicians are available; therefore, there is a heavy reliance on social networks to provide help and introduce services that may be required (Chakrabarti 2010).

Physical environment

Rising health issues in the Bangladeshi community, especially in children, were attributed to environmental conditions both within and surrounding homes. One health professional explained: "We see a lot of asthma, a lot of infectious disease, a lot of allergy-related conditions. It is because of overcrowding and poor living conditions in Hamtramck. Lead poisoning is an issue, everyone knows that. It is not something new, like news came out in Flint. Hamtramck is one of the zip code cities that need lead screening twice in the first 2 years of life because of the poor housing conditions. These houses were built in the 1940s, and we used to use lead paint. And these houses are not—it is not because you renovated the house and the effect of lead (paint) will go away."

In addition, many Bangladeshis work in factories and automotive companies in manual labor positions, and some participants associated these working conditions with health issues caused by long hours of standing, poor air quality, and occupational hazards.

Frameworks for Bangladeshi settlement health effects research

Based on the subjects that emerged in the literature and interviews, a framework of key factors affecting the health of US Bangladeshis is described in Fig. 1 to help guide future research in this area.

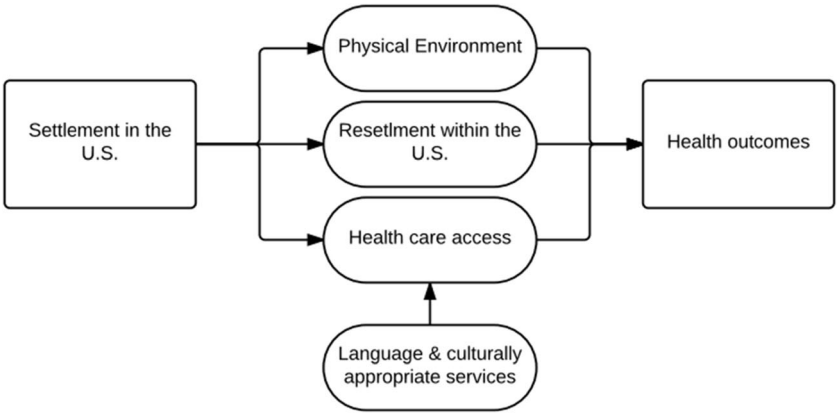

Fig. 1 Framework of identified health factors of settlement by US Bangladeshi populations

Discussion

Despite the limited evidence on the health effects of the settlement process experienced by Bangladeshis in Detroit and the USA, the existing literature still provides a foundation for future research in this area. Furthermore, the variation of methods used in these studies provides a balance of numbers and stories to make a strong case for more research to address the largely preventable health outcomes affecting this community.

Although the theme areas presented in Fig. 1 could be applicable to most Bangladeshi immigrants in the USA, we have also provided some detailed experiences of immigrants specifically in the Detroit area. Participants describe the resettlement to suburbs near Detroit as a success for long-term residents. However, such achievements are a departure from the city's narrative of high unemployment and rising residential foreclosures experienced by Detroit natives (Farley et al. 2002; Sugrue 2014). Although more evidence is needed, such results support the separate findings on the health effects of settlement and the resettlement process further described below.

Health effects of settlement and resettlement processes

Negative health effects of the settlement process are largely attributed to poor access to health care, and language and/or cultural barriers. However, it is also important to explore other social and physical determinants of health including employment, education, and housing. Research on place-based health effects including the physical environment are needed. Evidence should also be taken into account from places such as Canada and the UK with universal health care systems which still continue to show health inequalities in immigrants, disparities which increase with the length of time spent in these countries (Edberg et al. 2011; Singh and Miller 2004). More research in the US context is needed to develop and/or target services for immigrants to reduce health inequities within this population. Furthermore, more investigation of geographic differences, including urban versus rural areas at the time of settlement, is required.

It is also important to consider the effects of resettlement to other areas within the USA. Based on our findings, these populations can experience improvement in their health outcomes by either moving from community-isolated areas to areas with a strong Bangladeshi presence and access to culturally oriented services, or by improving their social status by upgrading to better neighborhoods. and securing access to better education and employment opportunities. Furthermore, resettlement appears to have a positive effect for recent incoming settlers, where often those moving can rent or lend their homes to newcomers and relieve some of the initial settlement stress.

Improving access to health care and health prevention

Language barriers and lack of culturally-appropriate resources, including physicians, have all been cited as barriers to accessing health care in various immigrant populations including the Bangladeshi populations (Ahmed and Lemkau 2000; Amin and Ingman 2014; Edberg et al. 2011). However, largely preventable health outcomes that affect the Bangladeshi community, including heart disease and diabetes, could be strong evidence that more focus is needed not just on access to health care but also on health education and promotion (Dutta and Jamil 2013; Riley et al. 2016; Sanchalika and Teresa 2015).

Mental health was a factor described in both the literature and in the interviews. A small qualitative study of South Asian women and mental wellbeing in Canada found that among female Hindi-speaking recent immigrants, compromised mental health status occurred after migrating (Ahmad et al. 2004). These findings were attributed to stress-inducing factors including loss of social support, economic uncertainties, downward social mobility, and mechanistic lifestyle; and factors involving change in environment and limited health insurance

contributed to the mental health burden (Ahmad et al. 2004. In the Detroit sample, similar contributors to mental health distress were discussed as affecting men, women, and young people. Although it was noted that there was a general awareness of mental health issues such as depression, anxiety, and mood disorders, there was a lack of understanding of about resources were available. More research is needed to understand how mental health care can be normalized to facilitate the addressing of stigma associated with mental health problems within the Bangladeshi community.

Community-based approaches to address health outcomes

It is well-established that social networks play a large role in settlement decisions and health care navigation for Bangladeshis (Chakrabarti 2010; Karasz et al. 2013). The concept of creating social networks is not unique to the Bangladeshi community, and it lends itself to learning from other similar populations who have successfully used community-based approaches to address health issues (Edberg et al. 2011). Although discouraged when conducting research, grouping communities that share characteristics could be helpful in areas that do not have a strong Bangladeshi community presence to mitigate the health effects of isolation. For example, when it comes to women's health, successful programs have been developed by and for South Asian women from other countries, based on similar needs that could be applied in the Detroit area (Ahmad et al. 2004).

Some studies were rooted in community-based participatory research (CBPR) principles that encouraged collective input in the planning, implementation, and evaluation process of various health interventions (Israel et al. 2013; Karasz et al. 2015). One study trained women living in NYC to conduct surveys of other women in the community (Patel et al. 2012). With a 90% response rate, important health issues were identified, including the strong relationship between time lived in the USA and higher risks of cardiovascular disease and diabetes (Patel et al. 2012). Another program using the CBPR approach was successful in reducing depression rates in women, in addition to providing skills to improve financial and social opportunities within the community (Karasz et al. 2015). While CBPR was not a common approach throughout the literature, other studies highlighted the need to better address culturally specific factors affecting health.

This paper has developed a framework based on existing research and interviews with stakeholders, and highlights the need for more evidence to strengthen our understanding of the link between the settlement process and health outcomes of US Bangladeshis. With this evidence, better planning can occur of future interventions which improve the wellbeing of this population as they continue to navigate life in a new country.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Michigan Institutional Review Board and with the 1964 Helsinki Declaration and its later amendments or a comparable ethical standard.

Informed consent Informed consent was obtained from all individual participants included in the study.

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