What health preparations do international students make for their academic sojourn?

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Abstract

The exponential growth in international student mobility since the 1990s brings issues of travel health preparedness in overseas students and the impact of studying in a foreign country on their health to the fore. The direction of travel for much 'education first' educational tourism is from less- to more-economically developed countries, yet the existing literature tends to focus on the health-related expectations, precautions and behaviours of students travelling in the other direction. We explore the health implications of the international sojourn for students in UK higher education from various developing countries, and attendant risks such as the translocation of disease (a concern elevated by the COVID-19 pandemic). Drawing on, fusing and extending ideas from research on education and health mobilities, we examine students' experiences beyond the much-discussed first few weeks after arrival which is typically understood in terms of culture shock. Using narrative research and interviews with a purposive sample of students from ten countries/ territories to establish their travel health preparations and perceptions, we reveal that they made extensive use of non-medical sources of advice including family and friends, the internet and study abroad agents. When they did become ill it was an isolating, distressing and frustrating experience due to delays in obtaining a doctor's appointment and the lack of social support away from home. Of some concern, these students perceived a low risk to traveling to and studying in the UK, and had given little thought to the possibility of inadvertently transmitting disease across borders. These findings will inform our understanding of international students' health, and have the potential to shape related policy and practice in origin and destination countries alike.

Keywords

Educational tourism, internationally mobile students, mobilities, travel health, disease, illness

Introduction

The travel health perceptions and preparations of international students studying in the United Kingdom, and their experience of becoming ill while in the country, are investigated in this study. International student mobility has grown exponentially in recent decades, mirroring the growth in international tourist arrivals. Indeed, it can be seen as a subset of tourism, namely educational tourism (Ritchie, 2003). UNESCO (2015; cited in OECD, 2018: 38-9) defines an internationally mobile student as 'an individual who has physically crossed an international border between two countries with the objective to participate in educational activities in a destination country, where the destination country is different from his or her country of origin'. There were 2 million such students in 2000, rising to over 4.8 million in 2016. During the same period, international tourist arrivals rose from 677 million to 1.25 billion (World Bank, 2019).

The growth in international student mobility, specifically, and international tourism in general can be attributed to the same enabling factors: rising incomes in origin countries/ markets; better connectivity between places and at a lower cost per person; relaxation of border and visa controls; and greater global reach and reputation (for education or for tourism) of destinations/ host countries, as a consequence of exposure and promotion overseas, a network of international offices and agents, and other factors (Ritchie, 2003). The role of education and economic policy in receiving countries should not be underestimated, either. With few exceptions this is neo-liberal in character and focussed on 'reducing national deficits through cuts in public spending, abolishing regulations in global trade and opening national markets to capital flows' (Brooks and Waters, 2013: 23).

The UK hosts 432,001 international students according to data supplied by UNESCO (2018), with four of the top ten originating nations classified by the World Trade Organisation as developing countries, namely China, Malaysia, India and Nigeria (see Table 1). International students account for 19 percent of all students in the UK (Higher Education Statistical Agency, 2018), and it is the second most popular destination after the United States (Morgan, 2017). Over the last two years, these students have been responsible for £10.8 billion of UK export earnings, £750 million to the UK transport industry and £690 million to the UK retail industry (HESA, 2018). The majority come from low- and middle-income countries in Africa and Asia (Universities UK International, 2017). The focus, here, on students moving from LEDCs to the UK to study mirrors the prevailing geography of student mobility, which at the global scale is characterised by East to West and non-English-speaking to English-speaking countries (Brooks and Waters, 2013). While representative of much international student mobility, we acknowledge that this excludes some flows, subjects and experiences that do not correspond to the norm.

[Table 1 about here]

Because their journeys require border crossings (which is critical to epidemic outbreaks and pandemics), there is a possibility that students can import diseases from their originating country with a potential risk of translocation of infectious agents (Stewardson et al., 2009).

Moreover, they can themselves encounter travel-related health and wellbeing problems whilst abroad. The international sojourn is associated with separation from family and social support, as well as exposure to new cultures and environments (Brown and Holloway, 2008). The accompanying psychological stress could explain why mental health issues are a leading cause of medical complaints amongst international students (McLafferty et al., 2017). There are also physical health consequences due to changes in the living environment (Dummer, 2008).

There have been studies on the uptake of travel health advice by tourists travelling from developed to less developed countries (Hartjes et al., 2009; Hamer et al., 2017), on the health-risk behaviours of students (Rosenthal et al., 2006; El-Ansari et al., 2013; Brown and Stephan, 2013), and on international students' adjustment and well-being as sojourners (Brown and Holloway, 2008). However, the health-related needs and preparations of inbound travellers from low and middle-income countries, including international students, are yet to be explored. This study addresses that knowledge gap through an interdisciplinary approach that combines health and tourism studies, which is informed by mobilities research. We hope that it will be a useful guide for stakeholders in the design of robust public health safety measures, as well as providing support to international students in their move to a new country and culture.

Literature review

Educational tourism and international student mobility/ ies

Educational tourism is categorised by Ritchie (2003) into general travel for education (or 'edu-tourism'), which includes guided study tours and formally organised programmes for adults or seniors such as those arranged by the University of the Third Age in the UK, and travel for purposeful study or education by those normally enrolled on a tertiary degree or higher, plus language school and overseas exchange students. This covers a variety of educational tourism experiences in terms of duration and other characteristics (Figure 1). At one end of the continuum are visits lasting a matter of hours, requiring little or no preparation or prior knowledge and undertaken in natural settings such as a museum. At the other end are undergraduate (three or four year) and postgraduate taught (one year) degree programmes, together with access and pre-Masters courses, completed away from one's home or country, at considerable expense and in institutional settings such as university campuses.

[Figure 1 about here]

With edu-tourism, tourism is the primary motive and education/ learning is secondary. Travel and stayovers falling into this category lie outside the scope of this study and are discounted. Instead, we focus on what Ritchie (2003) calls 'education first' educational tourism (EFET), which may periodically involve activities that are recognisable as tourism such as day excursions and overnight stays at the destination or visiting friends and relatives/ return travel during vacation periods; however, these are secondary to studying for and obtaining a recognised qualification. (That is not to say that destination attributes such as accessibility and attractiveness do not play a part in the international student's decision-making process,

when choosing where to study.) There is a further distinction to be made between 'diploma mobility' (spontaneous) and 'credit mobility' (organised), with the former involving students moving for the whole of a programme of study and the latter referring to bi- or multi-lateral study abroad schemes such as Erasmus where the student completes part of their programme overseas by studying equivalent subjects, typically for a semester or an academic year (Brooks and Waters, 2013).

Some would question whether EFET constitutes tourism at all. Many of the organisations implicated in this phenomenon, including higher education institutions (HEIs), would not see themselves as part of the tourism industry, and participants are likely to self-identify as students rather than tourists or travellers. Nevertheless, Ritchie (2003) argues that people in this category may be classified as tourists, and have tourism impacts and implications for regional development. To avoid arid and unproductive debates over what or who is a tourist, it may help to think of the mobility of international students as one of a number of temporary mobilities. Hall (2005) arranges these mobilities into three fields according to distance travelled and duration. Study abroad is in the 'migration field', distinguished from mobilities in the 'daytripping field' and 'tourism field' by virtue of the often huge distances travelled, the extended length of stay and their serious nature/ purpose.

Moving beyond labels, the influence of mobilities research may be detected in Ploner's (2014) study of international student experiences, including:

- the blurring of boundaries between seemingly stable and distinct mobilities and identities – namely student, migrant, refugee, traveller, etc – which intersect in and between mobile subjects;
- the decentring of the student experience from specific spaces and places (the university and locality as the place of study and residence), and designated periods of time (between registration and graduation), where performances of resilience are more than a matter of overcoming culture shock and adjusting to a new environment over the course of the 'student life cycle'; and
- the use of mobile methodologies/ methods, specifically biographical interviewing and memory work with international students (see also Büscher and Urry, 2009; Ricketts Hein et al., 2008)

Ploner (2014) underlines the importance of 'moorings' in mobilities research and identifies those moorings that are important in international student mobility such as airports, technological infrastructures, universities, friends and family, agents, etcetera, that maintain the interconnectedness of the system of – and allow for the smooth flow of – people, objects and information within and across this and other systems. One such mooring, the agent (or educational consultant or broker), is critically examined in a study by Thieme (2017), based on interviews with agents in Nepal. Far from the popular image of the exploitative and untrustworthy agent who facilitates student mobility for individual gain, she finds that her subjects successfully reconcile profit with social orientation, and do not just adhere to but co-create and advocate the professional standards set by their business association. Her conclusion, that students and agents are part of a 'constellation' of actors, regulations and

technologies which themselves 'migrate', resonates with the agenda for mobilities research advanced by Sheller and Urry (2006), Hannam et al. (2006) and others.

Mobile risks: the translocation of diseases

Mobilities research entails a concern for the undesirable and unforeseen consequences of living a mobile life which threaten that very mobility. In the late modern era, these include the transmission of disease by people on the move, and the potential for infection. Here, Gatrell (2011: 105) distinguishes between diseases that have re/ emerged due to poverty and inequality, notably tuberculosis and Human Immunodeficiency Virus (HIV), and diseases such as Severe Acute Respiratory Syndrome (SARS) and 'swine flu' (H1N1), which 'bind animals and humans into new networks'. Outbreaks of the latter tend to be sudden and short in duration, with fewer people affected but more media coverage and public concern relative to the former. The difference between the mobility of these diseases and those of the early modern era is perhaps best explained by Elbe (2008; cited in Gatrell, 2011: 23):

> ... the very attempt to create a world economy in which goods and people traverse the planet with growing ease and speed increases the chances of pathological viruses doing exactly the same – and with potentially devastating international social, economic and political consequences.

Much travel-related translocation of diseases has been documented across the world. This includes the SARS outbreak of 2003, which started in southern China and spread to some 30 countries, affecting more than 8,000 people and causing over 800 deaths (Schillmeier, 2008). More recently, the Ebola epidemic of 2014, originating in Guinea and affecting much of West Africa, saw reported cases in nine countries spread by travellers to/ from affected areas (CDCP, 2014). These occurrences seem almost insignificant compared to the current Coronavirus pandemic (COVID-19). Caused by a virus believed to have originated in animals and moved to humans in the context of a seafood and live animal market in Wuhan, China, COVID-19 spread in less than five months from the first reported case to affect over 180 countries. It was declared a pandemic by the World Health Organisation on 11 March 2020. At the time of writing (July 2021), 187 million people have been infected globally, with over 4 million deaths linked to a positive test for the virus (CSSE, 2021).

Travel and tourism is a compound and interdependent industry and activity, which makes it prone to external variables such as epidemics (Mansfeld and Pizam, 2006). The increasing number of legal, and illegal, border crossings over the last few decades has implications for public health, as does the speed of modern travel; this has outpaced the incubation periods of almost all infectious diseases (Gatrell, 2011). Indeed, it is possible to circumnavigate the globe without manifesting any symptoms; travellers may appear to be unaffected when crossing international borders and passing through immigration control, only to fall ill after arrival. To reduce the risk of pandemics, countries must intensify their health surveillance, control and reporting systems (Coltart and Behrens, 2012). Fenner et al. (2007) warn that those countries that receive a high population of inbound arrivals must have robust strategies in place to reduce the risk of importing disease.

Like all travellers, international students risk translocating disease and have been implicated in the re/ emergence of diseases, drug-resistant infections and even epidemics (CDCP, 2006; Lavender et al., 2009). Tellingly, the International Society of Travel Medicine has identified them as high-risk travellers (Neave et al., 2017). During their stay, many return to their home country for short periods to visit friends and relations, for example for New Year celebrations and other festivals (Heywood et al. 2012). This further increases the risk of translocation/ infection, because of the incidence of visits to rural and low resource areas where health risks are higher (Hamer et al., 2017). Even allowing for the possibility that the majority of international students are middle and upper-middle class (Ritter, 2016), and therefore carrying a lower health risk (Najman, 2006), it has been shown that socio-economic status alone does not insulate receiving countries from the risks (Kongnyuy et al., 2006). Episodes of disease mobility and transferability are facilitated by globalisation and the ease of transportation, reinforcing the notion among public health professionals that no one country is immune until the world is free from infectious diseases (Stewardson et al., 2009).

Health and mobility: challenges faced by internationally mobile students

Mobilities affect and are affected by health and wellbeing (Gatrell, 2011). The connections between these things have been explored in published studies on medical tourism, mobility in later life, automobility and public health, and the everyday mobilities of people with a physical or cognitive impairment. The list of topics is growing, and yet health mobilities would appear to remain a marginal subject, partly because 'health' and cognate words are often missing from the title and list of keywords for the works in question (Kaspar et al., 2019). Indeed, recent work has focussed on so-called 'therapeutic' im/ mobilities (Gatrell, 2013; Kaspar et al., 2019), encompassing the multiple mobilities of patients, medical professionals, information, pharmaceuticals, etcetera, and the transformative power and potential to 'do good' arising from contingent combinations of these people and things (e.g. to cure illness, alleviate symptoms or enhance well-being). This study takes a different direction in considering how certain mobile practices – namely international student mobility – can make subjects feel worse, not better. It could be said to be concerned with 'traumatic', not therapeutic mobilities (arguably two sides of the same coin).

International students face both psychological and physical health issues during their stay that need to be taken into consideration in pre-departure health preparations (Brown and Holloway, 2008; Valk, 2017). Learning in higher education involves adapting to a new academic and sociocultural context, and Brown and Holloway (2008) show that acculturative stress arises due to language difficulties and disparate academic and national cultures between the host country and the international student's home country. Kift (2004) argues that the magnitude of this stress means that a significant number of international students withdraw or consider withdrawing before they complete their studies, especially in the early months. It can be sufficiently traumatic as to trigger psychiatric illness. Wang (2017) states that more than 150,000 Chinese students studying in the UK are at risk of mental health difficulties, a problem made worse by linguistic inadequacy and a lack of social support. Similarly, Rosenthal et al. (2006) found that 43 percent of international students at the

University of Melbourne had anxiety and 38 percent had depression, believed to be due to the stress of adjusting to a new culture.

University students, because they mostly comprise young adults (Ritchie, 2003), have a high prevalence of risky behaviours that can negatively impact their health (Neave et al., 2017). These include drinking, smoking, unprotected sex and drug use (Rosenthal et al., 2006), which can predispose students to alcoholism, lung cancer, sexually transmitted infections and addiction to drugs (CDCP, 2017). El Ansari and Stock (2012) found that about 28 percent of students in seven UK universities smoke. In a separate study by El Ansari et al. (2013), again in seven universities in the UK, heavy drinking was reported. Research in two UK universities showed that 25 percent of 1,108 domestic and international students engage in high-risk sex, defined by inconsistent use of protection (Chanakira et al., 2014). Brown and Stephan (2013) also found a high propensity towards casual sex among international students in the UK, with little consideration of the risks to health.

Travel medicine is a specialist clinical field that addresses travel-related health risks (Aw et al., 2014). Within its remit are health promotion related to the destinations and destination societies visited, and the prevention of disease or other negative outcomes for the patient arising from international travel in addition to any potential impact on the health of the local population. It can help international students (and other travellers) develop self-efficacy and psychological stamina in order to cope with the challenges of studying or sojourning in a new country (Hudson, 2007). Those who understand and can manage the health-related risks of the international sojourn may be less susceptible to illness, psychological stress and mental health issues (McGuinness et al., 2015).

Methodology

A qualitative methodology was adopted for this study because of the depth and richness of data offered by such an approach. It also seemed an appropriate choice given the potential sensitivity of the topic (Jones et al., 2013). Studies of international students' travel health preparations cited in this paper have largely adopted a quantitative approach to collecting, analysing and reporting information. While they have indicated a low uptake of travel health advice, no one study has explored the reasons for this.

A narrative interview approach was used as it allowed participants to reflect on their travel health preparations prior to travelling to the UK, and on their health experiences once in the country. Narrative research is often characterised by chronological accounts and reflections on life experiences. The approach is unique, in that it makes the participant the central character from which less fractured and holistic stories are obtained (Jones et al., 2013). As is common in such research, an unstructured interview was adopted as the sole research method, in which only a few questions are predetermined; rather, the interview flows according to the social interaction between the researcher and the participant (Punch, 1998). At the start of the interview, participants were asked to narrate their pre-arrival preparations. They were then questioned about their health experiences since arrival. Interviews lasted

around one hour, and much use was made of 'prompt and probe' questions relating to the unfolding conversation (Zhang and Wildemuth, 2009).

Purposive sampling was adopted in order to generate rich, dense and focused information about the travel health preparations and experiences of international students. Since most previous studies related to this topic have focused on tourists travelling from developed countries to developing countries, this study was designed to address the gap in the available literature by exploring the reverse. It was decided that interviews be conducted with students from different countries using maximum variation sampling, including some of the top originating countries for internationally mobile students to the UK. The research was undertaken at Bournemouth University in the south of England, and all full- and part-time international students were deemed eligible to participate regardless of their course of study so long as they were a citizen of a 'developing country' (as defined by the World Trade Organisation). Ten participants were interviewed, which allowed a thorough examination of the research questions (Jones et al., 2013), while maximising the chances of collecting sufficient data to achieve saturation (Charmaz, 2006). A profile of participants is offered in Table 2, with their real names replaced by pseudonyms to maintain privacy.

[Table 2 about here]

Informed consent was obtained from participants and interviews were audio-recorded with their permission, and manually transcribed verbatim. They were analysed using the technique of thematic analysis (Braun and Clarke, 2006). In order to achieve familiarisation with the data, transcripts were read and re-read to note important or thought-provoking testimony. Subsequently, the process of coding and categorising was undertaken, resulting in sixteen themes and thirty nine sub-themes. The following section of the paper reports and analyses testimony pertaining to these themes and sub-themes in five sub-sections, namely:

1. participant perceptions of the health risks associated with traveling to and studying in the UK for an extended period of time (not less than one year);
2. participants' use of (formal) travel health services prior to departure;
3. participants' use of non-medical (informal) sources of health advice, both before and during the academic sojourn;
4. participants' fear of becoming ill while away from home, and the experience of being ill for those affected; and
5. specific issues raised by participants with pre-existing health conditions.

Results

Travel health risk perception

When participants were asked questions to assess their perception of the need for taking up travel health services before embarking on their studies, many did not see this as necessary:

> I did not think about any preparation. I was excited because I was coming to a new country, things were good. (Singh, India)

> Unless you have an underlying sickness, there shouldn't be any problem. What problem will there be? (Sarah, Uganda)

This low travel health risk perception supports the finding of Hartjes et al. (2009) and Neave et al. (2017), each reporting a low risk perception score among their respondents. Participants indicated that the act of seeking travel health advice is not a common practice in their country, as indicated below:

> Maybe we underestimate it in our country because it's not in our DNA to get health advice before we travel, it is not in our culture. We feel like you don't need to go to the hospital or doctor to ask for health advice until you get sick. (Simon, Malawi)

> We don't have the practice to seek health advice before we travel, usually we just care about our health when we go in the jungles with insects and creatures that will cause you really bad sickness, that's when we pay attention to health. I think it's because these countries, the developed countries, they have good healthcare systems and they don't have a lot of weird diseases or viruses. (Binh, Vietnam)

As Leder et al. (2017) note, the unpopularity of travel health services in developing countries is linked with perceived low risk among the general population. Doctors also share this perception, being more concerned with existing illnesses rather than those that may arise from studying in the UK:

> It was mainly about my specific condition in terms of medications, such as migraines, cold feet and hands, but everything else in terms of diet or health we didn't talk about. (Chipor, Zimbabwe)

The lack of concern among participants may be attributable to the fallacy of youth, the belief that they have years of life and relative good health ahead of them. The destination country is perceived as safe in relation to where they have come from, a dangerous idea that invests qualities of 'safety' and 'security' in the place and not the activity undertaken: the international sojourn. It is not just travellers but also health professionals that are implicated in this, with health-seeking behaviour being largely after the event and medical intervention reactive, not proactive. The perception of low risk would appear to be a systemic issue, involving both medical practitioners and the general public in developing countries.

Travel health preparations

Five of the interviewees cited a pre-existing health condition as an important reason to access travel health services and advice before embarking on the international sojourn:

> I have certain medical conditions that I had to think about so I talked to my family and also talked to my Aunt 'cos she is a doctor. I also went to one of my doctors who talked to me. (Chipor, Zimbabwe)

> Since it is very cold here my asthma will get worse, so they (her parents) worry about that, so they ask me to prepare. (Kannika, Thailand)

Travellers with underlying medical conditions require specific travel health risk assessments before they travel, as indicated in other studies (Han and Flaherty, 2015; Herman and Patel, 2017), including participants in this study:

> I went for a very basic check, the eyes, blood pressure, yes, very basic. I just tell the doctor I have to study in the UK and I don't know when I will come back, so maybe you can give me a small medicine for when a person is sick or for some fevers. (Ting-ting, Taiwan)

Although doctors should have a holistic approach to assessing the risk of travelling across borders (CDCP, 2011), participants' experiences suggest that they focused on speculative drug prescriptions and pre-existing health conditions only. Morgan et al. (2015) note that travel medicine is a challenging area of clinical practice which requires up-to-date knowledge and experience in a number of areas. However, due to insufficient training among primary care physicians, those providing advice often lack the required competence. Leder et al. (2017) observe that the practice of travel medicine in developing countries is not as well developed or understood as in developed countries. This may simply be due to there being a smaller number of outbound travellers from developing countries and, therefore, less demand for these services.

Although Juliet was screened for tuberculosis prior to travelling to the UK, which is mandatory for a visa application, she had very little time for any other preparations due to delays in obtaining her visa:

> I could not prepare at all, I had only two days and I had not bought anything because I did not know what the outcome (of the visa application) could have been. (Juliet, Ghana)

Yemi did not seek travel health advice, nor did she access tuberculosis screening services for immigration. Though she lived and studied in Nigeria, she had a UK resident permit and had been travelling in and out of the country since she was young. The ease of crossing borders without health check precautions may contribute to the translocation of diseases (Roohi and Wilson, 2012). Yemi did not undertake any travel health advice and exhibited a relaxed attitude towards (her) health. On questioning her about the Ebola crisis in Nigeria, she said:

> I remember the Ebola situation was really terrible. There's no underestimating the fact that, yes, health checks are very important before you travel because you are moving from one place to another in a crowd of hundreds of people and I think it's just general concern for humanity of not wanting to spread diseases.

However, this was not sufficient motivation for Yemi to access travel health services herself. Yemi's account corroborates other studies that reveal many international students do not seek travel health advice before commencing their studies (Neave et al., 2017), whereas others undertake it only on the recommendation of their employer or sponsor (Leder, 2017).

In summary, (travel) health advice tends to be sought or given only where there are pre-existing conditions. Health checks are determined by status/ residency, not the level of risk.

Participants engage with them because they are obliged to (by law), for example screening for tuberculosis, and not because they see any benefits for their health or the health of others.

Non-medical sources of health advice

Doctors and medical practitioners are not the only source of health advice for international students. There were several sources used by participants. Some searched online for travel health information prior to their trip. The use of the internet and social media in travel medicine is well established, as there are virtually no authoritative texts or journals that can provide current health risk information about particular destinations (Leggat, 2000). However, some participants felt that the internet did not help much:

> I logged onto the gov.uk website, yeah, but honestly their language is not very understandable to me, like it's not very comprehensive. It had a lot of things and I found it very hard to follow. The way they put all the information is very confusing. Maybe it's because of the British English, but the way they write is not very familiar to me and actually when I logged on to the NHS website I was, like, 'okay it's too complicated', and I just hoped that I would not get sick (laughs). (Binh, Vietnam)

Inaccuracies, confusions and misinformation constitute a constraint to accessing online travel health advice, especially from unofficial websites. As such, travel medicine practitioners are instructed to be mindful of the online sources they use when advising prospective travellers.

Participants also sought advice from family and friends who had knowledge of and/ or had been to the UK. Family and friends are known to provide non-professional health advice to travellers (Wilder-Smith et al., 2004). Most of the information offered centred on the weather and food, which has some links to health. Listening to participants' stories, it became apparent that the challenges they encountered in the UK went well beyond the food and weather, which suggests that advice from friends and family is not all-encompassing or sufficient.

Health advice was also obtained from agents and university representatives. However, Ting-ting felt that information from agents could be unreliable:

> Most of them will just tell you the good things, they won't tell you the bad things because if you hear the bad things you will be afraid and maybe you will decide, 'I don't want to go to study'. So, they always tell you the good things. (Ting-ting, Taiwan)

Leggat (2000) notes that agents are an important source of pre-travel health and safety advice, yet the quality and accuracy of this information has been criticised (Wilder-Smith et al., 2004). Without wishing to do a disservice to agents, who with few exceptions act in a professional manner and in accordance with strict guidelines (as confirmed by Thieme, 2017), there may be a potential conflict of interest whereby highlighting the risks and costs to would-be international students gets in the way of promoting universities and the benefits of travelling abroad for study.

The fear and experience of becoming ill abroad

The seven participants who brought drugs (medical, not recreational) with them were motivated to do so because they were afraid they might not get prompt treatment should they become ill in the UK. While self-care practices can boost the speed of recovery, the principle of the rational use of drugs enshrined in World Health Organisation (2012) may be compromised when students share medications with each other:

> I brought medicine for my allergies, but when I came here I never got ill and gave it to my friend because she's got really bad allergies and used all my medicines. (Binh, Vietnam)

In addition, individuals are sometimes poorly advised regarding the need for drugs. For example, malaria is not a health risk in the UK (being one of a number of countries in which it has never existed or has been eradicated), and yet Sarah received contradictory advice:

> There was the issue that, 'If you go to the UK and you get malaria there you will die', so I had to buy a huge amount of drugs which I haven't even taken. I had to get malaria injections to make sure that I don't get sick here, and then my Mum had to pack for me all kinds of medicines as well. (Sarah, Uganda)

As this shows, there was fear among participants of becoming ill while in the UK. Several participants did in fact go on to experience illness. Although their ailments were not serious, the experience of being ill was isolating and frightening as reflected in their choice of words. The absence of family, a source of comfort when ill at home, was keenly felt. Furthermore, becoming ill affected their academic progress, with the potential to cause additional and enduring distress.

The encounter with the UK healthcare system was challenging for some participants, who found that healthcare was not as accessible as it is back home. Singh reported a significant delay in getting an appointment for mental health issues:

> The entire process was so frustrating and I think that pissed me off and added towards the stress that I already had. I literally had to go and say, 'This is an extreme emergency and I am living alone and feeling suicidal'. (Singh, India)

Meanwhile Chipor reported a lack of attentiveness from the doctors she managed to get an appointment with:

> I think I've seen two or three different doctors. I felt like the doctor-patient relationship was not there. One doctor did not take the time to listen to me. She was trying to get rid of me as fast as possible. And then another one tried to put me on any sort of medication that she could think of. So, I felt like if I was to really get sick here so that I had to be hospitalised, I will not get adequate treatment. That worried me a bit, so I try as much as I can not to get sick (laughs). (Chipor, Zimbabwe)

There are pressures on the National Health Service in the 'age of austerity', including staff shortages, and this study reveals that international students are impacted by them (assuming that they do not pay for private health care).

The impact of the sojourn on pre-existing health conditions

In health geography, environmental changes have been shown to be associated with various health impacts (Dummer, 2008). Accordingly, international students can experience physical and psychological effects during the academic sojourn, especially if they have an underlying medical condition that may warrant accessing health services on a more frequent basis. For example, Singh experienced a psychological trauma before travelling to the UK, and shared her story on how this affected her well-being during her studies:

> I used to get nightmares a lot, and once I got to the UK they came back and I saw the same nightmare every day. It was distressing. I thought it would gradually go away, but it didn't. I had never been depressed in my life to the extent that you cut yourself off from all contact. I knew of course about culture shock and homesickness, but I didn't anticipate this at all. (Singh, India)

Singh did not access professional travel health services, outside of the required screening for tuberculosis, because she thought that it would not have helped her. It is certainly possible that pre-departure counselling would have made a difference to her experience.

Chipor, an asthmatic, was concerned about being in the vicinity of people that were smoking. Although she did not suffer an attack, she was tense and vigilant throughout her stay:

> The smoking, no one warned me about that. People smoke a lot here and I felt like I'm actually a passive smoker. After a month I felt like I could die just by walking in the street, because of the smoke. This is something I had to constantly cope with. I feel my chest sometimes is getting a bit tight, like I can't breathe. (Chipor, Zimbabwe)

The testimony of these participants is compelling. Moving to and studying in another country is challenging enough for someone in good health; for those with pre-existing conditions, it is especially difficult and possibly traumatic. Indeed, it might not be an exaggeration to say that all internationally mobile students that complete the academic sojourn, whether in good health at the commencement of their studies or not, demonstrate remarkable resilience and dedication.

Discussion: why mobilities?

Framing this as a study of mobility and of mobile subjects yields a number of advantages. Mobility is easier to define than tourism or migration, and means we can avoid debating what or who is a tourist and, instead, engage with the behaviours and experiences of our subjects. A focus on mobilities also surfaces connections between different things. The interconnectedness of the mobility of people to the mobility of objects and to imaginative, virtual and communicative (non-material) travel is demonstrated in the testimony of students

who participated in this study, who brought prescribed drugs, and ideas and beliefs about health and treatment from their home countries, and sought travel health advice through the internet and social networking sites, often from their peers rather than professionals. Also, mobility begets risk, and particular risks come with moving (temporarily) to another country to study, for the individual student and for other stakeholders, including publics. Of significant concern is the potential for translocating diseases, and we should all be alarmed not just by this prospect but also the 'blindness' to the risk of carrying disease across borders exhibited by participants in this study, that is, if they are typical of internationally mobile students in general.

The study builds on earlier research on educational and health mobilities. It takes its lead from Ploner's (2017) work with overseas students, by highlighting the 'messiness' of our research subjects' mobilities and identities; also by exploring pre-arrival actions and non-action – travel health preparations – and not just subject experiences during the academic sojourn; and finally by using mobile methods in the context of 'education first' educational tourism. Its contribution to the body of work on mobilities of health and wellbeing lies with inverting the idea that travelling and sojourning makes the mobile subject healthier in some way (e.g. by escaping to a 'stress-free' environment, by having necessary or elective surgery on preferable terms to locally-based alternatives), and in its characterisation of 'traumatic mobilities', named acts of mobility – moving overseas to study for and obtain a qualification in this case – that can end up making subjects feel worse, not better.

By investigating educational and health mobilities at the cusp of the tourism and migration fields, the study has revealed connections and interdependence between them that would have remained invisible had they been studied in isolation. This is a familiar justification for viewing phenomena through the prism of 'mobility', but in other ways the study diverges from the orthodoxy. For example, it does not share the positivistic or 'etic' character of early mobilities research by addressing, not avoiding, differences in motivation, experience and behaviour of students from the emerging world regions (see Cohen and Cohen, 2015 on tourism). In addition, it responds to criticisms of the mobilities discourse by McAllister (2011), Harrison (2017) and others by not fixating on physical human movement at the expense of movements of objects and information (here represented by medicines and medical advice), and also by resisting the tendency to valorise mobility as a good thing, something to be desired (which is challenged by the testimony of our respondents). Thus, the study contributes theoretically to mobilities as a 'movement-driven social science' (Urry, 2007: 43), as well as being situated within it.

Conclusions

Domestically, the start of the academic year represents one of the largest annual migration events, certainly in the UK. Add to that the arrival of international students from around the world and this becomes a hugely significant phenomenon in scale and scope that invites, indeed demands, further empirical mobilities research, especially now that COVID-19 has alerted us to the risks of movement both for participants (quarantine on arrival and isolation during lockdowns in residential accommodation, with potential mental health impacts) and

publics (the risk of contagion from students who may be infectious but asymptomatic, or not socially distancing from others who might have the virus). For now, the imposition of travel bans and other restrictions to reduce infection rates and the affordances of video conferencing software mean that remote learning has become the norm for international students (with different implications for health and wellbeing). However, as the world opens up again to international travel for education and other purposes, so these risks will re-emerge.

This study suggests that students from developing countries do not perceive much risk to their health and wellbeing from the international sojourn; in turn, their uptake of professional travel health services as a necessary precautionary measure does not feature to any great extent. The students' appraisal of the risks involved is affected by the notion of travelling to a developed country, relatively free of disease and with an advanced health care system. However, becoming ill in the UK can be an isolating, distressing and frustrating experience for students, not only because of their symptoms but also due to delays in obtaining an appointment with a doctor and the lack of social support. It is noticeable, also, that students have few concerns about diseases that they might bring with them. Typically, the travel health preparations they make are negligible, pre-existing conditions notwithstanding, and informed largely by non-medical sources of information including family and friends, the internet and social media, and study abroad agents. Some advice is provided by doctors and medical professionals, whether by appointment or serendipitously, but this is limited.

We recommend that the risk of translocating disease by travellers and controlling that risk must not be left solely to public health departments but, rather, approached through a well-integrated, joint-sector perspective. It is necessary that governing bodies in low- and middle-income countries encourage health professionals to undertake courses and training in travel medicine, to ensure that all travellers have access to quality advice; there is a pressing need to promote greater uptake of these services, too. Finally, HEIs in receiving countries must understand they are key players in the promotion of travel health preparations and healthy behaviours to students, both before and during the international sojourn. Having pursued the international student market and the fee income it generates, it is reasonable to expect institutions to lead on this.

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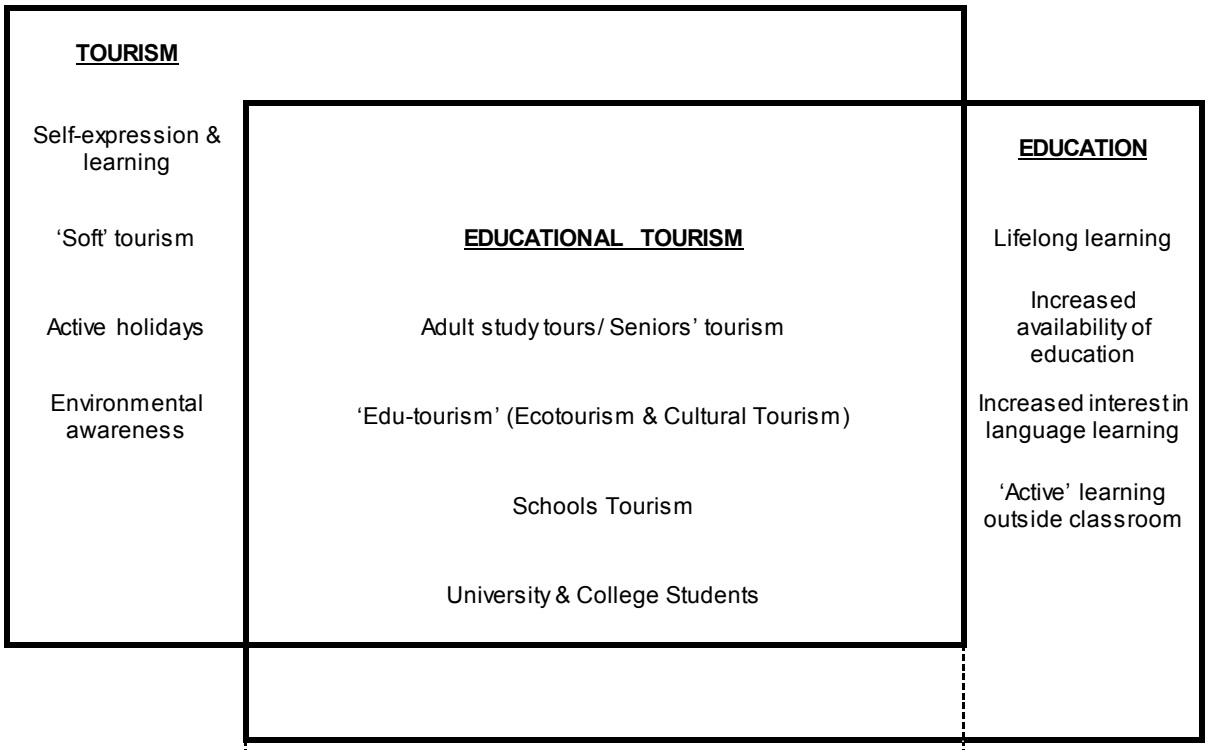
Table 1: Global flow of tertiary-level students to the United Kingdom (UNESCO, 2018)

Country of origin	**No. of mobile students hosted**	**% of total (432,001 students)**
1. China	89,318	20.6
2. Malaysia	17,360	4.0
3. Hong Kong, China	16,717	3.9
4. India	16,655	3.9
5. Nigeria	16,072	3.7
6. United States	15,654	3.6
7. Germany	12,963	3.0
8. Italy	12,086	2.8
9. France	12,076	2.8
10. Ireland	10,191	2.4
(Other countries)	(212,909)	(49.3)

Table 2: Respondent/ participant profiles (n=10)

Pseudonym	**Gender**	**Country**
Chipor	Female	Zimbabwe
Binh	Female	Vietnam
Juliet	Female	Ghana
Kannika	Female	Thailand
Li Jun	Male	China
Sarah	Female	Uganda
Simon	Male	Malawi
Singh	Female	India
Ting-ting	Female	Taiwan, China
Yemi	Female	Nigeria

Figure 1: Situating educational tourism (adapted from Ritchie, 2003)



'Tourism First' ET		'Education First' ET
<----------	***Parameters***	---------->
Minutes	*Length of time*	Years
No intentions	*Intentions*	Full intentions
Multiple purpose	*Motivation*	Sole purpose
Limited preparation	*Preparation*	Full preparation
Informal	*Formality level*	Formal
Natural	*Settings*	Human-made
<----------		---------->

In scope of this study