The health consequences of migration: Emerging directions in scholarship and research
MOVING TARGETS:

CONTRIBUTION OF LONGITUDINAL SURVEILLANCE TO THE UNDERSTANDING OF MIGRATION IN RELATION TO HEALTH IN AFRICA

27 Jan 2014

Prof. Philippe Bocquier on behalf of the MADIMAH working group*
**HDSS:** Health and Demographic Surveillance System

Definition: “population registration system that monitors health and demographic dynamics in a geographically defined population”

**Health systems** designed to service a population residing within reach (geographically targeted)

- People are mobile...
- …together with their diseases and health behaviours!
Initial question

Considering the importance of migration, do health outcomes as measured in local populations really reflect local health risks?
Health status impacts on subsequent health risks and resources

Enablers (e.g. health & educ systems)

Constraints (e.g. labour, gender roles, norms...)

Migration

Resources (assets, income, educ, services, network...)

Risks (disruption, exposure...)

Health status

Health status impacts on enablers and constraints

Health status impacts on subsequent health risks and resources

MADIMAH conceptual framework
The ‘SoSAD’ drivers of health-migration relationships

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<th>Rural to Urban (new) migration</th>
<th>Urban to Rural (return) migration</th>
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<td><strong>Socialisation</strong></td>
<td>Rural behaviour persists</td>
<td>Urban behaviour persists</td>
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<td><strong>Selectivity</strong></td>
<td>Selection of migrants in rural areas</td>
<td>Selection of migrants in urban areas</td>
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<td><strong>Adaptation</strong></td>
<td>To the urban behaviour</td>
<td>To the rural behaviour</td>
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<td><strong>Disruption</strong></td>
<td>Migration disrupts other behaviours</td>
<td>Migration disrupts other behaviours</td>
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</table>
Pre-migration health risks at origin

Socialisation & Selection

Disruption (arrival)

Adaptation

Disruption (return)

Post-migration health risks at origin

Re-adaptation

Health risks at destination
Motivations

- Research to better understand contradictory effects of migration on health
  - Migration as life-enhancing
  - Migration as life-threatening
- Inform policy makers...
  - To improve health of migrants and their relatives
  - To address ubiquitous nature of diseases
  - To bridge origin-destination gaps (e.g. Rural ↔ Urban)
    - Information systems and health measures that account for migrants
    - Referral mechanisms (e.g. digitalized health books)
    - Technologies to improve treatment adherence and compliance (e.g. health through mobile phone)
Some results

Using HDSS standardised datasets
1. Nouna HDSS Burkina Faso
2. Nanoro HDSS Burkina Faso
3. Ouagadougou HDSS Burkina Faso
4. Navrongo HDSS Ghana
5. Kintampo HDSS Ghana
6. Dodowa HDSS Ghana
7. Kisumu HDSS Kenya
8. Nairobi HDSS Kenya
9. Kilifi HDSS Kenya
10. Manhica HDSS Mozambique
11. Agincourt HDSS South Africa
High migration and high variation...

...for both males and females

(Ginsburg et al. to be published)
High circulation in rural Agincourt and urban Nairobi (2010-11)

Nairobi In-Migration

Agincourt In-Migration

Nairobi Out-Migration

Agincourt Out-Migration
Selectivity and disruption: Nelson-Aalen mortality curve by mother’s duration of residence (Bocquier et al. 2010)
Selectivity and Re-adaptation:
Return migration to Agincourt HDSS (South Africa)
(Bocquier et al. to be published)

Annual Death rate in %

Years since return-migration (0=non-migrants)

- Non-migrants 1994-1997
- Non-migrants 1998-2002
- Non-migrants 2003-mid-2006
- Migrants 1994-1997
- Migrants 1998-2002
- Migrants 2003-mid-2006

(Large dots: significant (p<0.05) migrant to non-migrant differences)
Many thanks for your kind attention!

* From the MADIMAH team…
Mark A. Collinson (Wits), Donatien Béguy (APHRC),
Philippe Bocquier (UCLouvain), Carren Ginsburg (Wits),
Michael J. White (Brown) and many others!

…and from Ouagadougou HDSS:
Clémentine Rossier (UGenève), Abdramane Soura (OPO-ISSP), Sara Randall (UCLondon) and many others!
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Nairobi, Kenya
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Columbia Population Research Center
Advancing Research in Population, Health, and Society

Columbia Global Centers
Assessing Immigrant Health: Opportunities and Challenges for Research and Public Policy

Van C. Tran
Columbia University
January 2014
Outline

What we already know:
- The immigrant “advantage”
- Disparities in health outcomes

What we need to know:
- Acculturation as a mechanism
- Emerging trends in immigrant health
- ACA and its implications for healthcare
What we already know

- Comparison: immigrants vs. natives
- Research focusing on outcomes
  - Physical health
  - Mental health
  - Access to care
- Disparities in health outcomes
  - Disparities by race/ethnicity
  - Disparities by neighborhood
  - Disparities over the life course
The conventional wisdom: “The healthy immigrant”

- Immigrants report better health than natives of similar demographic & social background.
- This “advantage” often declines with years in the U.S. and across immigrant generations.
- Explaining the immigrant advantage?
  - Immigrant selectivity
  - Unhealthy assimilation
  - Selective return migration
  - Ethnic concentration effect
  - The role of acculturation
### Top 10 health outcomes among foreign-born & native-born individuals (Cunningham et al. 2008)

<table>
<thead>
<tr>
<th></th>
<th>Mortality</th>
<th>Perinatal health&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Mental health</th>
<th>Overweight and obesity</th>
<th>Heart and circulatory disease&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Diabetes&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Cancers&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Infectious diseases&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Injuries&lt;sup&gt;f&lt;/sup&gt;</th>
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Acculturation as a mechanism: lack of conceptual and empirical clarity.

Hunt et al. (2004)

Fig. 1. Number of articles indexed for “acculturation” on Medline 1967–2001.
Emerging trends & implications

- The rise of mass illegality
- The rise of the second generation
- The emergence of new destinations
- The increase in intra-racial heterogeneity
- The implementation of the ACA (2014)
Rise of mass illegality (Massey 2013)
Number of unauthorized migrants (1970-2011)
The size of post-1965 second generation has doubled over the last two decades.

The second generation as a proportion of children under 17.
% change in Latino population by county (2000-2010): new destinations in the South & Midwest

Sources: U.S. Census Bureau, Census 2000 Summary File 1 and 2010 Census Summary File 1.
Latino internal diversity: total population by ethnic origin (2010)

Total Latino population: 50.5 (million)
Asthma prevalence among Latinos (2010)

Source: NYC Community Health Survey
What we need to know

- How acculturation matters to health?
- How legal status impacts health and access?
- How immigrant generation matters?
- How new immigrant destinations matter?

- The implications of the ACA on health access
  - FQHCs and the provision of healthcare to migrants
  - 1,200 FQHCs across the country, serving 1.5 million
  - 1 in 9 Hispanics; 1 in 8 uninsured; 1 in 7 in poverty
  - 2011-2016: $11 billion for community health center
Comments welcomed, thanks!

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The health consequences of migration: Emerging directions in scholarship and research
Migration and Heath: Governance vs Development Perspective

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Migration : Nature and Types

• In developing countries like India, migration is mainly a livelihood strategy, but people also migrate due to other reasons like marriage, education, disaster, conflict etc.

• Internal /international; permanent, temporary and seasonal, forced, regular/irregular; displaced/refugees.

• The internal migration is about five times larger than international migration (740 vs 214 million).

• Migrants are not a homogeneous group - age, sex, socio-economic status, skills, network etc.
Migration Policy

• Migration is treated as an issue of governance - controlling, regulating, managing migration; Both direct and indirect means are used.
• There is a lack of integration of migrants in the development planning. There should be two pronged strategies directed at both the place of origin and place of destination.
• There is a need to change the attitude and mindset about the role of migration in development process. More evidence based planning need to be promoted. So, collection of data and research on migration is of utmost important.
Migration Policy: the Indian Context

• There are a host of laws on labour issues but these are not enough to deal with migrants’ conditions.
• There are also anti trafficking laws.
• There exists an Inter-state Migrant Workmen Regulation Act 1979 which deals with contractor led movement of inter-state migrant labour. Moreover, while a segment of migrant workers moves along with contractors, many also move independently through the network of family, friends and kins.
• There is violation of right based entitlements—access to food grain, education of children, health insurance because of the lack of the portability of entitlement.
• Political exclusion, non-citizenship due to lack of identity and residential proofs, non-inclusion in the voter’s list (about 15 million seasonal and temporary migrants in India).
• Migration is merely seen as a law enforcement and governance issue; how to mainstream migration into development is lacking.
Migration and Health

• Migration is a human development strategy rightly emphasized by UNDP in its Human Development Report 2009, but this may not be true for seasonal, temporary migration/distress migration, internally displaced people, refugees, forced migrants, and irregular migrants.

• There is a negative attitude towards migrants; There is also a stigmatization in the context of HIV/AIDS, TB, Malaria, Polio. In crimes also, they are suspects.
Migration and Health

• A large group of migrants are vulnerable to health risks—3D jobs (dirty, dangerous and demeaning); Many live in slums, squatters and pavements; lack social security and health insurance.

• Non-functional public health services and exclusion based on identity proofs and domicile.

• Privatization of health services and affordability.

• Integration of migrants in health policy—the framework of National Urban Health Mission in India.
Thank you
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Columbia Global Centers
The Immigration Politics of Health Policy

MICHAEL JONES-CORREA
PROFESSOR OF GOVERNMENT
CORNELL UNIVERSITY

“The Health Consequences of Migration: Emerging Directions in Scholarship and Research”
School of Social Work, Columbia University
January 27, 2014
Migration and Health

• The voluntary and involuntary movement of people across national borders, for either short or long term stays, has health policy implications for migrants themselves, sending countries and receiving countries:

• 1) Migration itself can be triggered by public health crises, and the process of migration has direct health effects on migrants.

• 2) Migration can occasion new pressures on health policy for sending countries as well, as fiscal and social remittances trigger social changes in lifestyles and expectations.

• 3) Immigration can result in new public health challenges in receiving countries as migrants make demands and place pressure on public health systems.
Migration and Public Health Challenges in Receiving Countries

- The focus here is on questions raised by immigration for public health policies in receiving nations:
  - Who is eligible for treatment? Who is eligible for health insurance? Who should cover the costs of both treatment and insurance?
  - Most countries make a distinction in policy eligibility between documented and undocumented immigrants, excluding undocumented immigrants from receiving regular access to health services.
  - However, there’s wide variation among and even within countries on the kinds of access to benefits given to unauthorized immigrants.
Variation in Access Across Countries
Significant Populations of Unauthorized Residents in OECD Countries
Unauthorized Residents in OECD Countries: Access to Health Care

Source: ERA, 2021, based on national legislation.
Variation in Access Within Countries
ICE Removals and Returns of Unauthorized Migrants, 2000-2010

Immigration-Related Legislation Introduced and Enacted at the State Level, 2005 to 2011

Party Control at the State Level, 2013

Source: New York Times
Percent Uninsured Unauthorized Adults, 2011

Source: Migration Policy Institute

Note: The states that are not shaded on the map had samples too small to calculate insurance coverage reliably and include: Alaska, Maine, Montana, New Hampshire, North Dakota, South Dakota, Vermont, West Virginia, and Wyoming. Source: Analysis of data from the 2011 ACS and the 2008 SIPP by Bachmeier and Van Hook.
Consequences of Variation in Access
Consequences of Unequal Access:
Lower Rates of Health Insurance Coverage among Low Income Adults

Source: Migration Policy Institute
Consequences of Unequal Access: Fewer Medical Visits over the Previous Year among Low Income Adults

Notes: Low-Income adults are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding. Adults ages 65 and over are excluded because the vast majority is eligible for public health insurance coverage through Medicare. Source: George Washington University Department of Health Policy analysis of 2010 MEPS data.

Source: Migration Policy Institute
Consequences for the Second Generation

17,000,000 Children of Immigrant Descent

Source: Child Trends Data Bank, www.childtrends databank.org
Consequences of Unequal Access: Lower Rates of Health Insurance Coverage for Low Income Children

Source: Migration Policy Institute
Consequences of Unequal Access: Fewer Medical Visits over the Previous Year among Low Income Children

Source: Migration Policy Institute

Note: Low-income children are those with family incomes below 200 percent of the federal poverty level. Percentages may not add up to 100 due to overlaps in public and private coverage and rounding. Source: George Washington University Department of Health Policy analysis of data from the 2010 Medical Expenditure Panel Survey (MEPS).
Variation in Health Services among Immigrants: A Question of Politics

- Despite the EU framework there is considerable variation in access to health care among immigrants in Europe.

- Immigrant access to healthcare in the US varies dramatically across states.

- These differences are political in origin, the result of party and ideological differences resulting in differences in policy toward immigrants.

- Immigrant health is as much a question of politics as a question of the logistical issues of service provision.
The health consequences of migration: Emerging directions in scholarship and research
Health needs of young rural to urban migrants and policy implications—a case of China

ZHENG, Zhenzhen
Institute of Population and Labor Economics
Chinese Academy of Social Sciences

for
Global Web Meeting on “The health consequences of migration:
emerging directions in scholarship and research”
January 27, 2014
Internal migration in China: number and age structure

Number of migrants and average increase rate, 1982~2010

Age structure of migrants, 2005-2010:

- 15-24 age group makes 29% of migrants
- Most of them are unmarried
Health issues of migrant youth

• Migrant youth in cities (more than half of them from rural area)
  – New arrivals: left school, away from home and parents, more likely be influenced by workmates, less awareness on self-protection, and less information about local service
  – Unmarried migrant youth: with a more liberal opinion about sex and some knowledge, unprotected sex often results in unwanted pregnancy and followed by induced abortion
  – Young workers in production line and other workplace: often work overtime, mental health problems and stress is more prevalent

• Services available and unmet needs
  – Less preventive, most of service limited in treatment of problems
  – Almost no consulting service, limited information providing
  – Big gaps in service approach and scope to meet the needs and acceptability of youth regarding sexual and reproductive health (SRH)
Efforts and gaps

Efforts by governmental sectors and CSOs

- Education department: school education, in school consultancy, health promotion activity;
- Department of human resource and labor: pre-migration training and training in workplace, including health issues in training package;
- Department of health and family planning: health promotion (including SRH education, condom distribution), youth friendly clinic;

Gaps

- Scaled up faster on health promotion, very slow and limited progress on service providing;
- Almost all activities/interventions are non-institutionalized projects or temporary activities with temporary budgets.
Intervention assessment:
a challenge to research

- The role of research: enough have been learnt about the facts and problems, much more need to be done on evaluation of strategies and policies addressing them, and on assessment of intervention projects, programme, as well as any efforts that is worth to scale up.

- Challenges to such a research
  - Problems entangled with different systems, sectors, and on-going reforms: many changes at the same time.
  - Feasibility and efficiency of a “traditional” research design: young migrants are highly mobile; “youth” is a short age segment; behavior change takes longer time; →limitation of case-control and follow-up design, outcome indicators (it is relatively easier to evaluate maternal mortality, neonatal mortality, and children’s immunization coverage among migrants).
  - If process is more important rather than outcome for such a research, to find an appropriate design is a big challenge.
Thank you
The health consequences of migration: Emerging directions in scholarship and research
HEALTH CONSEQUENCES OF MIGRATION IN URBAN INFORMAL SETTLEMENTS IN EASTERN AFRICA

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I. INTRODUCTION

- The study focuses on Ethiopia, Kenya and Uganda – 3 EA countries with diverse evolution and development paradigms.
- Previous studies by the APHRC on Nairobi’s slum areas are instructive for urban centres in the other countries.
- UNHABITAT’s work in EA provides incisive findings on urbanization and housing.
- Lack of urban policies in the EA constraints efforts to contextualize urban issues in urban development programmes.
Previous Demographic and Health Surveys have depicted an array of relatively high-risk periods in the lives of women and their children (Montgomery and Hewett, 2005: 396).

Focus on slums has been accentuated by the UN Millennium Development Declaration (2000), which aimed to improve the lives of slum dwellers, including residents of informal settlements by 2020 to ensure environmental sustainability.

For the poor (often resident in urban informal settlements – my emphasis), exposure to varied social inequities could erode feelings of social confidence and weaken the sense of personal efficacy necessary for the sustenance of health-seeking behavior (Montgomery and Hewett, 2005: 401).
II. GENESIS OF INFORMAL SETTLEMENTS

- Post-War and emergence of urban informal settlements: Nairobi and Kampala.
- Heavy rural-urban migration after independence of Uganda and Kenya and during & post-civil war Ethiopia.
- Lack of urban infrastructure and dwindling employment opportunities drove urban migrants to informal settlements where they perpetuate rural lifestyles.
- The urban informal settlements lack basic amenities and are marginalized by civic authorities.
III. HEALTH DEMAND AND SUPPLY

- Urban informal settlements are typically poor environments with poor water supply and environmental sanitation.
- They represent the ‘other’ face of the large cities with large and very densely settled population.
- In EA, the 3 cities have forgotten informal settlements despite their sizes and significant contribution to urban and national economies.
- Health issues are of concern largely to the residents, seldom the civic authorities.
- Large populations of urban settlements wallow in abject poverty, reside in the worst health environments and are perpetrators and victims alike of serious crime.
Rapid population in informal settlements outstrips the health facilities.

Poor health facilities and services compromise the health of residents of informal settlements.

Large family sizes in urban informal settlements cannot be adequately met.

In most cases, the health situation in urban informal settlements is worse than that in rural areas.
Maternal and child health (MCH) remains a menace in view of deficient response to the needs of mothers and children.

Increased adolescent sexuality without adequate safe sex protection measures spurs unwanted pregnancies, STIs and HIV & AIDS.

The ageing population in urban informal settlements are rendered helpless, being the forgotten few.

In sum, urban informal settlements are unliveable on account of health infrastructure and services.
Urban in-migration and immigration offset the health supply of urban informal settlements.

They introduce new health practices that are inconsistent with urban health requirements.

Both migration and health have been influenced by the evolution and governance of different cities with virtually similar characteristics.
ETHIOPIA

- Ethiopia escaped European colonization which denied it classical a western urbanization system, with Addis Ababa becoming a primate city with poor infrastructure and environmental health shortcomings that have recently been undergoing transformation.
- The country underwent a long–drawn civil war, resulting in successive military regimes which paid little attention to urban conditions until 1993.
- A study on HIV & AIDS found that while 51.7 % of urban respondents and 62.8 % of their communities ranked HIV as the number one health concern (Bekalu and Eggermont, 2013).
- Urban informal settlements that are predominant in Addis Ababa, for instance, are the most affected communities.
- Addis Ababa is supposedly the haven of hope for urban migrants that never realize it.
KENYA

- Nairobi emerged in the colonial period along the ‘Kenya–Uganda railway’, growing rapidly to become Kenya’s primate city.
- The city has had the lion’s share of studies on urban settlements in Kenya, funded by various institutions and foundations. [The studies are instructive for all other EA’s large cities].
- The Nairobi Urban Health and Demographic Surveillance System (HDSS) considers Nairobi a typical sub-Saharan Africa city, with experiencing population explosion in the face of growing and chronic urban poverty and declining livelihood opportunities.
- Estimates suggest that 60 to 70% of the city’s population lives in informal settlements or slum like conditions. THIS IMPLIES THAT THE VAST MAJORITY EXPERIENCES VERY POOR HEALTH CONDITIONS.
UGANDA

- Kampala has experienced rapid urbanization due to economic transformation characterized by the proliferation of the informal sector with serious environmental and health implications.
- A study of Environmental health practices, constraints and possible interventions in peri-urban settlements in Kampala provides useful insights (Kulabako et al., 2010).
- The study (quoting UNHABITAT, 2007) suggests that more than 60% of the city’s population resides in these settlements with the lowest basic service levels (sanitation, water supply, solid waste collection, storm water and grey water disposal).
- Evidence from one settlement (Bwase) indicates that typhoid accounts for 47% of water-related diseases, followed by dysentery.
- The study is an informative case study of environmental health in a rapidly growing EA city.
V. THE WAY FORWARD

- There is a need for multidisciplinary studies of multidimensional aspects of migration–health nexus in urban informal settlements in the EA region.
- The studies should be contextualized in historical background, growth and governance systems of different urban areas.
- There are opportunities for systematic urban studies ultimately to lay the ground for periodic updates based on well-developed datasets.
- An Eastern African Urban Environment Research (EAUER) would provide the answer to all these and draw together a host of urban development stakeholders. These would feed into the agenda of the Inter-Governmental Authority on Development (IGAD) and the East African Community (EAC).
- Urban informal settlements need to be understood in the context of housing, environmental conditions and health challenges.
Thank You, God Bless!
The health consequences of migration: Emerging directions in scholarship and research
Health Crises and Migration

Michael Edelstein, Khalid Koser, David Heymann
Agenda

- Crisis migration
- Case studies
- Conclusions
- Recommendations
Crisis migration

- Migration from crisis, violence and conflict
- Protection gaps
- New legal, normative, and institutional responses
Case studies

- Cholera in Zimbabwe (2008-09)
- SARS (2003)
- H1N1 (2009)
- HIV-related travel restrictions
Conclusions

• Difficult to attribute large-scale cross-border migration directly to health crises
• Migration in search of better health care is a growing phenomenon
• Health crises may result in people being too sick or frail to migrate
• In many cases communities have coped with and mitigated the effects of health crises
• Volume and scale of global travel makes it impossible to stop infections at borders
• Role of IHR
Recommendations

- More research
- Greater coherence between IHR and national migration policies and procedures
- Greater national coordination between migration and health agencies
- National policies required to protect and assist migrants from or faced with deportation to areas of health crisis
- Global promotion of and increase of access to healthcare
The health consequences of migration: Emerging directions in scholarship and research
Conference Participants from at least 20 Countries

Argentina - Australia - Belgium - Brazil - Chile - China - Germany - India - Jordan - Kenya - Lebanon - Mexico - Mozambique - Netherlands - France - South Africa - Switzerland - Turkey - United Kingdom - United States
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