

WORLD MIGRATION REPORT 2015

MIGRATION, HEALTH AND CITIES Migration, health and urbanization: Interrelated challenges

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MIGRATION, HEALTH AND CITIES

MIGRATION, HEALTH AND URBANIZATION: INTERRELATED CHALLENGES

This background paper to the 2015 World Migration Report, commissioned by the International Organization for Migration (IOM) from the Research Unit of the Expert Council of German Foundations on Integration and Migration, seeks to determine the impact of migration and mobility on the health of migrants and host populations in urban settings. In addition, it aims at identifying the main policy related issues of health and urban migration, as well as providing key policy recommendations for local governments.

In 2014, with 54 per cent of the world's population, more people live in cities than in rural areas. According to the United Nations Department of Economic and Social Affairs (UNDESA) (2014) estimations, by 2050, two thirds of the world's population will be residing in cities – around five billion people.¹ Africa and Asia are the two regions with the highest growth rates of urbanization; it is projected that the urban population in these two regions will increase by 2.25 billion people by 2030, representing 90 per cent of the total projected increase of the world's urban population. Since 1990, the number of mega-cities that host more than 10 million inhabitants has nearly tripled, and by 2030, there will be 41 of them, the majority in the Global South.

Addressing health issues in the context of migration to cities is paramount, as migration and mobility are determinants of the health of migrants as well as of the health of non-migrants both at places of origin and destination (Mosca, Rijks and Schultz, 2013a). In addition to natural population growth, urbanization is driven mainly by rural-urban migration and migration between cities. Urban migrants form a hugely diverse group that comprises internal migrants originating from rural areas in search of better employment and education opportunities in cities, cross-border migrants, internally displaced persons and urban refugees, as well as victims of trafficking and forced labour. Half of the world's refugees now live in cities (United Nations High Commissioner for Refugees (UNHCR), 2011). The phenomenon that people move from rural to urban areas is not recent, and has been ongoing since the industrial revolution in the late 18th and early 19th century.

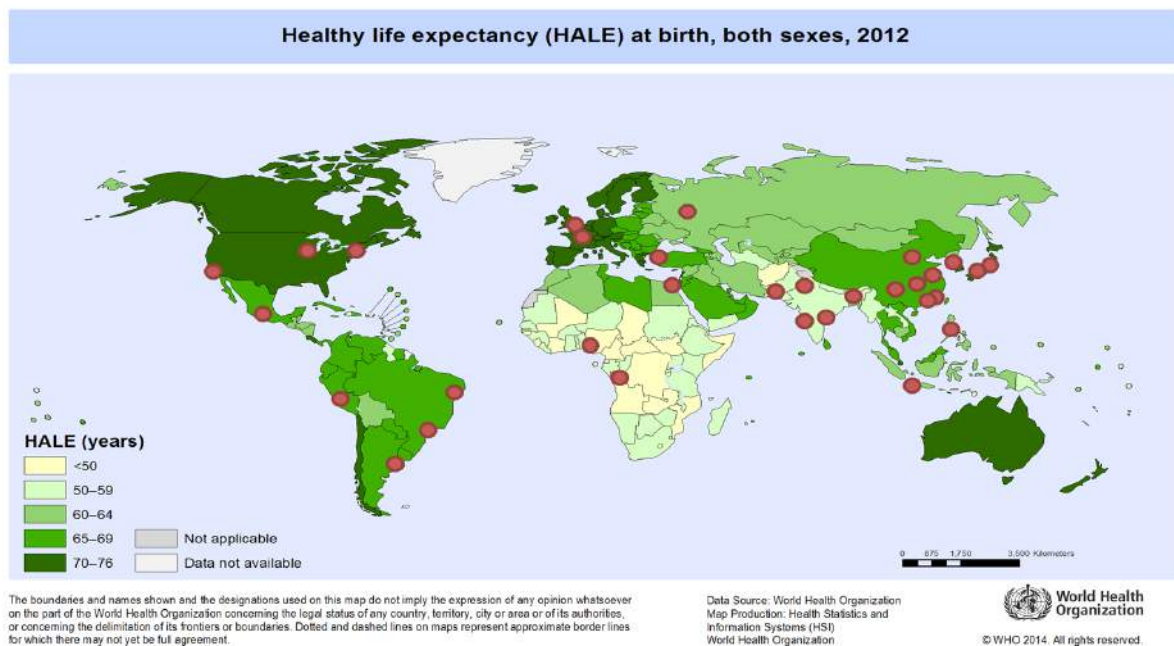
Urbanization indeed comes along with an array of sustainable development challenges. The scale and velocity of urbanization, especially in the developing world, poses significant challenges for the provision of public infrastructure, including safe housing and quality health services, particularly in resource-poor countries. As summed up by UNDESA (2014:3), “rapid and unplanned urban growth threatens sustainable development when the necessary infrastructure is not developed or when policies are not implemented to ensure that the benefits of city life are equitably shared.” Strikingly, urban poverty is on the rise (Baker, 2008): While many urban dwellers benefit from the opportunities that city life entails, many others remain in deprivation. The large socioeconomic inequality within cities stems from the fact that urban living and working conditions are very heterogeneous and, in addition to large global health inequities between countries (see Figure 1), one's place of residence within a city largely determines one's health and well-being. Moreover, in the last decades the number of poor urban dwellers residing in slums and informal settlements with inadequate infrastructure has been increasing and is currently estimated at some 863 million; this means that every third urban dweller lives in a slum (UN-Habitat, 2013:84).

These rapid urbanization processes pose severe challenges, in particular for public health authorities. The World Health Organization (WHO) and UN-Habitat (2010) have identified a “triple threat” that describes

¹ It is worth noting that all numbers referring to cities are from national statistical offices which do not define ‘city’ in a uniform way. Therefore the comparability of city-related data is not guaranteed. This problem has been well known for many decades, but a significant improvement is difficult to implement – and not yet to be seen.

the main drivers of health outcomes in urban areas. This “triple threat” consists of infectious diseases that thrive in poor and overcrowded urban environments, non-communicable diseases which are exacerbated by unhealthy lifestyles that are available in urban areas and are taken up in the course of settling in cities, and injuries and violence that stem from dangerous road traffic and unsafe working and living conditions.

Figure 1: Healthy life expectancy² at birth, 2012



Source: WHO, 2014a, own adaptation (Red: megacities of nine million inhabitants or more).

Migrant health is of special concern in urban settings as the conditions in which many migrants travel, live and work make them particularly vulnerable to infectious and non-communicable diseases, as well as accidents, violence and abuse, and adversely affect their mental and psychosocial well-being (Grover, 2013; Kontunen et al., 2014). However, migrants are often left out of public health services, if public health services exist at all. The most vulnerable among urban migrant populations are those who do not have a regular residence permit status, and those with specific health needs, such as women, children and the elderly.

Improving urban migrants' access to quality health services, and the conditions in which they live and work, is a prerequisite for achieving sustainable urban development. Not only is there a human right to health (IOM, WHO and UNHCHR, 2013)³, ill-health also carries negative social and economic consequences for the individual, the family and larger society – ill-health leads to lower educational attainment and lower employment, and therefore increases income poverty, which in turn has negative consequences for a person's physical and mental health and well-being.

The paper is structured as follows: The first chapter introduces the concepts of social determinants of health and urban spaces of vulnerability to describe the health-related vulnerabilities of various types of migrants, including female migrants, migrant children, low-skilled migrant workers, urban refugees and

2 Healthy life expectancy is defined as the “[a]verage number of years that a person can expect to live in “full health” by taking into account years lived in less than full health due to disease and/or injury” (WHO, 2014f).

3 Health as a human right for all was first enunciated by the WHO Constitution (WHO, 1946), and then reiterated in the Universal Declaration of Human Rights, Article 25, as well as in several other legally binding international human rights treaties. Article 12.1 of the International Covenant on Economic, Social and Cultural Rights recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (United Nations General Assembly, 1966). Even though the Committee on Economic, Social and Cultural Rights (CESR) has articulated that nationality must not be used as a ground for discrimination in relation to health care, many states continue to analyze an individual's right to health based on nationality or residence status, often limiting it only to their citizens.

internally displaced persons; also from a temporal perspective by taking into account the different phases of the migration process.⁴ The second chapter dives into the specific barriers to quality health care for urban migrants, and explores existing policy responses. Chapter three provides policy recommendations on how to address the challenges of migration and health in urban environments. Several info boxes with testimonies of migrants or small case studies (e.g. on Ebola) are inserted throughout the text to illustrate the main health risks migrants and host populations in cities encounter. In addition, good practice examples of municipally led policy or programmes or networks to address migrant health in cities are highlighted.

THE IMPACTS OF MIGRATION ON THE HEALTH OF MIGRANTS AND HOST COMMUNITIES IN URBAN CONTEXTS

Three interrelated concepts help to analyze and discuss the linkages between migration, urbanization and health: the social determinants of health, the spaces of vulnerability and, lastly, the temporal view on health risks and determinants throughout the different phases of the migration process, or the migration cycle as it is sometimes termed. Against the backdrop of these conceptual starting points, the specific health risks of migration to cities will be discussed, and the vulnerabilities of different migrant populations as evidenced in various scientific studies will be explained.

MIGRATION AND URBANIZATION AS SOCIAL DETERMINANTS OF HEALTH: URBAN SPACES OF VULNERABILITY

Social determinants of health: Cities as the best and worst environments

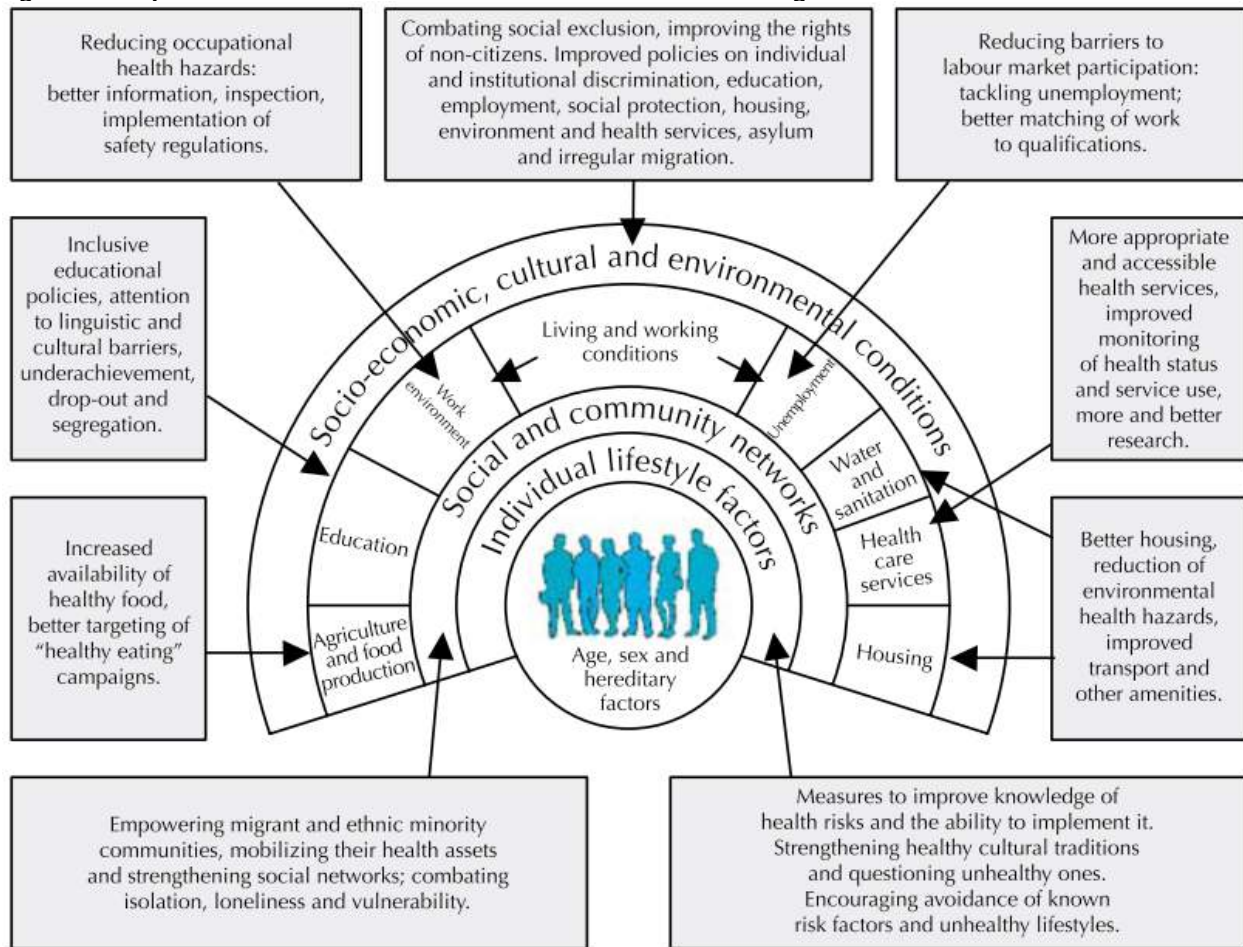
This paper uses the internationally accepted comprehensive definition of health as “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (WHO, 1946). The state of a person’s health is shaped not only by his or her access to health services, but by a multitude of factors, which have been coined the social determinants of health. These are the conditions in which people are born, grow, live, work and age, and which are mainly responsible for persisting health inequities within and across countries – and cities. These conditions result mainly from inadequate or non-existing social policies or unfavorable political and economic structures (Commission on Social Determinants of Health, 2008).

In recent years, it has become common knowledge among global health actors that due to the fact that health is mostly determined by conditions outside the health sector, a whole-of-government or multisectoral approach is needed to tackle the global burden of disease. Accordingly, in 2009 the World Health Assembly (WHA)⁵ adopted the resolution “Reducing health inequities through action on the social determinants of health” and called upon the international community to take action to address them (WHO, 2014b). Subsequently, the Rio Political Declaration on Social Determinants of Health (WHO, 2011), which was endorsed by WHO member states at the WHA in 2012, identified the conditions in which people are born, grow, live, work and age as mostly responsible for avoidable differences in health status within and between countries. Put simply, acting on the social determinants of health means tackling the root causes of health inequities.

4 A brief note on methodology: This paper is based on a broad literature research and desk review. As comparable cross-country, not to speak of cross-city, data on migrant health do not exist, the analysis inevitably has to rely on findings for certain population groups in certain settings, which is of course a major limitation. However, taken together, the findings indicate and corroborate the more theoretical debate on the importance of addressing the health of mobile populations in the context of urbanization. Most of the studies cited use quantitative methodologies, few of which are actually based on representative samples. Some studies cited use a qualitative approach (i.e. expert interviews or participant-observation). Some of the studies included do not or were not able to disentangle the effect of migrant status on health, but compared slum vs. non-slum residents, for instance. However, in those cases where the likelihood was high that slum residents are either themselves migrants or were born to migrant parents, these were included in the analysis.

5 The WHA is the main forum where the health ministers of the WHO’s 194 member states come together annually to decide upon major policy questions, the WHO work programme and budget and to elect its Director General.

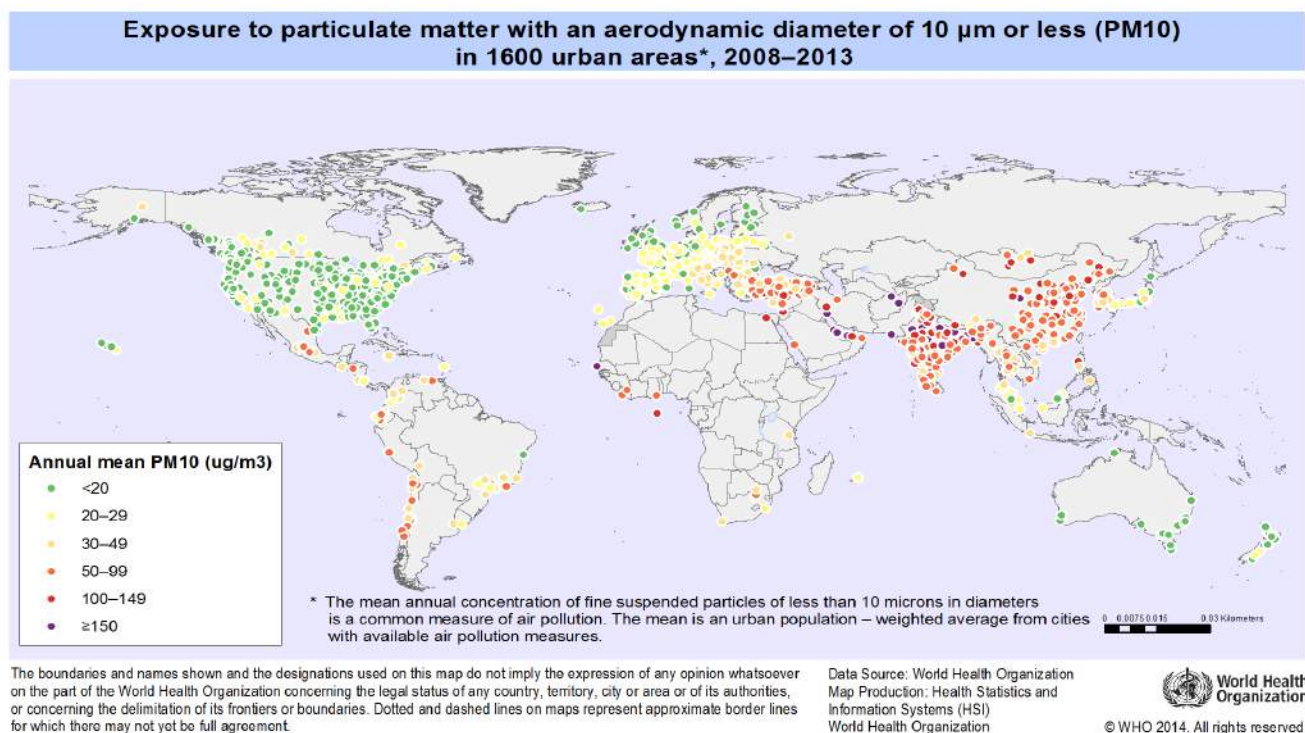
Figure 2: Policy measures to tackle the social determinants of health for migrants



Source: WHO Regional Office for Europe, 2010.

The conditions in which migrants travel, live and work often carry exceptional risks to their physical and mental well-being, and migration can therefore be regarded as a social determinant of health for migrants. This link has been acknowledged by the WHA, which adopted Resolution 61.17 on the “Health of Migrants” in 2008, in which Member States “recogniz[ed] that health outcomes can be influenced by the multiple dimensions of migration”. For example, migrants and their families often lack access to health care because of a lack of regular legal status. In addition, even if migrants have access to health services, they tend to avoid them due to fear of deportation, xenophobic and discriminatory attitudes, and other linguistic, cultural, and economic barriers. In addition to these questions of access to health care, there are underlying determinants of health for migrants. These include: restrictive immigration, employment, social protection and housing policies; i.e. reasons for which migrants often have to travel, live and work in unsafe and unhealthy conditions – these policies can hence be considered social determinants for the health of migrants (IOM, WHO and UNHCHR, 2013). Figure 2 illustrates the social determinants of health for migrants and suggests policy measures to tackle them.

Figure 3: Air pollution in urban areas, 2008-2013



Source: WHO, 2014c.

In urban settings, specific social determinants for health interact and mutually define an individual's vulnerability to disease (Alirol et al., 2010). As described in a joint global report by WHO and UN-Habitat (2010: 12), “[c]ities offer both the best and the worst environments for health and well-being.” As the factors that determine health in urban settings, the report identified the following: population characteristics, urban governance, the natural and built environment, the social and economic environment, food security and quality, and services and health emergency management. Ompad et al. (2007) provide a similar list of social determinants of health for urban dwellers, including also the place of residence within the city, race and ethnicity, gender, socioeconomic status and education (Alirol et al., 2010). From this list one can deduce that urban migrants might be especially vulnerable to ill health. As put in the above-mentioned report, “[t]hose who migrate to escape difficult circumstances often experience a double jeopardy in cities: pre-existing vulnerabilities combined with greater exposure to migration-associated stressors. A social and economic gap often emerges between long-time urban residents and migrants” (WHO and UN-Habitat, 2010:14). Hence, both migration and urbanization determine the health of urban migrants.

Urban spaces of vulnerability: Slums and informal settlements

Based on their experience with projects on migrant health, the International Organization for Migration (IOM) South Africa further developed the concept of “spaces of vulnerability”, that had first been introduced by Williams et al. (2002). This concept can help to further illustrate the social and environmental determinants of health for migrants. Spaces of vulnerability are defined as “those areas where migrants and mobile populations live, work, pass through or originate from and may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant sending sites, detention centers, and emergency settlements” (Mberu et al., forthcoming:4).

The most obvious urban spaces of vulnerability are informal urban settlements, often termed ‘slums’. Although no single definition of what constitutes a ‘slum’ exists, these settlements are generally negatively “defined by the absence of [...] services, along with lack of secure tenure, non-durable housing and overcrowding” (UN-Habitat, 2013:84). Living in slums is detrimental to health due to the lack of potable water and sanitation facilities (Subbaraman et al., 2012), combined with high levels of congestion, pollution (see Figure 3) and risk of traffic accidents, as slum areas are often located close to waste deposits, industrial areas or dangerous roads. Beyond these primarily hygiene and traffic-related risks, in many cases, slum dwellers have to live in constant fear of eviction which affects their mental and psychosocial well-being, and high rates of insecurity further exacerbate this (Mili, 2011; Bocquier et al., 2011). According to the UN, relative to the number of urban residents in the developing world, the numbers of slum dwellers have decreased in recent years. The Millennium Development Goal (MDG) target 7.D, “By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers” could be reached ahead of schedule, as in the decade from 2000 to 2012, more than 200 million of slum dwellers “gained access to either improved water, sanitation or durable and less crowded housing” (UN-Habitat, 2013:84). However, due at least partly to the speed of urbanization in the developing world, the absolute number of people living in slums has increased in past decades. While in 1990, 650 million people were estimated to live in slum conditions, in 2012, the number of slum dwellers reached 863 million. This means, one out of every three urban residents in the developing world was classified as living in slum conditions in 2012.

It is indispensable to note that “[s]lums are no longer just marginalized neighbourhoods housing a relatively small proportion of the urban population. In many cities, they are the dominant type of human settlement” (WHO and UN-Habitat, 2010:8). Slum prevalence is highest in sub-Saharan Africa, where more than half of the urban population (62 % in 2012) lives in slum conditions. In Asia, the share of urban dwellers living in slums ranges from 25 per cent in Western Asia to 35 per cent in Southern Asia; in Latin America and the Caribbean, 24 per cent of urban residents lived in slum conditions in 2012 (UN-Habitat, 2013:84). Slum settlements are also highly heterogeneous regarding the conditions and levels of infrastructure that exist, even within countries and also within cities. This has been pointed out for the slums of Nairobi, Kenya (Zulu et al., 2011), and is also very visible in India, where some slums are officially recognized by local governments, while others are not, which has a profound impact on the respective living conditions in these areas (Subbaraman et al., 2012).

Info Box 1: Migrant story: Basotho farm worker, Quthing, Lesotho

“Ntsebo (not her real name) is a 36-year-old farm worker from Quthing in the south of Lesotho. She was diagnosed with HIV in 2006. Faced with unemployment and limited livelihood options, she decided to cross the border to work on the farms in South Africa. In 2006 [...], Ntsebo got her first contract to work at an onion farm in Cape Town. Upon arrival, Ntsebo was instructed to identify a partner as this was said to be the ‘farm culture’, a strategy employed by farmers to avoid fights over partners. She thus got involved with a fellow male farm worker to whom she did not reveal her HIV status. Being a Basotho seasonal worker, Ntsebo was supposed to return to Lesotho to renew her contract. However, after her first contract expired in 2008, she did not return home. Instead she was illegally transferred to a tomato farm in Cape Town, where she worked with people from Zimbabwe, Mozambique and South Africa. Ntsebo then got ‘married’ to a South African man who was working as a farm security guard. They shared a single ‘container’ – used for accommodating workers – with three other couples and their children. [...] Ntsebo is angry about the exploitative nature of work, as senior management does not care about the well-being of workers as long as the job is done. As an HIV-positive farm worker, Ntsebo is mainly worried about the lack of health facilities as there are no clinics or hospitals in the vicinity. However, administrative procedures that include a ‘no work no pay’ policy and transport costs of R190 [about 13 euros] per trip deter her from using healthcare facilities and going for crucial medical checkups. HIV-related information and VCT [voluntary counselling and testing] services are also inadequate as Ntsebo can only access them through nurses who visit the farm once a week. Although Ntsebo did not reveal her status to workmates, she feels that she is discriminated against on the basis of her status as she has clear signs and symptoms of HIV/AIDS. The only people she finds friendly are other HIV-positive farm workers who happen to know her status as they travel together to access ART [antiretroviral therapy] at hospitals and clinics. Unfortunately, Ntsebo was recently dismissed for complaining too much about having to give up her sleeping mattress, which was given to another female employee by the supervisor in return for sexual services. She desperately wants to be recruited so that she can reunite with her husband and also resume ART in South Africa, where she believes medical services are better compared to Lesotho.”

Source: IOM Regional Office for Southern Africa, 2010.

Health and the migration process: A temporal view on health risks and determinants

The health of migrants and host communities is not only determined by the conditions prevalent in the urban spaces of living and working, but can be affected throughout all phases of the migration process (Gushulak, Weekers and MacPherson, 2009). Migrants move with their epidemiological health profiles – influenced by the factors identified above as the social determinants of health. Table 1 exemplifies the various aspects that can influence migrants’ health throughout the migration process, many of which are interrelated with each other. For instance, the working and living conditions of migrants at the place of destination largely depend on the migration-related policies that are enforced there. This third approach to analyze the health of migrants emphasizes the temporal dimension of shifting determinants of health that a migrant may encounter.⁶

6 Life-course approaches such as the one described by Zulu et al. (2011) provide further insights into health vulnerabilities of urban migrants according to age.

Table 1: Health aspects of the stages of the migration process

Phase	Aspects influencing migrants' health
Pre-departure	<ul style="list-style-type: none"> - Pre-migratory events, particularly trauma due to war, human rights violations, torture, sexual violence - Linguistic, cultural and geographic proximity to destination, including health beliefs and behaviours - Epidemiological profile and how it compares to the profile at destination - Efficiency of health system in providing preventive and curative health care
Travel	<ul style="list-style-type: none"> - Travel conditions and mode (perilous; lack of basic health necessities) - Duration of journey - Traumatic events, abuse, (sexual) violence - Alone or mass movement
Destination	<ul style="list-style-type: none"> - Migration-related policies/health policies - Inclusion into the host society or discrimination - Legal status and access to services - Language and cultural values - Separation from family and/or partner - Duration of stay - Existence of culturally, linguistically, and epidemiologically adjusted services - Potential abuse, (sexual) violence, exploitation - Working and living conditions
Return	<ul style="list-style-type: none"> - Level of home community services (possibly destroyed), especially after crises situations - Remaining community ties - Duration of absence - Behavioural and health profile as acquired in host communities

Source: Adapted from IOM, WHO and UNHCHR, 2013:29; based on B.D. Gushulak and D.W. MacPherson, 2006.

A by now well-researched and accepted phenomenon is the so-called 'healthy migrant effect'; i.e. the observation that recent immigrants to major industrialized immigration countries such as the US, Canada and Australia appear on average healthier than the native born population (Kennedy, McDonald and Biddle, 2006; Gushulak, Weekers and MacPherson, 2009). There have only been few attempts to disentangle the reasons for this effect, but the competing explanations include health screening of migrants prior to immigration or as a prerequisite for immigration, healthy behaviour prior to migration, and positive self-selection, i.e. it is on average healthier people, who also possess enough financial means, that take the decision to migrate (Kennedy, McDonald and Biddle, 2006).⁷ The last factor seems to be the most reliable one: who would migrate if his or her health condition is not good? However, it has also been found that, with increasing length of residence in the new country, immigrants' health often deteriorates. This phenomenon has been attributed to several probable causes: the adoption of unhealthy behaviors prevalent in the receiving society, such as smoking, alcohol consumption and physical inactivity as well as unhealthy diets, and also to the fact that migrants often have to take up physically demanding jobs (Moullan and Jusot, 2014). The mismatch between immigrants' educational credentials and their occupational achievements, the lack of social support networks and uncertain migration status may also constitute sources of stress and hence impact migrants' psychosocial well-being.

Yet, for immigration countries other than the traditionally researched US, Canada and Australia, findings on the health gap between migrants and the native born have been mixed or sometimes even contradictory. The study by Moullan and Jusot (2014), for instance, provides little evidence for the existence of a healthy immigrant effect in EU countries. For the specific case of rural-to-urban migration, there seems to be even less straightforward evidence of a healthy migrant effect. Chamchan, Chan and Punpuing (2014) found evidence of a healthy migrant effect for Thai rural-to-urban migrants. Andrade et al. (2012) found

⁷ There is a well-documented strong positive correlation between income and health (Kennedy, McDonald and Biddle, 2006), which corroborates the fact that socioeconomic factors largely determine one's health status.

that internal migrants in Sao Paulo, Brazil, showed on average better mental health than non-migrant residents. Hu, Cook and Salazar (2008:1718) summed up findings for Chinese rural-to-urban migrants and concluded that “[i]n essence, the countryside is exporting good health and reimporting ill-health”, pointing to a positively selected outmigration and a negatively selected remigration.

SPECIFIC HEALTH RISKS OF MIGRATION TO CITIES: WHAT DO WE KNOW? EXAMPLES FROM CITIES AROUND THE WORLD

Processes of urbanization are taking place parallel to another global phenomenon, which has been termed the ‘health transition’ or ‘epidemiological transition’, defined as “the process by which non-communicable and chronic diseases come to supplant communicable diseases in cause-of-death distributions and related health indicators” (Montgomery and Ezeh, 2005:207). The health transition is still underway in the developing world, where chronic illnesses are on the rise due to changes in lifestyles, food availability and tobacco consumption closely related with rapid urbanization and globalization, while infectious diseases still constitute the dominant cause of mortality and morbidity (Alirol et al., 2010; Khan et al., 2013). Cities in the developing world are therefore confronted by “a triple threat”, according to WHO and UN-Habitat (2010:28): infectious diseases; chronic non-communicable diseases; and injuries (including road traffic accidents) and violence.⁸ To this list, one needs to add a fourth, interrelated threat: the burden of mental disease and psychosocial ill-health. The following sections explain the types of diseases that are associated with migration to urban areas and give examples for their occurrence among urban migrant populations.

Communicable and infectious diseases: The persisting burden

In an increasingly mobile world, resource-poor urban agglomerations become catalysts for the transmission of infectious diseases (Alirol et al., 2010). Especially slums are “productive breeding grounds for tuberculosis, hepatitis, dengue, pneumonia, cholera and diarrhoeal diseases, which spread easily in highly concentrated populations” (WHO and UN-Habitat, 2010:28).⁹

In the past decades, migration has become ‘globalized’ in the sense that “migrants from an increasingly diverse array of non-European-origin countries have been concentrating in a shrinking pool of prime destination countries” (Czaika and de Haas, 2014:315). In 2013, 59 per cent of all international migrants were living in the ‘North’ (UNDESA, 2013).¹⁰ With the backdrop of the globalization of migration and increased cross border mobility, it becomes of special concern that, to state the obvious, the spread of communicable diseases knows no borders. Historically, “[i]n terms of infectious disease epidemiology, the association between the introduction of disease [into a country of transit or destination] and migration has long been recognized” (Gushulak and MacPherson, 2004:1743), and the development of border health quarantine practices is a legacy of this recognition. However, it needs to be emphasized that it is not necessarily migrants, but often other internationally mobile people who contribute to the cross-border spread of communicable diseases. For instance, a 78-year-old Canadian national is thought to have introduced severe acute respiratory syndrome (SARS) to Canada in 2003, returning from a ten-day holiday in Hong Kong (PHC, 2004). However, the blame for the international spread of diseases is still too often put on migrants, as the continuing practice of travel or stay restrictions related to treatable health conditions shows. Numerous countries automatically detain migrants and asylum-seekers because

8 Injuries and violence will not be treated as a separate sub-chapter. However, one example worth mentioning is that in India, “non-notified [i.e. not governmentally acknowledged] slums may be at increased risk of fires due to the presence of illegal electricity connections [...] and the lack of a legal water supply, which makes fires difficult to control once they have started. Slum fires may have direct health consequences, including loss of life, burns and respiratory complications. Such calamities may have profound indirect impacts on health, by deepening asset poverty and negatively impacting mental health” (Subbaranam et al., 2012:658).

9 A communicable disease is a disease that is capable of being transmitted from person to person, animal to animal, animal to human, or human to animal. Transmission of communicable diseases occurs in a variety of ways, including direct physical contact with an infected person, as well as contaminated bodily fluids and bites from infected insects or ticks (WHO, 2014d). Sexually transmitted infections constitute a subgroup of communicable diseases and are spread primarily through person-to-person sexual contact (WHO, 2013b).

10 In the referenced UNDESA analysis, “[t]he term “North” refers to countries or regions traditionally classified for statistical purposes as “developed,” while the term “South” refers to those classified as “developing.” The developed regions include Europe and Northern America plus Australia, New Zealand and Japan” (UNDESA, 2013). Certainly, one needs to be aware of the simplifying dichotomy: “Simple bipolar models of “developed” and “developing” or “North” and “South”, while perhaps indicative of some trends, are essentially too static and freeze the “underlying reality” at a point in time” (Skeldon, 2013:5).

of treatable infectious diseases, or practice measures such as deportation, limitations to travel, work or reside abroad (Human Rights Watch, 2009; Pebody, 2010). As emphasized for instance by Mosca, and Rijks and Schultz (2013a:98), “[t]hese practices [...] further aggravate social exclusion of migrants and stigmatization, discouraging migrants from seeking care, delaying or hampering early diagnosis and treatment and the achievement of global health goals, and hence exacerbating the risks of adverse health outcomes of migration”.

Yet, it remains true that today, as the risk to acquire certain infectious diseases continues to be much higher in the global South than in the North, in many high-income countries of destination, illnesses such as tuberculosis (TB) and HIV are primarily observed in the immigrant population (ECDC and WHO, 2014; Alami et al., 2014).¹¹ This needs to be considered by health care providers in receiving states, as “health care providers at the primary care and specialist level can expect to be faced with the challenges of recognition, diagnosis, and management of diseases that are themselves the consequences of international factors” (Gushulak and MacPherson, 2004:1743). Rural-to-urban migrants in low-income countries or those travelling to neighboring countries may acquire communicable diseases when residing in host communities, and introduce these conditions when returning to their communities of origin.

Communicable diseases are a constant concern among the urban poor. HIV/AIDS, still the most widely diffused deadly infectious disease, is said to be largely an urban phenomenon. In Latin America and the Caribbean, HIV/AIDS is most prevalent in cities, among transport corridors and ports (UNAIDS, 2014:84). Migrants are particularly susceptible to contracting HIV/AIDS, especially in urban settings, as several studies have shown. For instance, analyzing longitudinal survey data of about 56.000 slum residents of Nairobi, Kenya, many of whom are migrants,¹² Kyobutungi et al. (2008) found that HIV/AIDS and tuberculosis accounted for about half of the deaths among the population aged five years and above. In India, HIV prevalence among rural-to-urban migrants is estimated at 0.9 per cent, which is almost four times the national prevalence rate (UNAIDS, 2014:159). For China, Zou et al. (2014) found in a systematic review and meta-analysis of 411 studies that rural-to-urban migrants have a higher risk of sexually transmitted infections than the general Chinese population; migrant subgroups most at risk were construction workers, long-distance truck drivers and marriage migrant women. Richter et al. (2014) conducted a cross-sectional survey of female sex workers in three cities of South Africa (Johannesburg, Rustenburg and Cape Town), finding that cross-border sex workers had lower health service contact and more frequently engaged in unsafe sex than non-migrant sex workers. It has been observed that the higher vulnerability of migrants to sexually transmitted infections might be due to lack of access to prevention measures or timely treatment, as well as a consequence of unsafe sexual behaviours, such as having concurrent partners or unprotected sex with sex workers, especially when experiencing isolation and loneliness in places of destination (Mberu et al., forthcoming).

After HIV/AIDS, the second greatest killer worldwide due to a single infectious agent is TB. Especially worrisome is that of the nine million people a year who get sick with TB, three million are ‘missed’ by health systems (WHO and Stop TB Partnership, 2013). Although TB occurs in every part of the world, over 95 per cent of TB deaths occur in low- and middle-income countries. In absolute numbers, Asia was most affected by new TB cases in 2012; 60 per cent of new cases globally occurred on the Asian continent. Relatively, however, sub-Saharan Africa carried the greatest TB burden, with 255 new cases per 100.000 people in 2012 (WHO, 2014d). Migration as a social determinant of health has been associated with increased risk of TB infection (WHO and IOM, 2014); in South Africa, for instance, TB rates are higher for international migrants and mobile people than in the non-migrant population, the high TB prevalence among migrants being associated at least partly with migrant workers being exposed to high levels of silica dust in mines (Mberu et al., forthcoming). The heads of State of the Southern African Development Community (SADC)

11 For instance, in the United States, “[t]he TB incidence rate among foreign-born persons in 2013 was approximately 13 times greater than the incidence rate among U.S.-born persons, and the proportion of TB cases occurring in foreign-born persons continues to increase, reaching 64.6% in 2013” (Alami et al., 2014).

12 A high intensity of circular migration to and from the informal settlements of Nairobi has been documented by Beguy, Bocquier and Zulu (2010).

recognized the link of TB, HIV, silicosis and mining and in 2012 adopted the SADC Declaration on TB in the Mining Sector, which is currently being operationalized (Mosca, Rijks and Schultz, 2013b).

In Asia, for the cities of Shanghai and Beijing, China, it has been documented that new TB cases occur disproportionately among rural-to-urban migrant workers, while treatment outcomes are worse for migrant TB patients compared to TB patients among the general population (Wei et al., 2009). It has become common to associate the trend of drug-resistant TB in Chinese cities with rural-to-urban migration, a link that Wang et al. (2011:585) examined in a study comparing prevalence rates of multi-drug-resistant TB of migrants and long-term residents in Shanghai and Ningbo, China. They found no evidence for the hypothesis, however, but cautioned that “inadequate case management or poor treatment for this sub-population could result in the emergence or amplification of drug resistance”, as migrants face a number of increased risks: they are thought to be less likely to adhere to TB treatment, have limited knowledge about the disease and face multiple discrimination in Chinese cities.

Info Box 2: The Ebola outbreak and population mobility

In the spring of 2014, the Ebola virus disease (EVD), an often fatal illness in humans, broke out in Western Africa, with Guinea, Liberia and Sierra Leone most affected. An infected Liberian traveler introduced the virus to Nigeria; and there have also been a few cases in Europe and the United States. As of December 3rd, 2014, 6,202 people have been killed by Ebola (CDC, 2014).

It has been speculated that the overriding factor to make the current outbreak this big could be urbanization, which complicates contact tracing (MacKenzie, Skett and Wilson, 2014). Rural-to-urban migration and mobility exacerbated the outbreak, as Peter Piot, one of the researchers who discovered the Ebola virus in 1976, explained in an interview:

“[Interviewer:] The fact that the outbreak began in the densely populated border region between Guinea, Sierra Leone and Liberia ...

[Piot:] ... also contributed to the catastrophe. Because the people there are extremely mobile, it was much more difficult than usual to track down those who had had contact with the infected people. Because the dead in this region are traditionally buried in the towns and villages they were born in, there were highly contagious Ebola corpses travelling back and forth across the borders in pickups and taxis. The result was that the epidemic kept flaring up in different places.

[Interviewer:] For the first time in its history, the virus also reached metropolises such as Monrovia and Freetown. Is that the worst thing that can happen?

[Piot:] In large cities – particularly in chaotic slums – it is virtually impossible to find those who had contact with patients, no matter how great the effort. That is why I am so worried about Nigeria as well. The country is home to mega-cities like Lagos and Port Harcourt, and if the Ebola virus lodges there and begins to spread, it would be an unimaginable catastrophe” (van Bredow and Hackenbroch, 2014).

In reaction to the deadly epidemic, several countries have introduced travel bans or suspended migration from the countries hit worst by Ebola. Australia, for instance, stopped processing visa applications from Guinea, Liberia, and Sierra Leone in late October (MWC News, 2014). In the US, which like a number of other countries has introduced additional screening of travelers arriving from the three West African countries, there have been some calls for the introduction of a complete travel ban. Impeding travel from affected countries, however, is likely to be counterproductive. It would not stop travel per se, but make people who wish to come to a certain country of destination conceal their point of origin, and hence impede effective screening and monitoring. Therefore, “[i]solating countries or foreign nationals, once considered an appropriate response, may no longer match the realities of contemporary life” (Chishti, Hipsman and Pierce, 2014).

Non-communicable diseases

The four main groups of non-communicable diseases (NCDs), i.e. diseases that are not transmitted from person to person, are cardiovascular diseases (such as heart attacks and strokes), cancers, chronic respiratory diseases (such as asthma) and diabetes. These four represent the leading causes of mortality and disability worldwide (WHO, 2013a). The NCD risk is heightened in urban agglomerations, due to the associated changes in diet and physical activity levels, as well as air pollutants. For instance, “obesity is on the rise in cities around the world”, as on the one hand diets shift to more calorie-dense diets while on the other hand urban sprawl discourages physical activity (WHO and UN-Habitat, 2010:29). For instance, Khan et al. (2013) presented the baseline survey of a planned longitudinal study of a multi-ethnic migrant community in the megacity Karachi, Pakistan, which is “one of the fastest growing urban centers in the world”, concluding that a high burden of NCDs will likely manifest itself.

Migration influences the risk factors for NCDs. For instance, as has been found for South Asian migrants in Europe, migrants are more vulnerable to NCDs than the host population in all strata of society as they often experience socioeconomic inequalities and related stress, which increases exposure to NCD risk factors, such as an unhealthy diet, physical inactivity, tobacco use and harmful consumption of alcohol (Davies, Blake and Dhavan, 2011). Regarding rural-to-urban migration, Hernández et al. (2012) conducted a review and meta-analysis of studies that sought to evaluate the effect of this type of internal migration on cardiovascular risk factors in low- and middle-income countries. Of the 18 studies that fulfilled the criteria for inclusion in the meta-study, most showed a healthy migrant effect in that NCD values or rates in migrants were lower than in non-migrant urban residents. However, migrant NCD values or rates were also higher than in the non-migrant rural group, suggesting that risk factors increase with migration. For India, studies from the Indian Migration Study, a large sib-pair comparison study based on factory workers and their rural non-migrant siblings from four factories in urban centres of India (Lucknow, Nagpur, Hyderabad, Bangalore), strongly supported the hypothesis that rural-to-urban-migrants have a higher obesity prevalence rate and increased fat intake as compared with their rural counterparts (Ebrahim et al., 2010).

However, findings are heterogeneous for dietary changes: another finding of the Indian Migration Study was that “rural to urban migration appears to be associated with both positive (higher fruit and vegetables intake) and negative (higher energy and fat intake) dietary changes” (Bowen et al., 2011).

The urbanization of the refugee population, combined with the ageing of refugees in protracted refugee situations, also leads to NCDs becoming of greater concern for this population globally. Amara and Aljunid (2014) reviewed the literature to determine NCD prevalence among urban refugees in developing countries and found a high prevalence of NCDs among urban refugees in the Middle East.

Mental and psychosocial health and well-being

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014e). Rapid and unplanned urbanization poses threats to the mental health and well-being of people who live in cities. In particular, “[p]oor housing conditions, overcrowding, noise pollution, unemployment, poverty and cultural dislocation can cause or exacerbate a range of mental health problems, including anxiety, depression, insomnia and substance abuse” (WHO and UN-Habitat, 2010:29).

Info Box 3: Migrant story: Domestic worker, Cape Town, South Africa

“Maria (not her real name) was born on a farm in the eastern Free State in 1963, one of nine children born to migrant Basotho farm workers. Maria and her younger sister were sent to live with relatives in Lesotho when she was seven years old. After junior school, her guardians refused to send her to high school and she took a job at a supermarket. She then moved to her older sister’s house because her guardians were no longer treating her well. [...] Maria was eventually forced to marry [a man] and have his two sons. Maria’s husband was a migrant mineworker in Carltonville who was away for most of the time. When he was at home, he was very abusive and violent. She feared that he had other partners and was bitterly unhappy. After 10 years, Maria ran away with her sons to an uncle in Port Elizabeth. Once in Port Elizabeth, she stayed with her uncle for a while, until he tried to force her to have sex with him. Maria found work as a domestic worker for a middle-class black family in New Brighton. Her boss, however, repeatedly raped her but she was too afraid to tell anyone for fear that his wife might accuse her of seduction. In 1997, Maria heard about a domestic worker job in Cape Town through a friend. She moved but was again treated badly, although not sexually abused. Eventually, she was able to find better work in restaurants and domestic worker positions. [...] Fearing the worst, she went for an HIV test and tested positive. Her partner initially denied he could have given her HIV, but by the time he accepted this possibility, it was too late to save him. He died shortly after that. Maria now has to come to terms with the fact that she is HIV positive and has been going for counselling and medical treatment. So far, she has had a mixed experience of the government hospitals. Her various employers have been very supportive and helped her to obtain the medical assistance she needs. She has not yet had to go onto ARVs [antiretroviral drugs] because she is looking after herself well.”

Source: IOM Regional Office for Southern Africa, 2010.

Migration, especially (forced) displacement due to war, conflict, insecurity or natural disaster, is often accompanied by stressors that cannot be considered ‘normal’. These types of human mobility usually pose high threats to the mental and psychosocial health and well-being of migrants. Even carefully planned migration implies a redefinition of individual, familiar, group and collective roles and value systems, and may represent an upheaval and a source of stress for the individual and the family. Migration can therefore create specific psychosocial vulnerabilities that, if combined with other risk factors, can affect the mental health of migrants. Being separated from family and friends and possibly exposed to exploitation, discrimination, xenophobia or sexual and gender-based violence in countries of transit and destination can heighten the vulnerability of migrants to psychological illnesses (Bhugra and Jones, 2001).

In China, due to the household registration (*hukou*) system, the millions of internal rural-to-urban migrants do not have official documentation and are societally marginalized and excluded from urban services, including health care (Hu, Cook and Salazar, 2008).¹³ For rural-to-urban migrants in Beijing, Lin et al. (2011) found a correlation between discrimination and perceived social inequity with poorer mental health. The authors linked this deteriorating effect of migration on mental health status to the significant level of stigmatization that is connected to being a member of the so-called ‘floating population’ of rural-to-urban migrants in China, which is fuelled by vastly negative media reporting. Li et al. (2008) had already emphasized the link between stigmatization of migrants in their two areas of study, Beijing and Nanjing, and the substantial numbers of migrants experiencing mental health symptoms such as depression and anxiety.

For Sao Paulo, Brazil, Andrade et al. (2012) found high prevalence of mental health problems in a large representative cross-sectional household sample of approximately 5,000 residents, about half of whom

13 However, the Chinese government has started to address issues around the development of its migrant population and also recently began to reform the *hukou* system. A new “people-centred” plan for urbanization was released in March 2014, which includes granting urban *hukou* to 100 million internal migrants by 2020, still leaving roughly 150 million urban migrants without a regularly registered urban residence status (The Economist, 2014; Rietig, 2014).

had been born outside of the Sao Paulo Metropolitan Area and were hence categorized as migrants (mostly internal migrant workers). They found that migrants displayed on average better mental health than non-migrants; yet they emphasized that more detailed analysis needs to disentangle other factors such as gender and age at migration, etc.

Other studies on internal migration, however, did not observe any significant difference in the prevalence of common mental disorders between migrant and non-migrant urban residents – this is for instance the case for residents of a peri-urban shantytown in Lima, Peru, as Loret de Mola et al. (2011) found. Similarly, findings from a longitudinal study of the physical and mental health of rural-to-urban migrants in Thailand suggested that, when other factors are controlled, there is no effect by migration on mental health (Chamchan et al., 2014). For the city of Rotterdam, the Netherlands, Entzinger and Engbersen (2014:6) highlight in their paper, commissioned by the Transatlantic Council on Migration, that “mental health issues are of particular concern in Rotterdam’s Turkish and Moroccan communities”.

An assessment carried out jointly by the United Nations High Commissioner for Refugees (UNHCR), IOM and the US Bureau of Population, Refugees and Migration (PRM) on the psychosocial well-being of and suicide risk factors among Bhutanese refugees in Nepal and some resettled in the US found that suicide rates among Bhutanese refugees were significantly higher than rates in the US, in the world, and in a comparable Bhutanese district (Schinina et al., 2011). Usually, suicide or suicide attempt is caused by a confluence of reasons, and the study emphasized the generally high level of distress in the population, due to community disaggregation, family separation, and related grief, tension, stress and worries (ibid.).

HEALTH VULNERABILITIES OF DIFFERENT MIGRANT GROUPS

In line with the social determinants of health approach, it can be seen that different types of migrants display different levels of vulnerability to ill-health; health vulnerability being defined as “the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of diseases or epidemics” (Mberu et al., forthcoming:40). While some of the social determinants of health for migrants affect all or nearly all migrants, there are specific factors that increase health vulnerability, which are unequally distributed across different migrant groups, depending on their specific genetic or biological traits as well as behavior and socioeconomic circumstances (Gushulak, Weekers and MacPherson, 2009).

In general, health literacy (i.e. people’s knowledge about healthy behavior and disease prevention) could be suspected to be higher in urban than in rural settings, as urban residents can be more easily reached via mass media and health and disease prevention campaigns. However, striking intra-urban health literacy disparities remain, with health literacy and immunization coverage above all being much lower in slum residents – sometimes even lower than in rural areas (Alirol et al., 2010).

Migrant women: Vulnerabilities and unmet health needs in crowded urban settlements

Migration has become increasingly feminized in past decades; today, about half of international migrants are women (UNDESA, 2013). Female migrants face multiple health vulnerabilities: First of all, reproductive and maternal health care needs often remain unmet for migrant women. This has been recognized in the Programme of Action of the International Conference on Population and Development (ICPD) in 1994¹⁴, and holds especially true in overcrowded slum settings, where lack of clean water and privacy make it difficult for women to meet their additional cleansing needs during and after menstruation and child birth, as an in-depth analysis of ten slum and squatter settlements in Chittagong (Bangladesh), Dhaka (Bangladesh), Hyderabad (India) and Nairobi (Kenya) showed (Joshi, Fawcett and Mannan, 2011). In the

14 In action point 7.11 of the Programme, it says: “Migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence.”

slums of Nairobi, maternal mortality is very high, mainly as a consequence of unsafe abortions (following unwanted pregnancies) and indirectly caused by HIV/AIDS (Ziraba et al. 2009). In India, about a million babies are born in slums each year, with hardly any or no medical assistance at all (Shetty, 2011).

Looking at the less resource-poor context of China, it becomes clear that rural-to-urban migration can also have positive consequences on reproductive health and access to services of migrant women. Zheng, Lu and Lu (2013) used data from a two-part survey among migrant women in Beijing on self-reported reproductive health status, and found that the rates of child births carried out in the city (as opposed to in the rural hometown) increased significantly between 2005 and 2011 (the years in which the two parts of the survey were undertaken), and that those who delivered their child in Beijing did so more often in a hospital (i.e., with medical assistance). However, reviewing the wider literature on the reproductive and maternal health of migrant women in Chinese megacities, Zheng, Lu and Lu (2013) stated that although progress has been made in recent years, substantial gaps remain between migrants and long-term urban residents. For instance, “[a]ccording to the health statistics of Shanghai during 1999-2008, the neonatal mortality of Shanghai residents has been significantly lower than that of non-residents, although the gap has been significantly narrowing during the decade, mostly due to improvement in regular maternal check-up and prenatal diagnoses among migrants” (Zheng/Lu/Lu, 2013:4).

In addition to the special health needs of women, the sectors migrant women are most commonly employed in also make them vulnerable to ill-health: for instance, the majority of the about 52 million domestic workers worldwide are migrant women (ILO, 2013), and many are employed in conditions which render them particularly susceptible to exploitation and abuse – this has been reported, for instance, in Dubai, United Arab Emirates, and other Gulf Cooperation Countries (Sönmez et al., 2011). This applies of course even more to victims of trafficking and forced labour. The ILO (2014) estimated that of the almost 21 million victims of forced labour worldwide (of which 4.5 million are victims of forced sexual exploitation), 11.4 million are women and girls, with migrants being particularly vulnerable of becoming victims of forced labour. In Eastern and Southern Africa, the causes for female migrants’ increased health vulnerabilities (such as higher prevalence rates of HIV/AIDS compared to men) have been reported to be employment as sex workers or the widespread practice of transactional sex (Mberu et al., forthcoming).

Growing up in poor urban spaces: Migrant children and young people

More than a billion children live in cities and towns (UNICEF, 2012), and they are especially vulnerable to ill-health. Due to overcrowding, environmental and air pollution and poor access to health services, pneumonia and diarrhoeal diseases – the leading causes of childhood death globally – are often of particular concern in cities (WHO and UN-Habitat, 2010:13). Moreover, vaccination coverage is still low in many poor urban areas. For instance immunization of infants has been found to be even lower in some urban slums than in rural areas of Kenya (Mutua, Kimani-Murage and Ettarh, 2011). Focusing on migrant adolescents and youth (between 15 and 24 years of age), a recent publication edited by the United Nations Children’s Fund (UNICEF) highlighted that children, adolescents and youth affected by migration, especially in the context of irregular migration, also face increased health vulnerabilities, due to lack of protection and promotion of their rights (Rijks, 2014).

In Indian megacities, undernourishment and anemia are widespread among urban poor children, especially those who live in slum areas (Goli, Arokiasamy and Chattopadhyay, 2011). In Southern and Eastern Africa, children are also known to be at a higher risk of contracting malaria (Mberu et al., forthcoming: 58). In the slums of Nairobi, which are characterized by intense in- and outmigration, pneumonia, diarrhoeal diseases and stillbirths accounted for almost 60 per cent of deaths among children under the age of five (Kyobutungi et al., 2008). A longitudinal study that examined the impact of migration on the survival of 10,000 children in two of Nairobi’s slums found that the risk of dying was highest for children who were born in slum settlements and whose mother had been pregnant during the migration process, indicating that childbirth in the slums has particularly negative long-term health consequences for children (Bocquier et al., 2011).

In Colombia, about 5.7 million people (i.e. more than 10 per cent of the population) have been forcibly displaced from their home towns or villages due to the armed conflict that has been ongoing in the Andean country for decades. The majority of these internally displaced persons (IDPs) moved from rural areas to – often informal – urban settlements. A study conducted by the German Institute for Economic Research (DIW), using data of the Demographic and Health Survey from 2010, showed that, in Colombia, displaced children of all age groups display worse health outcomes, are less likely to have health insurance and are significantly more often malnourished than non-displaced children (in the control group) (Wald, 2014).

In addition, it has been found that “[y]oung people growing up in slum settlements face serious challenges as they transition from childhood to adolescence and to the key markers of adulthood, including employment, parenthood and independent housing” (Zulu et al., 2011:195). The same may apply to young migrant workers. For instance, in Yemen, adolescents and youth from the Horn of Africa (especially Ethiopians) who crossed the Gulf of Aden in search of better life and work prospects “through ruthless smuggling networks” were exposed to severe forms of exploitation and violence – “there is a growing humanitarian crisis at Yemen’s northern border town, Haradh” (Rijks, 2014:7). Reports of Human Rights Watch (2014) documented widespread torture of young migrants in order to extort ransom from families back home.

Low-skilled migrant workers

For the millions of migrants going abroad for work – or those who move from rural areas to cities within a country – health is their main asset (Mosca, Rijks and Schultz, 2013b). However, the hazardous conditions in which many migrants work put their health – and that of their communities of origin and transit – at high risk. This applies for instance to the thousands of migrant workers in the South African mining sector, which has a very high concentration of TB (Stuckler et al., 2011). In East and Southern Africa, not only mine workers but also several other migrants and mobile workers move back and forth between different urban centres for economic reasons, such as truckers, formal and informal traders, military personnel, sex workers and domestic workers (Mberu et al., forthcoming). Many of these migrant workers have limited access to health care.

For low-skilled construction workers in the United Arab Emirates, the inadequacy or non-existence of occupational health and safety measures assumes extremely alarming proportions. The Kafala (individual sponsorship) system ties migrant workers’ visas to individual employers and hence creates a severe form of structural dependence (ILO, 2013), thus favouring employment conditions which are highly detrimental to the physical and mental health of the foreign low-skilled workers, who come predominantly from Bangladesh, India, Indonesia, Pakistan, the Philippines and Sri Lanka. They face excessively long working hours, wage exploitation, poor housing conditions, and widespread physical and sexual abuse (Sönmez et al., 2011; Kristiansen and Sheikh, 2014). In Doha, Qatar, where about 1.4 million migrant workers are employed, many of whom work in the construction sector ahead of the 2022 world cup, human rights organizations found that “[m]igrant workers are dying at a rate of more than one a day, according to official figures compiled from foreign embassies in Doha” (Devi, 2014:1709; Amnesty International, 2013). Working in extreme heat and at great heights, many migrant workers die from falls or because of being hit by falling objects (Devi, 2014).

Refuge in the city: Urban refugees and internally displaced persons (IDPs)

According to UNHCR, today more than half of the world’s refugees live in urban areas, having moved there in the hope to find safety and economic independence. However, in many places, especially when lacking legal protection by the authorities of the host country, urban refugees face multiple challenges such as labour exploitation due to being forced to work in the informal economy and barriers to accessing basic services, such as health care. In 2009, UNHCR recognized the increasing need to comprehensively address the plight of refugees in urban situations, and accordingly adopted the “UNHCR policy on refugee protection and solutions in urban areas” (UNHCR, 2009). In this policy, it is acknowledged that urban refugees “are often confronted with a range of protection risks: the threat of arrest and detention, refoulement, harassment, exploitation, discrimination, inadequate and overcrowded shelter, as well as

vulnerability to sexual and gender-based violence (SGBV), HIV-AIDS, human smuggling and trafficking” (UNHCR, 2009:2).

The majority of the large numbers of Syrian refugees in Jordan, Lebanon and Iraq do not live in camps, but in non-camp settings, i.e. towns and cities (UNHCR, 2014a).¹⁵ A report by UNHCR (2013) specifically for the situation in Jordan showed that, although the support of the Jordanian Government had been called generous, for instance providing free health care to registered Syrians, urban refugees faced significant daily life challenges, such as rising rents and substandard housing and, in some areas, substandard water.

In Colombia, the internally displaced face difficulties to enter the regular housing market, as accessing subsidies requires a financial and credit history that they usually lack. As a consequence, most IDPs live in informal urban settlements in Bogotá (Albuja and Ceballos, 2010). In Kenya, Somali and Ethiopian refugees residing in the slums of Nairobi were abused, tortured and arbitrarily detained in inhuman conditions by Kenyan police in 2012 and 2013 (Human Rights Watch, 2013). Apart from their vulnerability to violence and crime, disease profiles of urban refugees are diverse; with non-communicable diseases being on the rise among the refugee population as well (Almara and Aljunid, 2014). This can be explained by the fact that today a larger proportion of refugees “than before are now fleeing from middle-income countries where the demographic and disease epidemiologic profiles are those of an older population with chronic diseases” (Spiegel, 2010).

In the shadows: The undocumented and the homeless

Apart from the forcibly displaced, there are numerous other subgroups of migrant populations who struggle for their livelihoods hidden in the shadows of the world’s megacities. This holds for various types of (mostly international, but in the case of China also internal) migrants without a legal residence status, as well as the homeless urban poor, also known as pavement dwellers in India. The legal status of a migrant obviously affects access to health care; at the same time, epidemiological data on unauthorized migrants is of course even less easily available (Gushulak, Weekers and MacPherson, 2010).

For (anecdotal) information about this population, one has to rely mainly on reports of non-governmental organizations (NGOs) and International Organizations (IOs). In many low- and high-income countries alike, undocumented migrants do not have access to regular health services (Kontunen et al., 2014). For instance, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that several European countries do not provide Anti-Retroviral Treatment to undocumented migrants living with HIV (UNAIDS, 2014:103), citing the European Centre for Disease Prevention and Control (ECDC). Because of financial constraints and fear of deportation, undocumented migrants often delay to seek health care (Mberu et al., forthcoming). However, for public health, economic and human rights reasons, it is crucial that undocumented migrants have access to quality health services without the fear of being reported to migration authorities. As UNAIDS (2014:103) argues, “[c]oupled with the falling costs of treatment, it is increasingly difficult to argue that people living with HIV incur greater costs to the destination country compared to the benefits they could contribute over a long-term stay while they are healthy”. Another related concern is that those who have been picked up by the police and are in detention might have their treatment disrupted (UNAIDS, 2014).

How does urbanization influence the health and access to health care for undocumented migrants? First of all, a positive impact might exist as informal networks and privately or NGO-funded initiatives that provide free-of-charge treatments to migrants without papers are more likely to be found in cities, as has been suggested for Europe (PICUM, 2007; see also info box 6). As pointed out by Joshi, Fawcett and Mannam (2011), the homeless urban poor (e.g. former slum dwellers who have been forcibly evicted) are an especially vulnerable population which is, however, largely ignored by national and local governments.

15 According to data in January 2014, 62 per cent of the 219,000 Syrian refugees in Iraq did not live in camps; the same applied for 82 per cent of the 589,000 Syrians in Jordan and 100 per cent of the 848,000 in Lebanon (UNHCR, 2014a). By December 2014, the number of Syrian refugees in these three neighboring countries, plus Turkey and Egypt, had further increased to more than 3.3 million people (UNHCR, 2014b).

POLICY ISSUES: CHALLENGES IN ADDRESSING THE SOCIAL DETERMINANTS OF MIGRANTS' HEALTH IN URBAN AREAS

BARRIERS TO HEALTH CARE FOR URBAN MIGRANTS

Migrants worldwide face various barriers to accessing health services, and this holds true for urban migrants and refugees as well. Before distinguishing the types of barriers that impede migrants to access health services, it can be fruitful to first distinguish different patterns of urban exclusion and marginalization. Three typologies are suggested by Matthews et al. (2010)¹⁶: a number of low- and middle-income countries are characterized by “substantial urban exclusion”, i.e. a large-scale exclusion in coverage of health services but substantial or even massive advantage of the few urban rich. In a second group of countries, the urban poor are marginalized (“marginalization of the urban poor”). In the third group of countries, only the poorest groups are excluded and do not obtain health services (“minimal urban exclusion”). The – interrelated – barriers to accessing health services, which are further exemplified below, play out differently for different migrant groups, and will be more distinct in those settings where health service infrastructure is poorest.

Legal barriers

Legal status is one of the main determinants of migrants' access to health services (IOM, WHO and UNHCHR, 2013). As has been explained above, despite the human right to health that requires states to provide quality health care not only to their own citizens but also to everyone living in the country, both irregular and regular migrants are often denied access and are formally excluded from country or city health systems. It has been speculated that the main reason for this are widespread myths about migrants being a burden on public health and social security systems in countries of destination, although evidence for these claims are scarce and reliance on emergency care and the potential spread of infectious diseases are more costly for the health system than the extension of timely prevention and primary health care services to migrant populations (*ibid.*). In some cases migrants are practically excluded from services despite an official policy of inclusion, as has been reported for South Africa (Mberu et al., forthcoming). In China, rural-to-urban migrants are often excluded from the city health systems and confront difficulties when trying to access medical services in the cities where they live (Qiu et al., 2011; see also footnote 13).

Financial barriers

A widespread lack of health insurance coverage coupled with prohibitively high costs of out-of-pocket-payment for health services constitutes probably the second most common barrier for poor urban migrants and displaced people to access medical services. Migrants frequently cannot afford health insurance and are excluded from state-subsidized health insurance plans (IOM, WHO and UNHCHR, 2013).

For instance, a study demonstrated that in the slums of Nairobi, 89 per cent of residents did not have any type of health insurance coverage (Kimani et al., 2012). The fact that the vast majority of urban dwellers in informal settlements does not possess any insurance demonstrates the urgent need for social health insurance programmes for the urban poor in order to reach health equity (Mberu et al., forthcoming). According to a study on migrant TB patients in Shanghai, China, financial constraints pose the biggest barriers to TB services (Wei et al., 2009). The fact that – in the absence of health insurance for rural-to-urban migrants – when a free TB treatment policy was introduced in Shanghai, it could ease these constraints only partially as many migrants simply had no knowledge of the existence of this policy. Costs had also first to be paid by the patients who were only to be reimbursed later. In the majority of cases, it took a long time until TB was actually diagnosed, by which time, most patients had already been financially depleted and lost their job (and hence, their source of income).

16 The analysis of Matthews et al. (2010) is for urban coverage of maternal-newborn services; but could be adapted for health services more generally.

In addition to the direct costs of financing health care services, indirect costs also have a deterrent effect on migrants' health-seeking behavior. These include the cost of transportation to hospitals or other health care facilities and the time lost for generating income. A household survey of slum residents in Mumbai, India, describes that low utilization of state hospitals is due to the fact that "going to [...] hospitals is a loss of half a day's wage" (Mili, 2011:84). Similarly, a case study among migrant HIV/AIDS patients in Johannesburg, South Africa, revealed that "clients participating in the ART [antiretroviral therapy] access study reported a lack of money for transportation as a barrier to collecting treatment, and also that it was problematic to take time away from their livelihood (especially if they were employed by someone else)" (Vearey, 2008:368).

Geographic accessibility: Lack of quality health care services in reach

Although one might think that this geographic accessibility is more of an issue for rural dwellers, it has repeatedly been reported that travel costs to health care facilities *within* cities can be prohibitive if no health care services are available at close proximity to poor urban dwellers. A study assessing the living conditions in eight Indian cities found that "[t]he major reason for non-utilization of [...] health care facilities is the unavailability or rather the lack of proximity of public health care facilities and poor quality of care" (Goli, Arokiasamy and Chattopadhyay, 2011:466). Because of the distance to the hospitals, slum dwellers in Mumbai, India, tend to seek assistance from general practitioners who live close by but, in most cases, do not have a medical licence and do not practice allopathic medicine (Mili, 2011). In the slums of Nairobi, the very few public health facilities that exist are located outside the slums and "inaccessible at night due to security concerns" (Ziraba et al., 2009:3).

Cultural, language and knowledge barriers and discrimination

Another frequent constraint is the lack of knowledge about the health system at the place of destination, including entitlements to access health services, as well as simply a lack of health literacy. For rural-to-urban migrants in China, for instance, it was found that their knowledge about TB was limited (Wei et al., 2009). Furthermore, communication and language barriers can negatively impact diagnostics, medication, medical follow-up, hospital visits and admission, as well as patients' adherence to treatment. Misunderstandings between a patient and health staff, for instance, when a patient describes his or her condition, can have very serious consequences and at worst even result in a patient's death (IOM, WHO and UNHCHR, 2013:43).

Perceived poor quality of health care and experience of discrimination by health workers or the wider society further prevent migrants, who often come from relatively low socioeconomic positions in society, from seeking medical assistance. In China, migrant TB patients reported that they were dismissed by their employers or generally avoided after having TB (Wei et al., 2009). People living with HIV/AIDS are exposed to high levels of stigma in most parts of the world (UNAIDS, 2014). In some cases, marginalization of migrant or other non-citizen population groups can amount to "pure discrimination against the poor" (Matthews et al., 2010:3). This is the case if the urban poor are treated with disproportionately lower standards than their better-off neighbours when using the same facilities in urban settings. This is detrimental to the aim of achieving greater health equity, as "[p]oor treatment translates into reluctance to use services, and ultimately the poor are marginalised when they perceive care to be rude, neglectful, indifferent or even abusive" (ibid.). Negative or even abusive attitudes of health staff against migrant patients were reported for instance in South African cities (IOM, WHO and UNHCHR, 2013:45).

Info Box 4: Good practice example: Telephone interpreting services, London, UK

“Language Line Inc. is a commercial interpreting provider that was initially a charity. British social activist Michael Young noticed that language barriers were leading to substandard services for ethnic minorities at Royal London Hospital in London, England, so he obtained funding to provide free telephone interpreters starting in 1990. He later began serving corporate clients and converted the charity into a commercial service. Telephone interpreting is provided when an interpreter, who is usually based in a remote location, provides interpretation via telephone for two individuals who do not speak the same language. The telephone interpreter converts the spoken language from one language to another, enabling listeners and speakers to understand one another. It is especially useful in situations where some patients, for reasons of modesty and/or anonymity, prefer not to have another person, like an interpreter, physically present in the room, especially when discussing sexual health issues.”

Source: European Union Agency for Fundamental Rights, 2013.

POLICY RESPONSES: WHAT IS (NOT) BEING DONE TO ADDRESS URBAN MIGRANT HEALTH

The plight of urban migrants and urban refugees, especially regarding their health and well-being, has unfortunately not been the topic of comprehensive comparative research. The conclusions that can be drawn from the evidence on different migrant populations in specific urban settings that have been cited above, however, strongly suggest that there are striking inequities between migrants and non-migrants within cities across the world, both regarding their (subjectively reported or objectively assessed) state of health as well as the accessibility and quality of health services. Although, due to the lack of reliable data, it cannot be said to what extent these observed gaps remain when socioeconomic factors are controlled, for all reviewed evidence suggests that in order to make the aim of sustainable urban development achievable, the health of migrants and urban populations needs to be addressed.

Info Box 5: A mayor's story: Miguel Lifschitz, mayor of Rosario, Argentina

Argentina has often been cited as a good practice example in the migration health area, as it adopted a national law in 2003 that gives all foreigners the right to health and education (Jachimowicz 2006). Rosario is the third largest city of Argentina, with about 1.1 million inhabitants. The mayor recounts the process of social reforms undertaken in the city in the past years and how this links to internal migration: “Rosario attracts a large number of migrants from northern Argentina, which is the poorest region in the country. As Rosario makes improvements to its health care services and housing provision, this has the adverse effect of attracting even more migrants in search of opportunities that do not exist in northern cities. Of course, this is the other face of the city's economic growth and reflects the dynamics of immigration at the international level. Nevertheless, how to deal with the influx of internal migrants is the great challenge facing Rosario. At present, Argentina does not have a national policy on internal migration, but it is clear that one is needed to respond to situations in which in-migration surpasses an urban centre's capacity to manage such growth. However, such a policy should be directed at supporting the city to accommodate migrants rather than turning them away, by helping new families to integrate into the city, although this is an expensive process. [...] Rosario today is nothing like it was 14 years ago. The things that existed previously have been transformed beyond recognition: the health care system has been modernized, the city has now adopted social policies, it places emphasis on culture, and has established municipal district centres and the city police.”

Source: F. Almansi, 2009.

Several aspects seem to render this especially difficult. First, the already mentioned lack of data is a major hindrance: In order to develop evidence-informed policies, comprehensive prevention programmes and health services, the nexus between urbanization and migrants' health needs to be better understood. For that, disaggregated data on migrants' health and the underlying determinants of it (access to basic infrastructure, exposure to pollution and poverty, etc.) is needed. Data on migrant health is scarce in general and, if it exists, definitions and indicators are seldom harmonized for cross-country comparisons. When studying rural-to-urban migration in developing countries, monitoring the health of migrants and mobile workers is complicated by the fact that they often return home to die, as frequently reported by researchers for Southern Africa (Bocquier et al., 2011).

Second, the literature reviewed in the previous sections paints a rather bleak picture of existing political action on migrants' health in cities. It seems that not much is being done by local (and national governments) to improve the health of urban migrants; in many countries and cities they remain excluded from the health system; even if formal policies of inclusion have been set up, they are often not implemented or respected by health or migration authorities. In many parts of the urban world, it is NGOs and private actors who take responsibility for improving the health of migrant populations (see info box 6 below). While their efforts need to be commended, it seems at least questionable whether these parallel services in fact release local governments from their responsibility of providing health care for all their residents.¹⁷

Info Box 6: Networks of voluntary doctors providing health services in German cities

In many cities in the global North, it is voluntary health workers who offer health services for free and anonymously for marginalized populations such as irregular migrants and asylum-seekers, the latter being often only entitled to minimal care in receiving countries. The Maltese Migrant Medicine (MMM) constitutes an example of this: MMM offers support to all people without health insurance, including undocumented residents, in several German cities. They provide help through examinations and counselling in medical situations, emergency treatment in case of acute illness, referral to specialized physicians if necessary, care during pregnancy and delivery, and referral to services for social and legal counselling. Anonymity is assured to all beneficiaries, who often fear to seek help at a normal doctor's practice or hospital. The first office was opened in 2001 in Berlin. Since then, the Maltese Order has opened twelve more offices in cities throughout Germany. Both health professionals and administrative staff work voluntarily, without being remunerated. Medical equipment and medicine is funded by financial and in-kind donations. MMM works in cooperation with a network of voluntary health professionals, and with churches, NGOs and associations. MMM has supported more than 40,000 patients in the past ten years. Frequent reasons for seeking help at MMM are pregnancy, injuries, acute dental conditions, tumours and communicable diseases.

Source: Malteser Migranten Medizin, 2014.

Third, although there have been significant advances in reducing poverty and its consequences in the last two decades, most of the responses to urban migrant health that have been taken by local governments seem to indicate a certain helplessness, lack of political will or simply lack of good management. For instance, health services seem to be ineffective in many places and referral systems are weak (Shetty, 2011). Health care facilities are often inaccessible for migrants due to geographic distance, high costs and sometimes negative attitudes of health professionals (Mberu et al., forthcoming). Of course, providing quality, accessible and acceptable health service facilities to migrants is not a trivial task, as is tackling the root causes of ill-health, i.e. the social determinants of health. It requires political will, resources, the cooperation of multiple government sectors and, ideally, other stakeholders such as civil society organizations, healthcare practitioners, etc. The issue seems to be that action on the health of urban

¹⁷ Moreover, "quality control and sustainability may be difficult to guarantee outside the mainstream health system, and if care outside the system becomes structural, the social exclusion of the groups being cared for may be further institutionalized" (WHO Regional Office for Europe, 2010: vii).

migrants often lacks priority in a government's agenda (Shetty, 2011). This might also be the case as many government representatives or receiving communities continue to see migrants as a strain on already-scarce local resources. Therefore, certainly, the first step needs to be that all stakeholders acknowledge that urbanization (and migration to the city) is simply inevitable (ibid.). As UNDESA (2014:17) emphasizes, "[h]istory has shown that policies that aim to restrict rural-urban migration are ineffective at forestalling city growth, and can even produce economic, social and environmental harms".

Fourth, it is clear that cities cannot be left alone with the health-related challenges posed by migration and urbanization. National governments and the international community need to assist governments at sub-national and city-level to improve the health of migrants, thereby taking a step towards sustainable urban development. As the majority of migrants and their families who stayed behind are typically of low socioeconomic status, they usually do not have a voice in politics, and remain hidden in the cities of the world (Mili, 2011). Clearly, a sustained, intensified joint action by diverse governmental and private actors at local, national and international level is called for.

Info Box 7: Good practice example: Community Health Centre, Nairobi, Kenya

Although, on the whole, the city of Nairobi in Kenya is not perceived to be welcoming of migrants and refugees, it has made significant progress in providing health care for migrants and refugees, according to a case study involving semi-structured interviews with relevant stakeholders, carried out as part of a research project on migrant and refugee integration in global cities by the Maastricht Economic and Social Research Institute on Innovation and Technology (UNU-MERIT), the Maastricht Graduate School of Governance (MGSOG) and The Hague Process on Refugees and Migration (THP). In particular, the City Council's Health Department, together with IOM, established the Eastleigh Community Health Centre in 2002. Eastleigh is a Nairobi neighbourhood which has by far the highest concentration of migrant residents. The Eastleigh Community Health Centre has been called "an example of effective collaboration between a [local] government department and a third party for the purpose of integrating migrants into the healthcare system. The project is successful because it brings healthcare to the place where the most vulnerable refugees live, thereby eliminating a significant barrier to healthcare access which was the danger and difficulty of travelling long distances in the city. The free, non-discriminatory and non-judgmental clinic also eliminates the problem of refugees foregoing healthcare due to insufficient means or fear of persecution."

Sources: Sturge, 2014; Juzwiak, McGregor and Siegel, 2014.

POLICY RECOMMENDATIONS: WHAT NEEDS TO BE DONE

Recommending adequate policy measures for local governments to tackle health-related challenges in the context of migration and urbanization is not straightforward as, in general, “the precise roles and responsibilities of municipal governments in reducing health inequities at the local level have been inadequately investigated and remain poorly understood” (Collins and Hayes, 2010:17).

However, based on the health needs of urban migrants and receiving cities compiled and described above, the following concluding chapter makes policy recommendations along the four dimensions of the operational framework identified at the Global Consultation on the Health of Migrants in Madrid 2010 (WHO, Government of Spain and IOM 2010)¹⁸:

- 1) Monitoring migrant health
- 2) Policy and legal frameworks affecting migrants’ health
- 3) Migrant-sensitive health systems
- 4) Partnerships, networks and multi-country frameworks.

MONITORING THE HEALTH OF MIGRANTS

More and better data is a prerequisite for the aim of healthier and more equitable cities. Up to now, estimations on the burden of disease have usually been on a global, regional and national scale and therefore masked intra-city differences, which limit their use for informing local policy-making. Moreover, public health metrics usually take into account separate risk factors or diseases, but neglect the cumulative impacts of interrelated environmental and socio-economic factors (Corburn and Cohen, 2012).

Good-quality data is also indispensable to measure the impact of services and policies on the health outcomes of migrants and other mobile urban residents. Monitoring migrant health should include the standardized recording of migration-related variables, such as country or region of birth and/or last residence, migration status, whether migrants live separate from their families, the nature of the migration process, and the duration of residence in the new country. Additional avenues for approaching migrant health monitoring are those based on population factors, similar to those already used in studies on health and diversity. Migrant health variables should be integrated into existing data collection systems in a way that allows for disaggregation by specific population groups, age and gender (WHO, Government of Spain and IOM, 2010).

One way would be to develop and use urban health equity indicators which should also be disaggregated by migrant status. Corburn and Cohen (2012:1) emphasize that simple cross-sectional measures can easily conceal health inequities. The example they use from their own work is access to a toilet in the slums of Nairobi: “[W]e have found that typical indicators that only measure population access to a toilet can misconstrue whether an ablution block is hygienic or safe. In Nairobi’s slums, accessing a toilet may be controlled by a local cartel that might extort a high price for users, disproportionately impacting family income, while at the same time acting as a location for rape and sexual violence against women, particularly at night, when the toilet has no lighting or security, which in-turn might contribute to the spread of sexually transmitted diseases.” The authors argue for locally developed health equity indicators, which are to be identified in a participatory process with community organizations, policy-makers, and academics.

18 The consultation was organized jointly by WHO, IOM and the Ministry of Health and Social Policy of Spain following the adoption of the Resolution on the Health of Migrants (WHA 61.17) by the World Health Assembly (WHA) two years previously, in 2008. One of its aims was to outline an operational framework to promote migrant health (see also page 5).

Info Box 8: Electronic health insurance card for asylum-seekers in Bremen, Germany

In Germany, the 16 federal states (*Bundesländer*) are in charge of organizing housing and healthcare for asylum-seekers. Regulations therefore differ, sometimes even across municipalities within one federal state. Usually, however, asylum-seekers first have to obtain a voucher from the relevant local authority (e.g. the welfare office) before they can see a doctor. Only in cases of emergency are they allowed to go directly to a health practitioner or a hospital. However, not all medical services that someone with statutory health insurance in Germany is entitled to are also covered for asylum-seekers. In the context of increasing numbers of people seeking asylum in Germany, medical practitioners frequently provide health care free of charge (see also info box 6).

The city state of Bremen introduced a different scheme in 2005, which has since been termed the “Bremen model”. The relevant authorities in Bremen made an agreement with a statutory health insurance company, the AOK, and since then asylum-seekers in Bremen have been handed out electronic health insurance cards. With these cards, they can obtain health services without prior consultation of the relevant authority. The city pays an administration fee to the insurance company, and reimburses it for the treatment costs later. The city state of Hamburg has already copied the “Bremen model”, and several other German *Bundesländer* have signaled interest. According to the German Federal Government, federal law allows the *Bundesländer* to enter into such agreements with statutory health insurance companies. Although asylum-seekers still do not automatically obtain all health services that people with statutory health insurance in Germany do, this can be considered an important step towards improved access to health care for this population in Germany.

Sources: Die Senatorin für Soziales, Kinder, Jugend und Frauen, 2014; Deutscher Bundestag, 2014; Bohsem, 2014.

POLICY AND LEGAL FRAMEWORKS AFFECTING MIGRANTS’ HEALTH

Legal barriers for accessing health services need to be brought down, as legal exclusion of a proportion of the inhabitants remains the paramount obstacle to improving urban population’s health, productivity, and well-being. The right to health of migrants¹⁹ needs to be realized in every national and local policy, as this is crucial for social, economic and public health reasons.

To ensure policy coherence, it is by now commonly acknowledged that the social determinants of health can only be meaningfully addressed in a multi-sectoral approach. The health sector alone cannot set and implement the policies necessary to significantly improve the living and working conditions of all urban citizens. Social and health equity, which go hand in hand, can only be achieved if health (and migrant health) is being mainstreamed in all policies. The Health in All Policies (HiAP) strategy has gained attention. Migrant health could and needs to be addressed within a HiAP approach, so that “[p]olicy-makers within the health sector as well as outside the health sector, such as the labour, immigration and foreign affairs sectors should take into account the impacts of public policies on the health determinants of migrants, as well as on health systems across sectors, in order to realize health-related rights and improve accountability for population health and health equity” (Kontunen et al., 2014:122). How this strategy can be adopted and implemented in a city – yet not a megalopolis – as a “Health in All Urban Policy” approach has been described with regard to the City of Richmond, California, US (Corburn et al., 2014).

19 See IOM, WHO and UNHCHR, 2013 for details.

Info Box 9: Good practice example: Access to health care for undocumented migrants, Seoul, South Korea

The Municipal Government of Seoul, South Korea, introduced medical aid for undocumented and uninsured foreign workers, their foreign spouses, undocumented migrant children and refugees in 2012. Formerly, these groups had not been entitled to receive any health benefits. In addition to fully covering surgery costs and hospital charges of up to a threshold of five million won (USD 4,400) and partially for those above that amount, interpretation and nursing services are provided. The benefits are available at eight designated hospitals. Officials from the municipality assured that the workers will not be in danger of deportation after receiving health benefits. In the South Korean capital city, home to almost 10 million people, the number of foreign undocumented workers is estimated at about 280,000. Most of them entered the country legally, but then overstayed when their visas expired.

Source: The Korea Herald, 7 March 2012: www.koreaherald.com/view.php?ud=20120307001296

One example of addressing the underlying determinants of health for urban migrants is what has been termed slum upgrading – i.e. improving the security of tenure, for instance through the regularization of land rights and improving the existing infrastructure up to a satisfactory and affordable standard. The WHO (2005) proposes slum upgrading as one of several potential strategic actions which should be more closely considered by policy-makers and donors, explaining that related improvements should include basic service provision such as water services, drainage systems, security lighting, as well as improved access to health care and education. However, slum upgrading can be difficult, as “[o]ften, they are tightly and haphazardly clustered together, so putting in electricity lines or water pipes is almost impossible” (Shetty, 2011:628). Yet, in some cases, slum upgrading measures were quite successful. For instance, the replacement of dirt with cement floors in Mexico City led to a significant reduction in parasitic protozoa infestations and in diarrhoea among children (Alirol et al., 2010).

Info Box 10: Good practice example: Educational and health support for unaccompanied migrant children, City of New York, USA

In the first seven months of 2014 alone, about 1,350 unaccompanied child migrants fleeing violence in Central America arrived in New York City and were placed with family members or other sponsors. In September 2014, the Mayor of the City of New York and the Commissioner of Immigrant Affairs announced that they will respond to the arrival of these vulnerable unaccompanied minors by providing direct services to children and families at the NYC Immigration Court for the first time ever. In partnership, representatives from the Department of Education, the Department of Health and Mental Hygiene, and the Health and Hospital Corporation, will address the needs of unaccompanied minors who are waiting for their cases to be processed. The immediate goals of the task force are to target neighborhoods and schools for outreach, assist with school and health insurance enrollment, legal screenings and referrals, and provide families with information. Moreover, a comprehensive guide of resources is to be produced, containing referral information on legal, medical, mental health and social services.

Source: City of New York, 2014.

MIGRANT-SENSITIVE HEALTH SYSTEMS

A third recommendation is to build and/or adapt existing health services to make them migrant-friendly. Migrant-friendly health systems, also often referred to as migrant-sensitive health systems, consciously and systematically incorporate the needs of migrants into health financing, policy, planning, implementation and evaluation, including such considerations as the epidemiological profiles of migrant populations, relevant cultural, language and socioeconomic factors, and the impact of the migration process on the health of migrants. Types of services that can enhance the ability of health systems to deliver migrant-sensitive care include interpretation and translation services and cultural competence in health care including the use of migrants as cultural support staff, such as intercultural mediators and community health workers (WHO, Government of Spain and IOM, 2010; Fortier, 2010).

Info Box 11: Good practice example: Prevention through empowerment of migrant women, Bilbao, Spain

The project “Mujer, Salud y Violencia” (Women, Health and Violence) of the Municipality of Bilbao, Basque Country, Spain, started in 2008 and has been identified as an innovative and successful practice by the European Migrant Integration Academy (EU-MIA).¹ Bilbao is the tenth largest city in Spain with about 350,000 inhabitants in 2013; the metropolitan area surrounding the city is home to about 850,000 people in total. Today, 8.15 per cent of the population are migrants, 83.8 per cent of whom originate from non-EU countries. Addressing the socio-emotional needs of third-country migrant women living in Bilbao and Greater Bilbao (i.e. who migrated to Bilbao from outside the European Union), the project “Mujer, Salud y Violencia” is focused on prevention through the empowerment of migrant women through: a) health self-management, b) sexual and reproductive health promotion, and c) gender violence prevention. The idea is to help the women develop their autonomy in life decision-making. This is being achieved through the training of “empowerment agents”, i.e. women from the migrant communities themselves, who act as multipliers in their respective communities. Workshops are being organized in cooperation with various stakeholders (such as migrants’ associations, voluntary associations providing support for victims of gender-based violence or in situations of economic difficulty, disability or drug addiction rehabilitation) to inform and raise awareness of gender violence prevention and the specific health needs of women. Pilot workshops have been held on the topic of Female Genital Mutilation (FGM). Moreover, within the scope of the project, a multilingual guide on health and violence prevention for the women was produced and diffused in the training courses. The city department in charge of developing the project is the Department of Equality, Citizenship and Cooperation. Since the start of the project, 167 women have been empowered.

Source: Tarantino, 2013. The EU-MIA documentary on the Bilbao project can be found online at www.youtube.com/watch?v=vy-64l4ca5U&index=3&list=PLI9HabXuvUN4ckKAeAMbiLymxLPdIYsuF.

The right to health of migrants to available, acceptable, accessible and quality health care needs to be realized by successively removing all the barriers identified in the previous chapter, i.e. legal, financial, geographic and cultural, linguistic and discriminatory. “Access must therefore be broadly defined to encompass its physical, social, cultural and economic dimensions. Transportation for example, though outside of the health care system is a critical determinant of access to health care. Improvement of access may be led by the health sector, but it is apparent that the role of other sectors is equally important” (WHO, 2005:16). There is no one-size-fits-all approach to making health systems migrant-sensitive. Outreach campaigns or insurance systems need to be tailored to the context and the type of exclusion a specific urban population group faces (Matthews et al., 2010).

The training of culturally competent health care staff is central to overcoming any existing cultural, communication or discrimination barriers to the successful implementation of migrant inclusion into health prevention, promotion and care programmes. As put by Vearey (2008:371) with regard to the situation in South African cities, “[a]ppropriate training within the public healthcare sector (especially

among institutional managers) relating to the rights of all international migrants, including refugees and asylum seekers, to access [antiretroviral therapy] is urgently required”.

Moreover, the institutional setup of health systems needs to be reviewed, as there can be inbuilt disincentives that hamper efforts to improve the health of migrants: For instance, in China, “[u]nder the current fee-for-service system, China’s public health facilities rely heavily on patient medical fees for their profits [...]. Hospitals have a financial incentive to keep patients longer than necessary and to over-prescribe unnecessary drugs/examinations, resulting in high costs and long diagnostic delays for TB patients in China” (Wei et al., 2009:758).

The call for migrant-sensitive health systems is simultaneously a call for mainstreaming efforts to improve migrants’ health and its underlying determinants and include them into wider policy approaches. Indeed, the reinforcement of existing health delivery systems can help to make migrants a part of urban societies rather than consolidating their marginalization.

A promising practice (identified by the European Union Agency for Fundamental Rights) to achieve migrant-sensitive health care facilities in cities is to incorporate (future) patients’ views when setting up a new hospital, as has been done by municipal authorities in Göteborg, Sweden. There, a close dialogue has been conducted with local inhabitants of a suburb having a large percentage of residents with a migrant background, involving meetings, interviews and focus group discussions to consult these potential future patients about their experiences with and expectations about healthcare services (European Union Agency for Fundamental Rights, 2013).

PARTNERSHIPS, NETWORKS AND MULTI COUNTRY FRAMEWORKS

Vertical responses to address migrants’ health in urban settings are bound to fall short of achieving their objectives in a comprehensive and coherent way. Just as via the migration process, places and communities of origin, transit and destination are linked, responses also need to be linked. All available evidence “calls for trans-border collaboration, surveillance and implementation of more specific mobile and migrants populations programs including mobile clinics and outreach activities.” (Mberu et al., forthcoming: xvii).

Moreover, also within cities, partnerships and network approaches are crucial, especially in resource-poor settings (Juzwiak, McGregor and Siegel, 2014). And good practice examples from various cities around the world (such as the ones cited here from Bilbao (Spain), Seoul (South Korea), Nairobi (Kenya), Johannesburg (South Africa) and New York (USA)) show that inter-city networks that provide a platform for the exchange of experiences and ideas could be a further mechanism to improve policies and programmes for healthier and more equitable cities.

Info Box 12: Good practice example: Policy dialogue on urban health, HIV and migration in Johannesburg, South Africa

The African Centre for Migration and Society, the University of the Witwatersrand, and the City of Johannesburg organized a policy dialogue to address urban health, HIV, and migration due to urbanization as a result of natural urban growth and internal and international migration. The highest HIV prevalence nationally is found within urban informal settlements. The policy dialogue aimed to bring policy makers, implementers, researchers, and civil society together to discuss the current health challenges faced by migrants in Johannesburg, share current responses in the city, and develop recommendations for action; it was attended by 50 participants from various government offices, NGOs, and academic institutions.

Source: Vearey, 2012.

CONCLUSION

Both migration and urbanization are important and multidimensional social determinants of health for migrants and their families. Especially rapidly growing informal urban settlements constitute urban spaces of vulnerability, as municipalities, particularly in resource-poor settings, are struggling to provide necessary basic infrastructure, such as water, sanitation, safe electricity, safe transport, and access to quality health care services for all. Against this structural backdrop, individual health vulnerabilities depend on the socio-demographic profile of a person, in combination with his or her legal migrant status. Cities, especially in low- and middle-income countries that undergo the highest rates of urbanization worldwide, are confronted with a multiple health threat comprised of communicable and non-communicable diseases, mental and psychosocial health hazards, and morbidity and mortality due to violence and accidents affecting migrant populations residing in urban areas around the world. While recommending adequate policy measures for local governments to tackle health-related challenges in the context of migration and urbanization is not straightforward, several points of action for different stakeholders show that the health of urban migrants and host communities can be improved in order to come closer to the target of eliminating urban health inequities and achieving sustainable urban development for all. However, cross-city or cross-country comparative research on the triangle health, migration and cities is scarce and needs to be further encouraged to enable evidence-based policy-making.

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