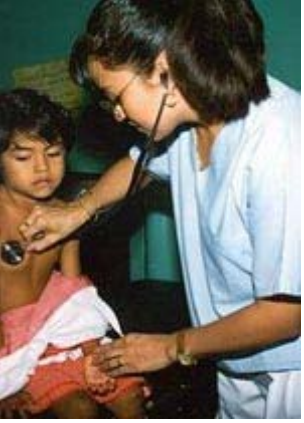

Workshop Report
Migration, Urban Poverty and Health

Sussex, 10 May 2005

Welcome

Richard Black, director of the Migration DRC, welcomed all the participants and drew attention to the many links that exist between the issues of migration and health though there has been a paucity of research on these areas. The DRC's work in the area is concerned with the effects of migration on health outcomes for poor people, particularly children, and is an important dimension to evaluate the costs and benefits of migration.

The following is a summary of the presentations made through the day. The morning session of the workshop was chaired by Kirsty McNay (co-organiser) and the afternoon session by Meera Warrier (research manager of the DRC)

Introduction

A broad outline of the aims of the workshop was presented by Maya Unnithan (co-organiser) which were, firstly, to reflect on the concepts and related categories used in migration and health research, and secondly, to consider the methodological issues arising from cross-disciplinary research in this field. It was hoped that there would be opportunities to learn from other participants and that this workshop would provide a forum where people working in cross-disciplinary areas on migration and health would share their ideas and experiences.

The ongoing DRC project on migration and child health investigates the health consequences of rural-urban migration on poor families in Rajasthan. Related to this research several questions have arisen: how does one address a lack of available information on how members of mobile groups (and individuals) are affected by mobility in all its complexity (its nature, shifts and changes over time). There are problems of definitions/categories in terms of mobility, so the question of who are the mobile becomes of central importance: are these sub-populations, individuals, family members, communities? Whether the mobility of individuals or groups is chronic or not, is a further significant issue in thinking about their health and well being. Mobile populations especially challenge health services because such services tend to be conceptualised in stationary terms. Through their movement mobile groups become vulnerable in terms of health because they often fall between or beyond existing health facilities.

Maya felt there was a need to recognise 'health' in its broadest sense to include not just access to health care facilities but as related to the environment and living conditions. In terms of children's health, this would include a focus on, for example, everyday practices of hygiene in cooking, eating, washing, cleaning and nutrition as well as emotional conditions as in the care and affection of parents and other significant kinspersons, and conditions which promoted physical well-being such as the access to safe areas for play and exercise.

Maya also underscored the invisibility of health as a reason for movement in the first place. Health-related reasons for migration might get submerged under more pressing and visible problems such as the economic (access to employment and wage labour) and political (where

there is state oppression or ethnic conflict, for example). Here the impact on health may be an unintended consequence (adverse or beneficial) of the migration process.

Given the complexity of the issues involved in a study of migration and health, it becomes necessary to think of an array or mixture of methods with which to approach the issue of the interrelationship between the two. What might be required is a combination of methods which are sensitive to migrant experiences and perceptions.

A Pilot Study on the Interrelation between Internal Migration and Child Mortality in Ghana
Claudia Natali, Sussex

Drawing on her ongoing pilot study, Claudia underlined how the inter-connections between migration and health can raise issues that have consequences for public health. Whilst migration can often benefit members of a family, it can also expose others to health risks. Any rigorous investigation of migration and health requires a definition of the type of migration that is being studied, whose health status is being considered, as well as what is meant by health, since it is a very difficult concept to measure. Different health status indices are used to study the health effects of migration (usually mortality and morbidity rates, with mortality rates being used more frequently). The distinction was made between children who migrate with one or both parents with direct effects of migration on their health, and children who are left behind, with a more indirect effect of migration on their health.

Claudia's project researches the impact of internal migration on migrants' children and to look at childhood mortality. The location is Ghana and the sample looks at women and babies between the ages of 0 to 5, and only includes those children who migrate with their parents. It focuses on the determinants of infant and child mortality and of infant and child survival. Socio-economic characteristics, such as maternal education, work status of the mother, literacy and environmental factors are considered, as are demographic determinants, such as birth interval, mother's age at birth, birth order and the sex of the child. Preventive health services such as immunisation programmes were found to have influenced survival later in childhood.

The *methodology* involved both quantitative and qualitative techniques. The quantitative study used secondary data from the Ghana Demographic and Health Survey (GDHS) for 1993, 1998 and 2003 to calculate the probability that a woman lost at least one baby before the age of five. The research concentrated on the mortality of children born within five years before the date of the surveys. Steps were taken to create migration status variables using the residence questions in the DHS and resulted in six categories -- urban native, rural native, rural-urban migrant, urban-rural migrant, rural return migrant and urban return migrant. The qualitative study aimed to uncover the channels through which migration impacts on children's health and focused on 18 stakeholders who were interviewed in Accra to find out the different perceptions of health among people working in a range of organisations. Some of the agencies targeted in this sample were UNICEF, CARE, the Ghana Ministry of Women and Children's Affairs, WHO and DFID. The respondents were asked to consider their experience with migrants in general, but especially with migrants' children, their perception about rural-urban migrants' health in Accra and channels of impact of migration on health. The study revealed just how differently the health of migrants' children was perceived by various organisations, so that whilst most of the international organisations had little idea of who the migrants were, many of the NGOs had a clearer understanding of the problems affecting migrants' children. Many of the respondents held the perception that children are worse off when moving from rural settings to urban ones

and considered barriers to health to be financial, geographical, socio-cultural and constraints in service provision.

The quantitative analysis showed that rural-urban migrants have a lower percentage of babies who die before the age of five. The qualitative study showed a very different result -- that children are likely to be better off back in their rural locations. The poor living conditions of migrants in cities and towns was likely to offset the positive health outcomes of rural-urban migration. This inconsistency needed to be explained, and several factors were highlighted. The DHS is not representative of the overall urban population and would not cover shanty town dwellers, seasonal migrants, street women and so on. Most of the people interviewed had knowledge of visible migrants, but seemed unaware of those who might not have such a visible presence. It would be interesting to conduct future research in rural settings to compare health situations there to those obtaining in Accra in order to establish whether migration is a successful strategy to improve children's health. The pilot study also found that no international organisation has looked at this problem and that whilst they often try to solve the migration 'problem' at the origin, they do not deal with the consequences of migration.

One point that came out of the discussion that followed was that it would be useful to divide the age group 0-5 into smaller groupings, especially to distinguish between very young babies and older children. Very small children could be affected by changes in the mother's breastfeeding behaviour, while older children are more likely to be affected by external factors.

Reconstructing Diet and Food Habits: Thinking about Challenges and Concerns in Adapting to a New Food and Health Environment.
Peroline Ainsworth (Oxford and AUC)

This presentation reported on a research project on forced migrants' feeding patterns. The respondents were Southern Sudanese refugees living in Cairo, and consisted of Christian, English speaking groups who had arrived in Cairo over 10 years ago. Although official figures put the number of Sudanese refugees at 20,000, there are more likely to be approximately 80,000 people within the city. Very little rigorous research in refugee situations has been undertaken and this project focused on the food selection of the subject group, covering issues such as availability, cost and how the food that was chosen might affect health, as well as the processes people go through in choosing food types. Research has been undertaken amongst home environments but a need was identified to look at forced migrants as a specific group.

But who exactly is a 'forced' migrant? Based on their own subjective experience of forced migration, people take on fluid definitions and this project looked at how they discussed food intake in terms of their experience of migration. The study used a mixed methodology; a food frequency survey was undertaken (131 respondents), in which people were asked to remember Sudan (then) and now, a method that relied mainly on people's memories. This was followed by asking questions about food preparation and a list was drawn up of people's perceptions. It was made clear that this was not intended to be a representative sample.

Some of the difficulties of doing fieldwork in this situation were highlighted, such as those of locating and talking to people in Cairo, security issues and the fact that the researchers were regarded with suspicion and hostility and tended to be associated with officialdom and agencies such as the UNHCR. It was difficult to conduct in-depth interviews, and to get

permission to conduct research and it was also problematic to get comparisons between low income Egyptians and Sudanese.

As an anthropologist working in the field of nutritional science, there were methodological difficulties in taking a multi-disciplinary approach and in designing and defining the study. One of the methodological concerns related to how to use and integrate the two sets of data, survey material and field notes. The first attempt to use field notes to analyse patterns in quantitative data was unsuccessful and the researcher is currently trying to extract risk factors from both sets of data, such as low consumption of meat and green vegetables being linked to suspicion of Egyptian vendors, depression and lack of income.

The study looked at the UN Right to Adequate Food Definition (UNHCR) and the links to provision of medical services, health care, cultural/social factors and dietary needs. It was interesting to note that while in Cairo, certain food types disappeared from the subject group's diets and this included both symbolic and nutritional foods, such as peanuts, mangoes and sorghum (this was found to be unavailable) and fresh milk. This was not purely due to unavailability of these food types. Other factors included a prioritising of risks, and health was not the primary reason given in most cases. Informal information channels were found to be particularly important amongst the refugees. Risks were identified such as the corruption of food from chemicals, which was perceived to be a high risk within food bought in Egypt, and a mistrust of milk, with the belief being expressed that formaldihide was being used as a preservative in milk. It was also thought that anti-fertility drugs were being added to some foods, and this was cited as a primary reason why certain foods were being avoided.

Some of the potential consequences of choosing certain food types and avoiding others were highlighted For example, if people developed a bodily itch, it was blamed on the consumption of eggs, one of their few sources of protein and iron. Another concern cited by the respondents was the danger of becoming Egyptian and losing their Sudanese identity. Strategies to combat these perceived dangers were avoidance of certain foods and replacement of staples with other substitutes, such as spinach.

Infant Growth in the context of Poverty and Conflict in Nepal
Catherine Panter-Brick (University of Durham)

This presentation reported on a project undertaken in 1993, which itself was a follow-up on a study conducted ten years earlier (1982-83). The research in the 1980s had looked at mother and child health, workload and reproduction in rural areas of Nepal. The 1993 study, conducted with street children and their peers, aimed at revisiting three children, who had also been subjects of the 1980s research, in an attempt to understand reasons for the prevalence of stunted growth among children, a big problem in Nepal.

The new study found that stunting was prevalent. Significant hygiene problems and the presence of common parasite infections was also detected. The key research question related to how far poor nutrition was responsible for the lack of growth. Blood markers, it was found, was a better determinant of nutrition-status than self-reporting. Significantly, poor hygiene and infection were found to have a greater role in determining stunted growth compared to poor hygiene. After an initial period of three months of normal growth whilst children were breastfed, growth slowed down in the period between 3 and 12 months. Why did infants fare so badly? Was it because of insufficient breastmilk? The research results showed that supplements had

very little effect on the growth of infants. From birth up to 24 months, feeding children better did not affect their growth significantly. Infection was found to be the main cause of lack of growth, as the guts became shredded and could not absorb nutrients through breast milk. The research looked at what causes giardia (gut damage) and what would improve the situation. As the children are living in dirty conditions, the elimination of pathogens is problematic.

The study compared children in different areas. In the peri-urban area, children fared well, unsurprisingly. In the squatter areas, hygiene problems were found to be prevalent, and children between 6 and 12 months seemed to lose growth velocity. Homeless street children tended to be taller than squatter children and villagers, because they tended to have good coping strategies. Children in villages were most affected by stunted growth, then squatters and the homeless; the least affected group was the middle class. The presentation concluded with the argument that if living in an unhygienic environment, better hygiene and not just nutrients influenced growth, with the policy implication that concentrating on dietary measures alone could be futile.

Migration, Poverty and Childhealth in Rajasthan
Kirsty McNay (Oxford) and Maya Unnithan (Sussex)

The research question here focused on whether rural-urban migration enhances the survival prospects of children in Rajasthan. Previous studies showed that infant mortality rates in India between the ages of 0-2 years are higher in migrant than among non-migrant groups. This research project sought to identify the reasons for those differences especially through an emphasis on migrants own perceptions and experiences of migration. The presentation concentrated on migration patterns and experiences around three specific areas of healthcare: childbirth, preventive (immunisation) health care and curative health care (i.e. health seeking activities as they arise when children become ill). Other factors such as nutrition, breastfeeding, hygiene, safety, access to physical infrastructure, access to other health services, emotional support, the stability of marital relationships, including physical abuse and violence, covered by the research project were not discussed here.

The study was conducted amongst over a 100 women and their children in a medium-sized 'basti' (urban slum) in Jaipur in northern India, popuated by Hindu Untouchable and Muslim families, who worked principally as wage labourers, domestic workers and lower-class government functionaries. Many of the residents, of both genders, work as rag pickers. Other than residents, there are transient workers, for example some shopkeepers come into the basti on a daily basis, usually to sell items in small quantities.

From a demographic perspective, the study looked at women's migration histories in order to get a broader picture of their patterns since birth. Most migration was found to be intra-state or inter-state(from other northern states). The reasons why people moved varied. For example, with rural-rural migration it was often associated with marriage, usually to live with the in-laws. Marriage was a factor influencing migration also in urban-urban migration. There were often also economic considerations such as to seek employment, or a desire to move up the social hierarchy. These motives were consistent with demographic surveys and census information. Women were predominant in shorter distance migration, and better health care facilities were not cited as a reason to move.

The questionnaire sought information on mothers' migration experiences since birth, childbirth conditions and also immunisation and health-seeking behaviour. A link was found between marriage migration and a return to the husband's family to give birth at the in-laws' home (not in a medical facility). Other smaller cycles of migration related to childbirth were noted, such as to and from in-laws' homes. The home environment was the favoured location for giving birth, particularly among migrants, especially if a relative was available to help with the delivery. Women who had always lived in the city were more likely to give birth in an institution. Some of the reasons cited for not wishing to give birth in a hospital were linked to fears of what might happen, such as the fear of being given injections. Other factors constraining them were the costs involved and, importantly, the perception that birth was not an event that required medical intervention. Thus women only tended to seek an institutional birth if problems arose. It was not routine behaviour to use health facilities, but those women who had lived in Jaipur (or moved within the city), i.e., non-migrants, were more likely to use a hospital. So although there was an ambivalence about using a hospital facility, this was much more the case for migrants than non-migrants.

In terms of preventive healthcare, migrants were found to be less likely to immunise their children or seek preventive health care. Qualitative evidence revealed a perception that intervention was not necessary if a problem did not seem readily apparent. Those women who had their children immunised were those who had had an institutional delivery in a government hospital. Immunisation against polio, however, was high amongst migrant and non-migrant groups alike. This reflected not only the fact that aggressive polio health campaigns had been carried out by the state but more significantly that there was greater acceptance of this non-invasive vaccine (since it was not delivered through an injection). Injections, although regarded with suspicion when seen in immunisation terms, were nevertheless sought after when it came to curative care.

Curative health seeking behaviour was high for both migrants and non-migrants. Compared to non-migrants there was, however, a wider range of health service providers identified by migrants, including spiritual healers, traditional and government facilities. Moreover, whereas non-migrants tended to use more private providers, more migrants relied on government (free) facilities.

Some Reflections on Cross-Disciplinary Methodologies
Gabby Barker (Sussex) and Jilly Bluck (Sussex)

This presentation was linked to the paper given by Maya and Kirsty, and provided a subjective, reflective account of some aspects of the speakers' work as research assistants on that research project. It focused on some of the difficulties involved in using data sets that had been collected through structured questionnaires, and that was intended to provide both quantitative and qualitative data.

A background was given to the methodology that was used in the project, highlighting the structure of the questionnaire, the way the forms were used, the differing backgrounds of the local research assistants and how these affected the way the data was analysed. Some of the difficulties of using structured questionnaires to gain qualitative information were highlighted and examples were given of how qualitative information might burst through. The process of displaying the qualitative data in a visual format, using a matrix or grid was described, and the ways in which this enabled a substantive visualisation of the qualitative material was outlined.

Sexual Behaviour and Perceptions of Risk: Male Rural-Urban Migrants in Tanzania
Ernestina Coast (LSE)

This presentation focused on male rural-urban migration in Tanzania and its interaction with HIV risk. The analysis compared results of two populations, one comprising recent rural-urban migrants in an urban area, and the other in a rural area. Three key research questions formed the framework for this study, namely: Does the sexual behaviour of rural-urban migrants differ from rural residents? How does sexual behaviour of migrants differ from that of rural residents? Do rural-urban migrants have higher levels of HIV knowledge than rural residents?

Detailed migration histories were taken of 96 rural-urban migrants, and in-depth interviews were conducted with the same group and 51 rural residents. In addition, focus group discussions were conducted with 8 respondents. The sample consisted of men from the Maasai ethnic group and only covered heterosexual behaviour. The exclusion of women from the research project was an acknowledged shortcoming. The urban study was conducted in the Arusha area, and the subjects were men who worked as night watchmen (askaris), a highly visible group. The rural site was a Maasai village, located approximately 30 kilometres from the nearest road.

All interviews were tape-recorded in the vernacular, and it was noted that the language was contested, and linguistic differences highlighted. For instance, if a question was asked as to whether the respondents had heard of HIV, the way the question was framed linguistically affected the interpretation. The researcher was not present at the interviews, as the presence of a non-Maasai women was deemed to be problematic and might have affected the quality of the interviews and response rates.

A difference in knowledge between rural-urban migrants and rural residents was identified. Rural men were more likely to refer to abstinence while rural-urban men talked of reducing their number of partners. Their knowledge sources were also different: for urban residents it was mainly the television and radio, whereas for rural residents it was friends and relatives. Knowledge of whether HIV could be cured was found to be different too, with rural-urban migrants more likely to know that there was no cure available. A lack of knowledge of how to use condoms was noted and while there was no significant difference between rural residents and rural-urban migrants in terms of knowing what a condom was, there was a difference between whether the respondent had seen a condom, with rural-urban migrants more likely to report having seen one.

The ethnographic research revealed perceptions of contraception as ‘wasting sperm’ which were essential for physiological development. Men in rural areas had more sex and partners than in the urban area, where unmarried men saw sex in town as being too risky, with 41 percent of the unmarried migrants reporting to have had no sex in the last 12 months. However, there was a widespread perception iIn rural areas that urban migrants were the purveyors of HIV.

Rural-urban migrants, both married and unmarried, avoided sex in town, since it was seen to be too risky. This constituted a rational decision on the part of urban-rural migrants; a deliberate strategy to avoid infection. Perceptions of risk were seen in binary oppositions -- in

terms of town and rural, with risk being constructed largely at the societal level, rather than at the individual level.

Round Table Discussion: Ann Whitehead (Sussex), Asha George (IDS), Maya and Kirsty, joined by observations from all participants.

The workshop concluded with observations from a number of people on significant issues which they felt had emerged, some gaps in various projects which could be addressed, and the ways in which the findings could be carried forward.

It was felt overall that the emerging links between migration and health showed how important it was to take the specificity of each context very seriously. The urban context itself was shown through the papers to be a source of variation – either providing an opportunity or being perceived as a source of harm for migrant communities and individuals. Another issue is the way migration itself emerges and disappears in thinking about the health of migrants in contexts of urban poverty. It also emerged that though there may not be gross differences between migrant and non-migrant urban poor in terms of accessing certain types of health care, there may nevertheless be small but significant differences. Here a focus on the very constrained choices that people are making needs to be considered.

If the link between migration and childhealth is complex, how do we find ways of addressing this issue: what are the policy implications of such a complex interrelationship? Do we need specific policies for different categories of migrants? Should we think in terms of service delivery or inclusive social citizenship? At a wider level, how does movement have an impact on social identities and the way social differences are constructed and experienced (this would be important for a consideration of the broader social determinants of health).

The discussion generated by the papers and the further questions raised pointed to how stimulating the workshop had been. As one discussant suggested she felt that rural utopias were being challenged through this kind of research and of course on the flip side urban poverty was being seen in a much more nuanced way. The workshop ended on a sombre reminder that migration and poverty were a ‘killer combination’ and research on its impact on health and well-being was urgent.