Chapter 2

Connecting the Dots: Cultivating a Sustainable Interdisciplinary Discourse Around Migration, Urbanisation, and Health in Southern Africa

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2.1 Introduction

Migration and urbanisation attract much interest globally, reflecting growing concerns associated with the management of urban growth (UN-Habitat 2016) and, increasingly, around the ways in which these social and demographic processes are associated with health and wellbeing (Galea and Vladhov 2005; Grant et al. 2017; Nauman et al. 2016). Recognising that there are complex – but poorly understood – linkages between migration, urbanisation and health globally, the key elements of an emerging research agenda have recently begun to be mapped out (Grant et al. 2017; IOM 2016; Hanefeld et al. 2017). However – with few notable exceptions (Oni et al. 2016) – these agendas tend to focus on ways in which migration *or* urbanisation is associated with health, and are insufficiently Africa-oriented. In an attempt to contribute to addressing this gap, we use this chapter to reflect on our experiences in supporting early-career scholars to further the research agenda associated with migration, urbanisation and health in Southern African Development Community (SADC).

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The SADC population is expected to double from 250 million to approximately 500 million people by 2040 (IOM 2010) and, by 2035, over 50% of the population is anticipated to reside in cities (UN 2014). The region is associated with high levels of historical and contemporary population movements including internal migration – dominated by movement between rural and urban spaces, and increasingly by inter- and intra-urban movements; cross-border migration from neighbouring countries; and long distance moves within and between continents (Walls et al. 2016). Additionally, the region is associated with a high prevalence of communicable diseases – notably HIV, tuberculosis (TB) and malaria, – and an increasing burden of non-communicable diseases (NCDs), mental ill-health, and injury (McMichael 2000; Vearey 2014). The public health systems of member states are struggling, creating additional tensions when exploring the intersections between migration, urbanisation and health (Vearey 2014), and researchers and policy makers increasingly recognise the need to better understand these complex linkages (Vearey 2014; Walls et al. 2016). This is particularly relevant when working to improve intersectoral responses to ensure that ‘no-one is left behind’ when working to achieve good health for all (United Nations 2016). In this chapter, we focus on the case of South Africa (SA) for several reasons: it is the most urbanised country in SADC; it receives the largest number of cross-border migrants within the region; it is home to a large internal migrant population that far outnumbers cross-border migrants; and, it bears a high communicable – and an increasing NCD – burden (Vearey 2014). However, regional research focuses on SA, producing a lopsided view of the region – highlighting the need for renewed research focus in other SADC member states.

Migration is a central determinant of health We consider migration a central determinant of health, and recognise the complex bidirectional relationship at play: migration can affect health, and health status can affect decisions to move (Castañeda et al. 2015; Davies et al. 2009; Vearey 2014). Given this, and the knowledge that healthy migration is good for development (Vearey 2014; IOM 2010), it is surprising that existing health responses at regional and country levels do not adequately engage with and respond to migration, mobility and urbanisation (Walls et al. 2016; Vearey et al. 2017). Despite being positively selected and often being in better health than the host population at their time of arrival in the city, some migrant groups – including both internal and cross-border migrants – experience an ‘urban health penalty’ due to their exposure to unhealthy physical and social conditions, and uneven landscapes of risk in the urban context (Carballo and Nerukar 2001; Freudenberg et al. 2005). These inequitable outcomes in poor health manifest in both urban and rural areas, where the burden of sick migrants returning home to receive care is borne by the sending households and (often rural) healthcare systems (Carballo and Nerukar 2001).

Demographic Shifts Migration is generally a selective process, with migrants clustering in specific economic and reproductive age groups, which influences fertility rates in receiving areas (StatsSA 2011). Both internal and cross border migrants affect the demographic composition of destination countries, provinces and municipalities, such that the compositional heterogeneity of the population changes– by age, gender,

ethnicity and socioeconomic position – exacerbating the appropriateness of the services provided (Morrison 1979; Gelatt et al. 2014). Changing age and gender compositions are interconnected with emerging challenges related to new health and disease (mortality and morbidity) profiles, social gradients of health, and the provisioning of equitable levels of service for preventive and reproductive health (Marmot 2004).

A range of socio-political, economic and demographic factors have led to the movement of people within the SADC region, and the associated growth observed in urban areas (Vearey 2013). This is associated with a growing population of the ‘urban poor’ and vulnerable subgroups, many of whom are recent migrants to the city and occupy the peripheries, with marginal access to health and social welfare (Vearey 2010, 2013). Key concerns relate to a lack of focus on the social determinants of urban health as well as the lack of effective management of chronic conditions – including communicable diseases – for those who move (Sargent and Larchanche 2011). This has negative public health implications, affecting the morbidity and mortality of a highly mobile population in both urban and rural areas (Vearey 2014), and on those who do not move (Gushulak and MacPherson 2006). These negative implications extend beyond the individual, and include the healthcare systems and family structures that are forced to manage the costs associated with the current limited responses to migration and health in the region (IOM 2010).

South Africa South African cities present unique spaces within which to explore the complex and multidirectional ways in which migration, urbanisation and health are connected, as the country is witnessing multiple simultaneous and interconnected transitions (health, demographic, social, economic and political). Before democracy, the apartheid government promoted racial/spatial segregation, restricted and controlled movement of people internally and across borders– resulting in distorted urbanisation, and today’s pattern of intra-urban disparities and inequities in health. The transition to democracy in SA provided a new context for the process of urbanisation as free movement for the local population was guaranteed and cross-border migration increased due to the search for improved livelihood opportunities and political unrest in neighbouring countries (Landau and Segatti 2011). Today, cross border migrants arriving in South Africa are diverse and include highly-skilled and low-skilled immigrants, refugees, asylum seekers, and other documented and undocumented migrants (Landau and Segatti 2011).

2.2 A Workshop for Interdisciplinary Discussion of Migration, Urbanisation, and Health

The dynamics of urbanisation and migration, and their implications for health in the SADC region, led researchers from the University of the Witwatersrand (WITS), the University of Cape Town, and Pennsylvania State University to convene a 3-day meeting in July 2015. The workshop brought together senior and early-career scholars working on urban and/or migration and health across the social and health sciences, to discuss ways of engaging with migration and health in the context of

urbanisation in SADC. Once abstracts were accepted for presentation, presenting early-career scholars were matched with the four workshop organisers who provided feedback on papers before the workshop. The workshop privileged emerging scholars; there were ten in total: five doctoral students whose presentations focused on their dissertations; three post-doctoral researchers; and, two MA graduates—one working as a researcher and one in a non-governmental organisation.

The workshop aimed to understand the current social and political contexts shaping migrant health, migration trajectories and health histories; the lived experiences of urban (internal and cross-border) migrants and the ways in which these lived experiences can shape the research agenda with regard to health; and, how current policy and practice can contribute to migrant well-being or marginality. The workshop was guided by four overarching questions:

1. What are the current social and political contexts shaping the health of migrants¹ in SADC?
2. What are the migration trajectories, health histories and lived experiences of urban migrants – with a focus of comparing long-term residents with new arrivals – within SADC?
3. How does current policy and practice contribute to migrant wellbeing or marginality in SADC?
4. How should what is known about the lived experiences of migrants contribute to the urban health research agenda, and how should insights emerging from this agenda inform the migration and health agenda?

These questions informed discussions around three key themes – access, lived experiences, and governance – that are described below.

Access Access refers to a range of positive determinants of health, including healthcare, social services or the realisation of food security. Presentations and discussions highlighted multiple forms of marginalisation in urban areas of SA, including of Zimbabwean, Cameroonian, Congolese (Democratic Republic of Congo – DRC) and internal migrants. Migrants are often marginalised and devalued, including when accessing healthcare; and – as a result – may turn to clinics and hospitals only as a last resort, especially female migrants during pregnancy and childbirth. Despite the availability of healthcare facilities they may be under-utilised by some migrant groups due to previous negative experiences, or for fear of deportation associated with a lack of documentation required to be in the country legally. These fears are fanned by a lack of political voice, representation and legal protection among migrant population. The political contexts that migrants operate in are inhospitable and hinder maintenance of optimal health and health seeking behaviours. Significantly, a number of healthcare barriers impeding migrant access to healthcare were identified. These include the nature of their employment, language, power relations, and discrimination on the basis of nationality or place of origin.

¹ Migrants refers to both cross-border and internal migrant groups.

Lived Experiences The challenges of realising good health in an urban context affect both internal and cross-border migrants. These challenges include poor mental health; mediated by education level, marital status and socio-economic situation, as well as country or province of origin. The urban environment contributes to growing inequity in wellbeing; in the case of peripheral urban spaces, economic, social and physical changes over the past few decades have reinforced marginalisation. Pathways that affect the health of migrants living on the periphery relate to unemployment and crime; inadequate shelter, infrastructure and services; a complex food environment in which it is difficult to achieve food security; a built environment that is not conducive to safe physical activity; and high levels of depression and stress – linked to, poverty, crime and fear of crime and deportation. Improving the understanding of lived experiences requires engagement with differing understandings of health and ill health, and alternative health and help-seeking strategies, such as churches and community support – including from others from their country of origin, and from those back home.

Role of Governance and Policy A key focus of many researchers at the symposium was on how cross-border migrants navigate and negotiate healthcare in public facilities and in turn how migrants are perceived as a public health threat or a liability by the state, by healthcare professionals and by local citizens. Securitisation with regard to migration is not limited to border control but extends to the (increasing) securitisation of healthcare and communicable diseases surveillance in SA. This is despite the fact that, often, rather than bringing communicable diseases, it is the marginalisation that cross-border and internal migrants face in SA cities that can put them at risk of contracting communicable diseases *after* arriving in the city. Migrants' well-being in host societies is partly informed by the extent to which they can access healthcare and other social services, safe housing, and secure livelihoods.

One important dimension of speaking to policy involved the explicit definition and consideration of contested terms. For example, it was vital to engage in a discussion of what is meant by human mobility. In SADC, this was determined to encompass travel that is circular and involves cycles of return that can be rapid (daily, weekly, monthly), as well as more permanent movement (annual trips home, or even less frequently). Mobility in the region is still dominated by working-aged individuals and families, meaning that issues related to maternal and child health remain important focal areas for consideration. Furthermore, the legal experience of those who migrate relates to health. For example, the category of refugee has (unevenly) invoked legal protection, and also specific health responses on the part of the state.

2.3 Towards a Collective Agenda: Connecting the Dots

We wanted to tap into the research emerging from multiple disciplines in order to 'connect the dots': to identify the overlapping research and policy priorities surrounding migration, urbanisation and health more effectively. During the

Table 2.1 Towards an emerging research agenda on migration, urbanisation and health in SADC

Key issue	Some key considerations
We need to establish common definitions of key concepts.	Urban/rural; mobility; migration; health; medical; traditional; urban advantage; urban health penalty; resilience
We need to better understand the complex contexts in which we work.	Legal frameworks; epidemiological profiles; working/living/travelling environments; social determinants of (urban) health framework; role of social networks; social capital
We need to acknowledge and engage with the heterogeneity of movement and mobility.	Daily; weekly; monthly; circular, categories of migrant; age; sex; moving alone; moving with family; forced movements; livelihood seeking movement
We need to better understand the lived experiences of people who move and enter the urban space.	Heterogeneity; migration trajectories; urbanisation experiences; embodied experiences
We need to enact a holistic view of health and wellbeing, and move away from the prevailing focus on access to biomedical services.	Plural health systems; understandings of health and wellbeing; idioms of distress; somatisation
We need to develop more effective ways for translating research into policy.	Engagement with the state – empirically and in practice; exploring ways of generating and communicating research; involved research approaches
We need to develop improved, pragmatic and interdisciplinary methodologies to address the concerns identified above.	Engaging with complexity; quantitative; qualitative; involved research practice; working with communities to co-develop and co-produce research; visual; medical; multiple places; comparative; place-based approaches; research along migration trajectories

workshop organizing process, we identified the importance of cultivating a network through which to communicate and continue to grapple with the identified policy and research themes. The *Migration, Urbanisation and Health Network (HumNet)* aims to provide a virtual way of continuing the conversation started in the workshop, and for ongoing support to early career scholars. A key concern identified in the workshop revolved around the idea of how to use our research to inform policy and practice. For example, we discussed concepts and definitions as they applied to the lived experiences of migrants in the SADC region. A central theme that emerged was in foregrounding community-based research, and in unpacking the layers of connections between emerging researchers, more established researchers, policy makers, and civil society. Some of the key issues identified for an emerging research agenda on migration, urbanisation and health in SADC are presented in Table 2.1. The issues are identified as a guide only; it is essential that the key concerns are mapped for different contexts.

Scholars working on migration, urbanisation and health come from many different disciplinary traditions. It is vital that we find a common language to allow our research to be understood across disciplines. Meaningfully engaging across disciplines—as was the case in this workshop—requires methodological pragmatism and plain language. We discussed the use of methodologies that unpack our disciplinary jargon and allow us to engage in the complexity of migration, experimenting

with terms and language that best captured the contexts and audiences in our region. For example, the term migration itself comes with particular preconceptions of human movement in a particular region. For us, it was valuable to consider the role of circular migration in mediating (poor) health outcomes in both sending and receiving communities.

Considering various ways of approaching migration in the region represented a first effort to engage and connect different people who can contribute to research, policy, and practice related to migration, urbanisation and health. At our meeting, the main focus was figuring out ways to speak that were less alienating to those engaged in practice, and those for whom urban or migrant health was a more peripheral part of their work. There needs to be multiple layers of engagement and multiple entry points into understanding linkages between migration, urbanisation and health in SADC—from research that serves to dispel myths, to that which builds much deeper knowledge in the region.

In addition to exploring ways to use language and approaches that not only speak across disciplines, we wished to understand ways to directly engage with those who are mobile, and who may experience health penalties as a result of their mobility or migration status. These methods should—we felt—be participatory, highly local, and support participatory action. Our focus on local, rather than reproducible, large scale, or transferable, kinds of knowledge, reflected a need to understand and foreground our local context. Place-based contextual knowledge allows for opportunities to connect and understand local policy and practice. Being connected to and engaging with the state is vital in our research, as the state is a key actor – both in defining who migrates, and in defining their experience of migration.

2.4 Cultivating a Sustainable Interdisciplinary Conversation

Migration, urbanisation and health are important contemporary social challenges and – as reflected in the diverse themes shared at the workshop – these challenges are dynamic. While a single disciplinary focus may be able to etch out small incremental gains in knowledge, there is a general recognition that collaboration across disciplines has the potential to be transformative, generate innovative ideas – and even solutions, and ultimately improve collective understanding of the most important real world problems (Ledford 2015). Interdisciplinary perspectives are especially relevant when examining the influence of global, national and local processes on individual outcomes, and in circumstances where the core policy and research questions require an analysis of complex patterns of interrelated social, behavioural, health, economic, and environmental phenomena – as in the general focus on the theme of migration, urbanisation and health.

Recognising the need for sustainable interdisciplinary research and facilitating it are, however, two different things. There are certainly risks to interdisciplinary collaboration, not least of which is the lack of incentives to engage in such collaboration (van Rijnsoever and Hessels 2011). But big questions require closer

integration across disciplines on concepts, data, and methods – as well as multilevel and multi-sectoral frameworks of analysis. It is then necessary to discuss the benefits, risks and challenges for the current and next-generation of scholars and to identify mechanisms that can promote readiness for collaboration.

As implied above, big questions require big ideas or frameworks, and specifically frameworks that are seemingly holistic and flexible; frameworks are not static and should be utilised as a tool to assist in the development of relevant research agendas. Fortunately for urban health researchers, several inclusive frameworks already exist and it was evident at the workshop that all participants comfortably fit under the umbrella of the ‘Social Determinants of Health’ (SDH) or similarly multilevel and multisectoral frameworks.

If sustainable interdisciplinary research requires a common set of critical questions and an integrative framework, then the study of urbanisation, migration and health is ideal –providing opportunities to transcend disciplinary perspectives and silos (Syme 2008) and seeds have already been sown for promoting interdisciplinary research in undergraduate and postgraduate training programmes around questions of society and human health. However, there is always room for reframing and extending opportunities promoting interdisciplinary research and for hearing the perspective from early-career researchers in this field. It was with this in mind that our workshop helped foster interdisciplinary engagement—sharing ideas in an open forum and exploring collaboration—around urbanisation, migration and health.

While senior scholars collaborated to organize and frame the event, the workshop focused on presentations by two distinct groups of participants: early-career scholars presenting their *own* work, and inputs from invited speakers whose work transcended the academic and policy divide. The involvement of participants from outside academia can contextualise and provide alternative views on a ‘real-world’ problem. This workshop structure reflected ideas reported in the literature where promoting the opportunity for interdisciplinary, multisector *encounters* and supporting open communication in both formal and informal (and unstructured) settings are an effective means to facilitate the development of future interdisciplinary researchers (Bridle et al. 2013).

Bridle et al. (2013) distinguish between “*cultivation*” and “*development*” encounters. Cultivation encounters are designed to expose researchers who are not yet involved in interdisciplinary projects to other disciplines, perspectives, concepts, ideas, measures, language, approaches, and tools as well as to help participants to understand what those disciplines have to offer and to explore potential areas of collaboration. Follow-up encounters are more likely framed as development encounters, where the premise is that people are brought together to generate new ideas or initiate concrete collaborative outputs—joint research papers and or funding proposals.

Our workshop touched on both the cultivation and development aspects of promoting collaboration across fields. While individual early career scholars came to the table with their own work and perspectives, the diversity of topics, research methods, and levels of integration with policy and legal actors across the sessions was impressive (see Table 2.1). This diverse coverage reflects the idea of cultivation; when we reflected as a group on the issues identified during the workshop, it was evident that there was both common ground and areas of intersection but also much

to be learned from each other. A short term outcome of the meeting linked to the opportunities for the early-career scholars to improve and refine their communication skills when presenting their own work to a diverse audience, as well as for some the opportunity to lead and facilitate group discussions.

The challenge is to move to the next step, explicitly focusing on further encounters to develop and sustain capacity within SADC to influence research and public policy. While interdisciplinary research can have considerable benefits it can also incur substantial costs, owing to the need to invest significant time in building truly collaborative relationships, developing shared language and honing a common perspective from disparate viewpoints (Bromham et al. 2016).

We have made concerted efforts to promote the transfer of knowledge and information from the established to the early-career scholars that attended the workshop, and these have focused on topics related to research practice within academia, the interface with public policy, and community engagement – as well other components of professional development such as sharing calls for papers, conference announcements, and strategies for publishing. The exchange of ideas and practice vis-à-vis professional development, while it may be asymmetrical between established and early-career scholars, should not be one way. Emerging areas of research and new ideas (e.g., lived experiences), new measurement and data needs (e.g., capturing the heterogeneity of mobility), contexts (e.g., legal environments) and new research methods (e.g., visual) and the integration of mixed methods (Hesse-Biber and Johnson 2015) can be areas where innovation is spurred on by the next generation of scholars. Among the many strategies to be simultaneously explored, we would prioritise training and instruction – specifically the provisioning of opportunities related to early-career development such as post-doctoral fellowships, exchange visits between departments, institutes and universities during both graduate and postgraduate studies, as well as exploring the placement of scholars within government and non-government agencies. We see opportunities for mentoring and exchange between all levels of the academy and with non-academic partners. Technology – emails, listserves, blogs² and social media^{3,4} – offers a vehicle for new ways of sharing and collaborating but face-to-face meetings can build better and more sustainable teams. Collectively, we continue to promote cultivating links and development opportunities as the *Migration, Urbanisation and Health Network (HumNet)* but we have a long way to go.

Challenges

- Scholars working on migration, urbanisation and health come from many different disciplinary traditions. It is vital that we find a common language to allow our research to be understood across disciplines.

²<http://migrationurbanisationhealth.tumblr.com/>.

³<https://goo.gl/bSD8ti>.

⁴<https://twitter.com/HumNet2015>.

- There needs to be multiple layers of engagement and multiple entry points into understanding linkages between migration, urbanisation and health in SADC—from research that serves to dispel myths, to that which builds much deeper knowledge in the region.
- We need to develop more effective ways for translating research into policy.

Lessons Learned

- Our focus on local, rather than reproducible, large scale, or transferable, kinds of knowledge, reflected a need to understand and foreground our local context. Place-based contextual knowledge allows for opportunities to connect and understand local policy and practice.
- Our workshop structure that prioritized emerging researchers and connections with policy makers facilitated dialogue between groups and allowed for both formal and informal conversations about creating bridges between the two.
- Technology offers a vehicle for new ways of sharing and collaborating but face-to-face meetings can build better and more sustainable teams.

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