



COVID-19, migrants, and world large urban areas: a thematic policy brief

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Abstract

Migrants living in large urban areas are disproportionately impacted by health crises such as pandemics. This policy brief explores how urban areas mitigate and/or exacerbate the impact of COVID-19 on migrant groups and provides policy recommendations. We conducted a policy review to focus on the effects of COVID-19 on migrants living in cities with > 500,000 residents. We found that structural inequity, lack of migrants' inclusion in relief programs, and residential segregation exacerbated COVID-19 impacts. Engagement of Civil Society Organizations (CSOs) and e-governance showed promising effects mitigating the impact of COVID-19 on these groups; yet the use of technology introduced additional barriers such as access to devices and internet connection. We recommend increasing policy attention to systemic social inequities faced by migrant groups in urban areas and supporting innovative and inclusive implementation of public health policies, urban design, and greater engagement of CSOs in the delivery of services to migrants.

Keywords COVID-19 · Health policy · Migrants · Urban · Cities

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Key messages

- Pre-existing inequities exacerbated COVID-19 impacts among urban migrants.
- Civil society engagement mitigated COVID-19 impacts among urban migrants.
- There is a need for strengthened relationships between governments and civil society, as local authorities would benefit from CSO networks offering cultural mediation and high levels of trust with migrant communities.

Introduction

Migrants and COVID-19

Migrants are defined as any individual or group who voluntarily or forcibly left their origin country and have a documented or undocumented immigration status in the host country. This definition includes immigrants (immigrating for reasons including but not limited to family reunification and improved economic opportunities), refugees, asylum seekers, and foreign workers [1]. A review of the academic literature indicated that migrants have been disproportionately affected by COVID-19 and its associated public health measures such as quarantines, shelter-in-place orders, travel bans, and closures of government and community services [2, 3]. Several ecological studies found a positive association between neighborhood-level proportions of immigrants and COVID-19 cases, suggesting that systemic factors make migrant communities more vulnerable to infections, mortality, and socioeconomic impacts of the pandemic [4, 5].

The main reason for a greater vulnerability to COVID-19 has been attributed to pre-existing inequities between migrant and host communities [6]. Inequity here refers to the targeted exclusion of certain communities from service and resource utilization through systemic barriers [7]. Socioeconomic and health inequities among migrant communities include higher rates of poverty, comorbidities, and mental health issues such as trauma, anxiety, and post-traumatic stress disorder [2, 3, 8, 9]. Migrants must also overcome language barriers, xenophobia in the host country, and impaired access to information and community services [2, 10, 11]. Inequities are further exacerbated by several other interconnected factors, including governance mechanisms that impact how policies are formulated and social services are organized.

Policies have been negatively affecting migrants since pre-pandemic times, including barriers to health care, punitive immigration laws, and policies that neglect to include particularly vulnerable communities such as refugees and undocumented migrants in planning and decision-making [8, 10, 12]. Inequities related to the living environment include residential segregation and unequal, overcrowded, and unhealthy housing conditions [2, 3, 9–13]. These pre-existing



inequities create vulnerabilities among migrant communities which are further exacerbated by COVID-19 and associated public health measures. Specifically, the pandemic exacerbated migrants' vulnerabilities through the suspension of resettlement services, economic hardship, employment in high-risk occupations, restrictive immigration policies, and communication challenges [2, 9–11, 13].

Large urban areas and COVID-19

There has been significant attention to the impact of health crises—including the COVID-19 pandemic—on residents in large urban areas, and how cities can either exacerbate or mitigate these impacts. The Organization for Economic Co-Operation and Development differentiates urban areas into the following categories: large metropolitan areas with a population of more than 1,500,000, metropolitan areas with a population of 500,000–1,500,000, and small- and medium-sized urban areas with < 500,000 residents [14].

Multiple factors exacerbated the impact of COVID-19 in large urban areas. The urban design and living environment made cities particularly vulnerable to the spread of COVID-19 due to high population density, business and tourism travel, poor housing conditions, dependency on public transportation, and poor air quality [12, 15]. During COVID-19, dependency on public transportation contributed to difficulties of social distancing and increased risk of COVID-19 spread in these settings [16].

In addition, a single-focused economic structure dependent on only one revenue source, such as tourism, made some cities vulnerable to economic losses due to reduced tax revenue income [12, 17]. For example, international tourism to Lviv, Ukraine decreased by up to 60% during the pandemic, leading to an estimated 80 to 135 million Euros in financial losses for the city [12, 18]. A fragmented political structure also contributed to the vulnerability of some large urban areas to the pandemic [12]. This involved incoherence in public health responses between different government levels, such as federal, state, or local authorities [12]. Higher degrees of inequity and a diminished sense of community also exacerbated COVID-19 impacts in urban areas [12, 15].

Multiple urban factors mitigated COVID-19 impacts. For example, travel and mobility restrictions and stay-at-home orders reduced COVID-19 cases in cities due to less utilization of public transportation [12, 19]. These same measures also reduced carbon dioxide emissions, therefore improving air quality in cities [12, 19]. In addition, some cities showed strong networks and collaboration between volunteers, non-profit or civil-society organizations (CSOs), and communities in need [12]. These collaborations provided access to basic necessities such as food and medical services [12].

Other mitigating effects of COVID-19 impacts also arose in cities that emphasized urban design that facilitated non-motorized transportation, such as biking or walking, which promoted social distancing and lessened the demand of public transportation [12]. Paired with the so-called 15- or 20-minute cities, an urban design strategy that places essential services such as grocery stores and medical services



within 15–20 minutes walking distance from people’s homes, residents were able to retrieve all necessities while avoiding crowded public transportation [19]. However, this was only feasible in cities that already emphasized this type of urban design before the pandemic [19].

Large urban environments could both mitigate and exacerbate the impact of COVID-19 and similar health crises. However, less is known about how factors of large urban areas impacted the disproportionate burden of health crises like COVID-19 on migrant communities in the large urban metropolitan areas with more than 500,000 residents. Therefore, this policy brief will explore what we know about this issue, how existing knowledge can inform urban policies, and which areas should be prioritized for further study.

Data and methods

We conducted a global literature review in the World Health Organization’s COVID-19 database, which compiles literature from 33 separate databases. The inclusion criteria encompassed English and German literature with a focus on COVID-19 effects on migrants in cities with >500,000 residents. We also included viewpoints and perspective pieces to account for the novelty of this emerging topic. We excluded clinical studies, newspaper articles, individual-level case studies, and studies using only neighborhood-level COVID-19 rates. We employed the following search string to identify studies: (COVID-19 OR covid OR corona OR coronavirus OR SARS-CoV-2 OR sars-cov-2) AND (migrant OR migrants OR Immigrant* OR Immigration OR newcomer* OR "asylum seeker*" OR asylee* OR "displaced person" OR "displaced people" OR "foreign born" OR "foreign worker*" OR "foreign domestic worker*" OR refugee* OR undocumented) AND(city OR urban OR cities OR metropolitan OR metropolis OR megacity OR suburb*).

We screened search results by their titles and abstracts; a full-text review of the studies identified as most relevant was then completed by at least two researchers to determine if they should be included in the final data synthesis. In line with previous literature and based on the merging of themes from included studies, we developed a thematic framework with four categories reflecting the main exacerbators and mitigators of COVID-19 impact on migrant communities in large urban areas: (1) underlying structural inequities, (2) implementation of COVID-19 Policies and Procedures, (3) urban design, and (4) engagement of CSOs. Each study was classified according to these themes based on their main policy key takeaways.

Findings

We identified 367 studies for the initial review of titles and abstracts, and from that review, we selected 40 studies for a full-text review. We included 24 studies in the final data synthesis and extracted policy-relevant information from each of the studies [20–43]. We excluded 16 papers due to a lack of topical relevance to



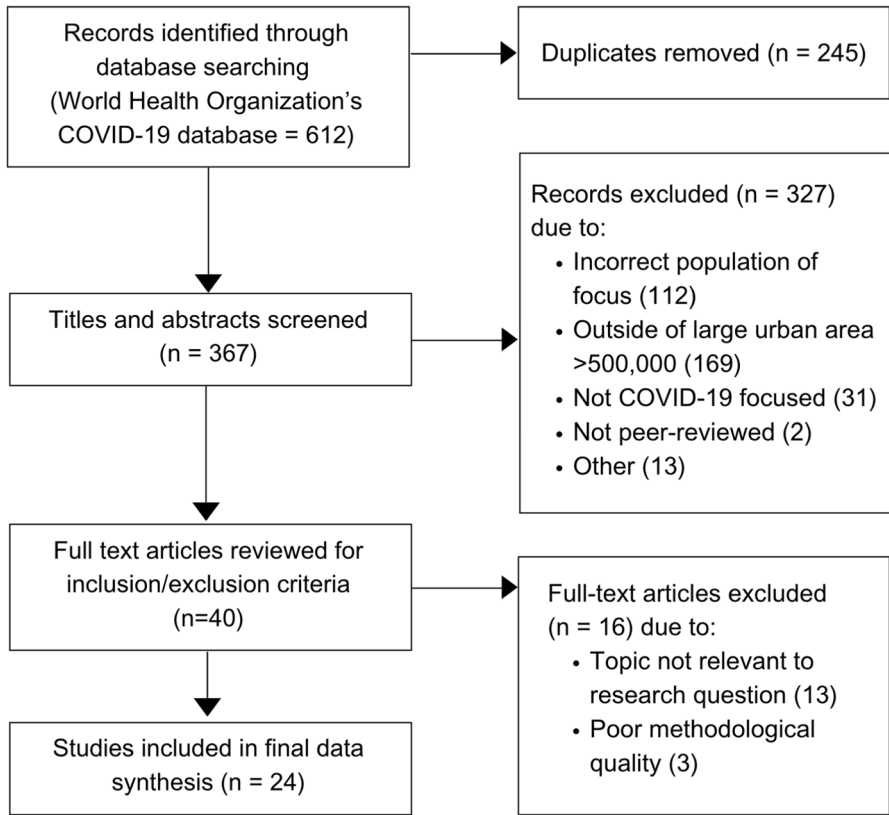


Fig. 1 Inclusion/exclusion criteria flow chart

the research question or poor methodological quality (see Fig. 1 for a flow chart illustrating the study inclusion and exclusion criteria).

The 24 studies encompassed cities from 12 different countries: 6 studies from Europe (Germany, France, Portugal, Spain, Italy, Norway), 10 from North America (the United States and Canada), 1 from Euro-Asia (Turkey), 5 from Asia (Singapore and India), and 2 from Africa (South Africa and Kenya). Based on this breakdown, the study was primarily focused on North American and European urban areas. Within Asia, most studies focused on Indian urban areas. Notably, most studies did not differentiate between subgroups of migrants.

We identified additional differences in the contextual factors that impacted the health and health outcomes of COVID-19 urban migrants. For example, local COVID-19 severity/incidence was heightened in European countries such as Italy, Spain, and France as well as the United States (US), which were early epicenters of the pandemic in April 2020 [20, 21]. Similarly, the local COVID-19 policy context in the various countries had a tremendous impact on migrants.



This could be seen when comparing policies in social welfare states vs dependence on unemployment/CARES Act in the US [22, 23].

Underlying structural inequities

Migrant communities are more likely to have a lower socioeconomic status than their host community, thus exacerbating their vulnerability to the COVID-19 pandemic [24]. Several studies confirmed this trend in large urban areas [24–26]. Migrants experienced disproportionate losses in employment, financial stability, and access to and utilization of public and healthcare services [25–27]. In Istanbul, migrants were financially more impaired than their rural counterparts [28]. Similarly, early in the pandemic in cities in the US, migrants who were unable to work from home reported disproportionate financial insecurities. This directly affected migrants as well as their families in origin countries due to loss of remittances [29]. Following new COVID-19 policies designating “essential worker” occupations, many migrants were unable to stay home from work, placing them at an increased risk of COVID-19 [26, 28]. Underlying socioeconomic inequities were further exacerbated by limited access to community and healthcare services and the exclusion of most migrants—particularly undocumented migrants—from safety nets and relief funds [25, 26]. In some countries, for example in Istanbul (Turkey), urban migrants were excluded from relief funds, whereas rural migrants were not, causing an urban–rural exodus [28]. Furthermore, xenophobia and discrimination against migrant communities during the pandemic contributed to unequal job opportunities and underutilized services, as demonstrated by case studies from Durban (South Africa), and New York City (US) [25, 30].

The disproportionate impact of COVID-19 on migrants in large urban areas could also be attributed to language barriers, cultural discrepancies, and higher rates of unauthorized employment compared to rural areas, which was particularly pronounced among undocumented migrants. Language barriers were especially a source of health inequities during the COVID-19 pandemic as they could hinder public health messaging and communication with the healthcare workforce [32]. In the United States, people whose preferred language was not English were more likely to test positive for COVID-19 [33]. In Canada, people with language barriers had limited access to information and services which might have increased their exposure to the virus and hospitalization, while a large percentage of them did not have access to interpreters after hospitalization [34]. Migrant-serving organizations in New York City advocated for the need to provide language translation and interpretation assistance, as multilingual health information was essential in the context of the COVID-19 pandemic to improve community knowledge and prevention [35, 36].

We determined other factors that could also be responsible for further marginalizing migrants and exacerbating existing vulnerabilities. For example, elderly, disabled migrants faced more challenges compared to young, healthy migrants [37]. This emphasizes the role of the intersectionality of the different social categories for individuals and communities on health inequities. We



found that underlying socioeconomic and structural inequities were pronounced in large urban areas and impacted migrants disproportionately. Efforts to address these underlying inequities may help mitigate the impact of the health crisis on migrants and should be considered in policy solutions.

Implementation of COVID-19 policies and procedures

Various studies demonstrated the impact of policies and procedures as both exacerbating and mitigating factors vis-a-vis COVID-19 and migrant groups in large urban areas. Inaction from city and state governments led to migrants' exclusion from economic relief programs, such as stimulus money, unemployment benefits, or salary continuation after the closure of businesses [25, 38]. This was especially pronounced for undocumented and temporary migrants and was further exacerbated by bureaucratic and language barriers and the fear of "becoming visible" to immigration authorities [25, 29]. In the US, the Immigration and Customs Enforcement agency failed to contain the spread of COVID-19 within detention centers in Newark, New Jersey [39]. Both the exclusion of and failure to protect migrant communities highlighted how government actions (or lack thereof) can exacerbate the impact of COVID-19 among migrant communities in large urban areas [39].

In addition, anti-immigration and exclusionary policies deterred migrants from leaving their host country, limiting both circular and return migration. Policies like the Public Charge Rule in the US led to increased fear of deportation [40]. According to this rule, immigration rights could be denied if overuse of public benefits is suspected and thus an immigrant becomes a "public charge." Public benefits include Medicaid, rental assistance, and the Supplemental Nutrition Assistance Program, which are critical programs for marginalized, low-income communities [40]. While the rule targeted immigrants prior to their immigration, some migrants who resided in the US avoided utilizing such public benefits or services due to fear of becoming "visible" and risking a change in immigration status or deportation [38, 40, 41].

Alternatively, e-governance and technology showed potential for increasing access to public services [30, 31]. E-governance is defined as the utilization of technology by national, state, or municipal government offices to enhance access to their services and/or improve communication between government structures and constituents [30]. However, e-governance and transferring services to the online sphere may still pose unique difficulties for migrant communities. Without personal contact or translation services, language barriers may be amplified [7]. In addition, crowded housing may pose privacy issues where migrants are not comfortable sharing personal information through teleservices [42, 43]. A lack of access to the internet and/or other communication devices also disproportionately affected communities who had fewer resources available, such as migrant communities [42]. To maximize the mitigating effects of e-governance and teleservices, barriers to these services for migrant communities must be addressed [43, 44].



Urban design

Evidence suggests that urban design impacted the spread of COVID-19 in large urban areas. Some studies highlighted the negative aspects of residential segregation in large urban areas, which is associated with precarious living conditions [45–47]. The National Bureau of Economic Research defines housing precarity as a situation in which the resident may be at risk of eviction [48]. The main reason for precarious housing during the pandemic was employment insecurity and the inability to pay rent [48, 49]. Higher rates of unemployment during the COVID-19 pandemic exacerbated precarious living conditions [48]. As a result, many migrants felt obliged to keep working in often overcrowded or high-risk occupations to prevent evictions or utility disconnections [48].

High-density living arrangements in remote or outlying areas of cities also led to greater spread of COVID-19 and a greater impact on migrant communities living there [46, 47]. An example from Singapore showed that migrants often traveled great distances to other parts of the city for job opportunities and essential services, such as grocery stores and medical resources [47]. However, a high utilization of public transportation during the COVID-19 pandemic exposed migrants disproportionately to the virus, especially when other means of transportation such as walking or biking were not feasible [46, 47]. Hence, during emergency situations, it needs to be ensured that essential services are not only available in city centers, but in remote or outlying areas as well [47].

While these are crucial findings, the literature on how urban design exacerbated the COVID-19 impact for urban migrants has been scarce. To our knowledge, very few or no mitigating effects of the urban design on COVID-19 impacts for migrants have been documented.

Engagement of Civil-Society Organizations

Several studies identified the engagement of CSOs as an important mitigating factor on the impact of COVID-19 on migrant groups in large urban areas. In many cities, CSOs filled governmental and institutional gaps that excluded migrants by providing food, necessities, childcare, translation services, COVID-19-related information, and cultural mediation [42, 44, 50, 51].

For example, in Germany, Chinese Heritage Schools adapted to include more childcare services to cater toward the specific pandemic-related needs of their community [50]. Cultural mediation also included utilizing *health care navigators* to connect migrants with health care providers, services, or health-related information [52]. This is particularly important during a public health crisis such as COVID-19 to combat misinformation, overcome language barriers, and increase access to medical care [42]. In practice, health care navigators are often migrants themselves or have extensive experience with migrants' barriers and needs [52]. By providing information in migrants' native language, information asymmetry can be reduced. In addition, health care navigators were able to accompany migrants to health care services such as COVID-19 testing and treatment [52]. CSOs also created and managed



extensive networks of volunteers, translators, and health and law professionals to improve access to care and services [40]. For example, in the US, CSOs provided information about eligibility for government benefits and combated misinformation regarding the Public Charge Rule [40].

CSOs and the provision of COVID-19 technologies

In some cities, CSOs used technology to move mental health consultations online and provide information through video conferencing [42, 43]. However, this mitigating effect was hindered by a lack of access to devices or the internet or a lack of understanding of how certain software should be used [43]. CSOs can play an important part here as well. By working with migrant communities, introductory sessions can be hosted to introduce technology and instructions can be distributed in various languages [43]. In addition, some CSOs placed value on including other migrant family members in the process of teaching technology and alternative services to enable migrants to access these services [43].

As laid out, CSOs played a significant role in mitigating COVID-19 impacts for migrant communities. However, these mitigating effects are contingent on two factors: (1) a trust relationship between CSOs, volunteers, and communities in need, and (2) systematic organization of efforts [44, 53]. Municipal governments should therefore recognize and support the efforts of CSOs to enable more targeted, systematic organization of assistance [44].

Summary of key findings

- COVID-19 has highlighted *underlying socioeconomic and structural inequities*, many of which have exacerbated the impact of the pandemic on migrant groups—particularly undocumented migrants—in large urban areas [24–26, 28, 30]. In most countries, government responses, relief funds, and benefits often excluded non-residents, (i.e., immigrants, asylum seekers, refugees, and foreign workers), further exacerbating inequities [27, 29, 38].
- Effective *implementation of COVID-19 policies and procedures* made a difference in mitigating the impact of COVID-19 on vulnerable groups, including migrants. Examples of effective strategies included inclusive relief measures that provide migrants with basic financial and social support; suspension of policies that invoked fear and avoidance of services; support of local CSOs to fill gaps and complement municipal services; and e-governance initiatives taking into account the technology and connectivity challenges faced by migrant communities [30, 31, 42, 43].
- *Urban design* can impact the exposure of vulnerable groups to health threats. In the case of COVID-19, urban areas with high levels of residential segregation placed migrants and refugees outside the city center into suburbs or resettlement camps, therefore risking higher levels of infection among those groups [45–47]. Overcrowding in these neighborhoods can contribute to this disparity, as well as



the length and type of journeys people take to arrive at their places of employment [45–47].

- *CSO engagement* is a mitigating factor for the impact of COVID-19 among migrant groups in large urban areas. If adequately supported and financed, CSOs filled service gaps, bridged cultural divides, and strengthened community engagement in ways that protected migrant groups from exposure and increased access to preventive information and services [40, 42, 44, 50, 51].

Policy recommendations

Based on these findings, we recommend the following broad policy considerations to enhance mitigating factors and minimize exacerbating factors:

- **Reduce underlying structural inequities:** Structural inequities in large urban areas are one of the main drivers of the disproportionate impact of COVID-19 on urban migrant communities. Reducing structural inequities requires policy changes to improve employment and income security and increase access to relief funds. Language and cultural barriers can be overcome in part by incorporating more CSOs into program design and delivery and including migrants in discussions on the nature of and solutions to the problems they face. Unless these issues are addressed, migrants and other vulnerable populations will experience the same disproportionate impacts during the next pandemic or other health emergencies.
- **Inclusive COVID-19 policies and procedures and e-governance:** Evidence suggests that COVID-19 policies and procedures have a significant influence on how health emergencies impact migrants and other vulnerable groups in large urban areas. On one hand, exclusionary policies exacerbate vulnerabilities and inequities by barring migrants from accessing services and governmental programs either through fear of deportation or other barriers and conditions. On the other hand, more inclusive approaches—including support to CSOs and e-governance initiatives—have the opposite effect. We recommend strengthening inclusive COVID-19 policies and procedures by including migrants in governmental relief programs, amplifying CSOs efforts through funding and partnerships, and utilizing e-governance to increase access to services for migrant communities. However, as this brief suggests, more research is needed on how e-governance can support migrant communities most effectively without increasing already existing gaps in access to health and social services.
- **More research on urban design and residential segregation:** Limited evidence suggests an association between urban design, in particular residential segregation and precarious housing conditions, and disproportionate impacts of COVID-19 on migrant communities. More research is needed to determine what specific factors of residential segregation contribute to these disproportionate impacts, or whether other underlying factors, such as socioeconomic status, are the main drivers of this association.
- **Support engagement of CSOs:** The engagement of CSOs in the design and delivery of services to migrant communities in large urban areas is a strong mitigating



factor on the impact of COVID-19 among these groups. CSO advocacy efforts and service provision filled gaps caused by governmental exclusion. Evidence suggests that CSO efforts would be even more effective if supported by and/or conducted in partnership with municipal governments. In this way, local authorities would benefit fully from CSO networks, cultural mediation abilities, and high levels of trust with migrant communities.

Conclusions

In this policy brief, we reviewed existing literature on the impact of COVID-19 on migrants living in large urban areas on the global level and suggested ways in which public health policies can mitigate these impacts. We highlighted four key factors: underlying social inequities, COVID-19 policies and procedures, urban design, and the engagement of CSOs. We recommend greater attention to addressing inequities, promoting more inclusive health policies and procedures (particularly at the municipal level), understanding how the design of large urban areas protects or exposes vulnerable groups to health threats, and supporting the engagement of CSOs in advocacy and service provision. We noted that migrants with different ethnic origins or immigration statuses (such as documented, undocumented, refugees, asylum seekers) may be impacted differently and require uniquely tailored policy solutions. Future works should consider the differentiation of migrant groups to ensure the preservation of heterogeneity and tailored solutions to these subgroups.

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Declarations

Conflict of interest The authors declare no conflicts of interest.

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