

Extended Abstract: The Health of Child Migrants in South Africa

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South Africa has a long history as a site of south-south migration. Citizens of neighboring African countries have traditionally been drawn to South Africa as a place of relative economic prosperity and opportunity; but it is also true for South Africans themselves, who migrate within the country at ever increasing rates. (Posel, 2006, 2009) Under the apartheid system, the government encouraged strictly controlled male labor migration to provide labor for mines and industry. However, restrictions on the movement of women and children ensured a pattern of circular migration- with labor migrants returning to rural areas periodically. Fifteen years after the abolishment of apartheid, the circular migration patterns seem to be abating, but migration is still a common fact of life for Black South Africans, particularly to urban areas. And although the numbers of migrants are increasing, their characteristics have changed dramatically. The typical migrant is now younger and increasingly likely to be female, less likely to report themselves as moving for work, and less likely to report an expectation of returning home. (Posel 2009). In short, South Africa, like many of other developing nations, is experiencing rapid urbanization- and the face of these urbanizing migrants are no longer solely men planning short stays, but women and families moving towards opportunity together.

This changing pattern of migration implies also that more children are migrating with parents and/or being born to recently migrated parents. The immediate health implications of migration are difficult to disentangle for adults, and largely unexamined in children. This paper makes an effort to empirically examine the health implications of migration for children who migrate within South Africa. The potential impacts on children's health are bi-directional. When children find themselves in places with better health infrastructure and living with adults with improved earnings, then migration can contribute to marked improvements in children's health and wellbeing. Alternately (and perhaps simultaneously) migration can involve disruption, psychosocial stress, loss of schooling, and increased exposure to communicable disease (particularly in crowded urban environments). Understanding whether, on average, the health of children is being improved or challenged by the migration process is vital for policy makers responding to the shifts in migration currently underway in the developing world.

Data

This analysis takes advantage of the first wave of a new nationally representative data set from South Africa- The National Income Dynamics Study (NIDS). This comprehensive survey of over 7000 households combines individual level and household level questionnaires along with health measurements of adults and children. It also contains specific information on adult and child migration patterns- including origin of migration, years since migration and circular migration. Collectively, this information allows direct evaluation of the health, socioeconomic profile, and place of residence for the 31,170 adults and children surveyed. Although information was collected on child mortality, the data does not allow for direct estimation of infant and child mortality (Moultrie and Dorrington, 2009) . Consequently, this analysis focuses on child morbidity. Ultimately, the analysis relies on full health and socioeconomic data for approximately 7000 children, and 1200 migrant children. The analysis relies on Ordinary Least Squares and Probit regression strategies to examine several outcomes of child health and their relationship to child migration status.

Findings

The paper finds that children are most likely to migrate at younger ages (before schooling begins) and most often in conjunction with their mother. In keeping with previous work on the healthy migrant hypothesis, migrant children come from slightly more advantaged circumstances on average. They live in smaller and slightly wealthier households and have mothers who are older, have more education and better self reported health than the mothers of non-migrant children. Given this relative socioeconomic advantage, one might expect migrant children to have slightly better health outcomes than non-migrants. However, I find that health outcomes are either the same or worse than those of non-migrant children, even when socioeconomic factors are controlled for. There is little difference in stunting and wasting, but migrant children seem to suffer in terms of illness. The table below shows probability that the child has been sick more than three days out of the last thirty. As you can see, having a migrant parent and living in an urban area increases a child's probability of frequent illness, but the child themselves being a migrant has an independent effect of more than double the size. Similarly, the paper finds that migrant children have worse caregiver reported health status and miss more days of school than

non migrant children, even when socioeconomic and social factors are controlled for. Migrant children do, however, benefit from lower obesity rates than non-migrant children.

Table 1: Probability That Child Was Ill More Than Three Days Out of the Last Thirty

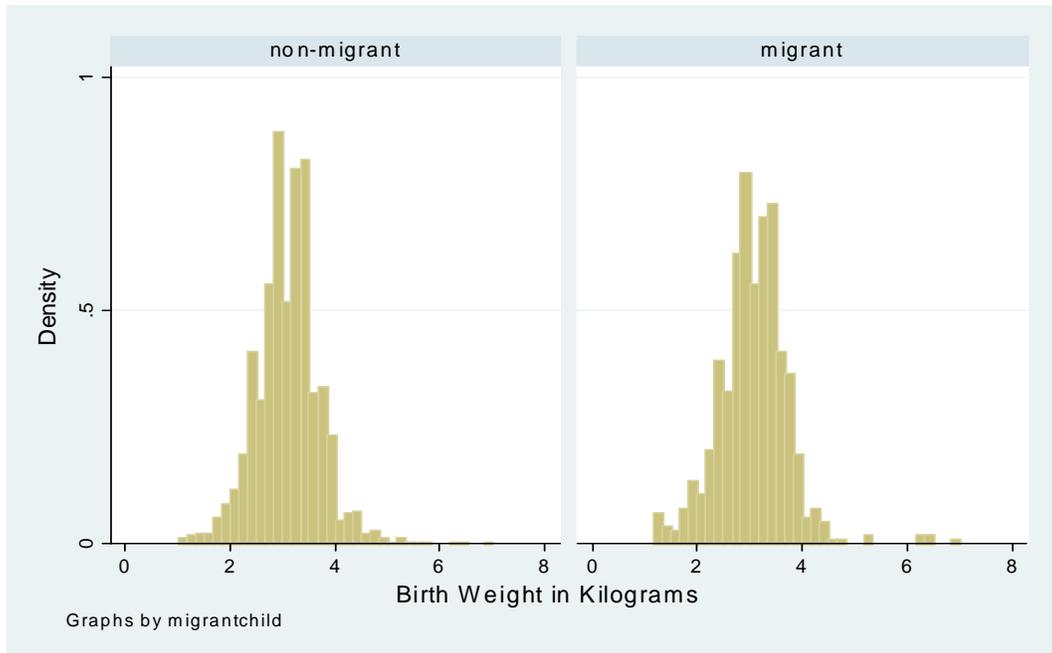
| | (1) | (2) | (3) |
|---|-------------------------|-------------------------|-------------------------|
| Age | -0.0146*** (0.00270) | -0.0151*** (0.00268) | -0.0151*** (0.00270) |
| Male | -0.000758 (0.00650) | -0.00219 (0.00636) | -0.000636 (0.00648) |
| Urban Residence | 0.0114 (0.00836) | 0.0148* (0.00822) | 0.00921 (0.00829) |
| Mother's education | -0.000216 (0.000982) | -0.000481 (0.000949) | -0.000280 (0.000979) |
| Child's mother migrant | 0.0170* (0.00908) | | 0.00933 (0.00924) |
| Child is Migrant | | 0.0395*** (0.0125) | 0.0403*** (0.0135) |
| <i>Joint significance of mother and child pvalue-</i> | | | 0.0004 |
| Observations | 6619 | 7011 | 6617 |
| F test | 0 | 0 | 0 |

*** p<0.01, ** p<0.05, * p<0.1

Standard errors in parentheses are robust and clustered by household

Additional controls included for deceased mother, non resident mother, age squared, log of household size, log household income, and mother's age at child's birth

The most obvious challenge to this finding is the argument that there is a selection process going on, that parents of sickly children are more motivated to migrate in order to seek better circumstances for their children and themselves. As this data is from the first wave of a longitudinal study, I can not address this directly. However, the data does include information on all the children's early life health outcomes, including birth weight and head circumference, whether the child had an attended birth, and whether the child was born in a hospital or clinic. If migrant children are different or disadvantaged in some way before migration, we might expect to see some difference in these early life health measures. However, as the figure below demonstrates, birth weights of migrant children do not significantly differ from non migrant children in either mean or distribution.



Further regression analysis confirms that migrant children have no early life differences in birth weight or head circumference, and are no more or less likely to have attended births or hospital births. It seems from this, that the health disadvantages found later among migrant children are not easily explained by negative selection on the child's health. Since we know also that the migrant parents are, on average, a healthier than their non-migrant counterparts, it's unlikely that negative selection on the parents' health explains increased sickness rates in children. It is possible that migration increases interaction with formal medical care which somehow makes caregivers of migrant children more likely to report illness. However, since non-migrant children with similar proximity to medical care do not report increased illness, the mechanism by which proximity to health care increases sickness would have to work on migrant children alone. Another potential explanation is that most migrant children are living in informal urban environments which may increase their exposure to crowding and communicable disease. This explanation is not contrary to these findings, but as the analysis controls for both formal and informal urban residence, and still finds a migrant disadvantage, it can not be the full explanation. Ultimately, it seems that there is something happening in the process of migration that leads to relative deterioration in the health of children who migrate. Given the rapid urbanization in the developing world and the increasing levels of south-south migration, this pattern seems worthy of further attention by researchers and policy makers.

Bibliography

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