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Internal Adult Women Migrants' Use and Access to Health Services in 15 Countries (AS87)

An Analysis Brief from The DHS Program

Why study internal migration?

In 2005, it was estimated that nearly 1 in 7 people on the planet were migrants. The majority of migrants in the world are internal migrants who have moved within a country. However, much of the research on health behaviors of migrants has focused on international migrants or does not distinguish between rural and urban migrants.

This study explores the relationship between migration status and health outcomes among different types of migrants (rural to urban and urban to rural) who have lived at their current residence for different lengths of time. A better understanding of how internal migration influences health behaviors and outcomes can help policy makers and planners design policies and programs that ensure the most vulnerable have access to the health care they need.



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Which countries were included in the study?

This analysis includes data from 27 DHS surveys conducted between 2003 and 2020 from 15 countries: Bangladesh, Benin, Cameroon, Haiti, Kenya, Liberia, Nepal, Philippines, Rwanda, Sierra Leone, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

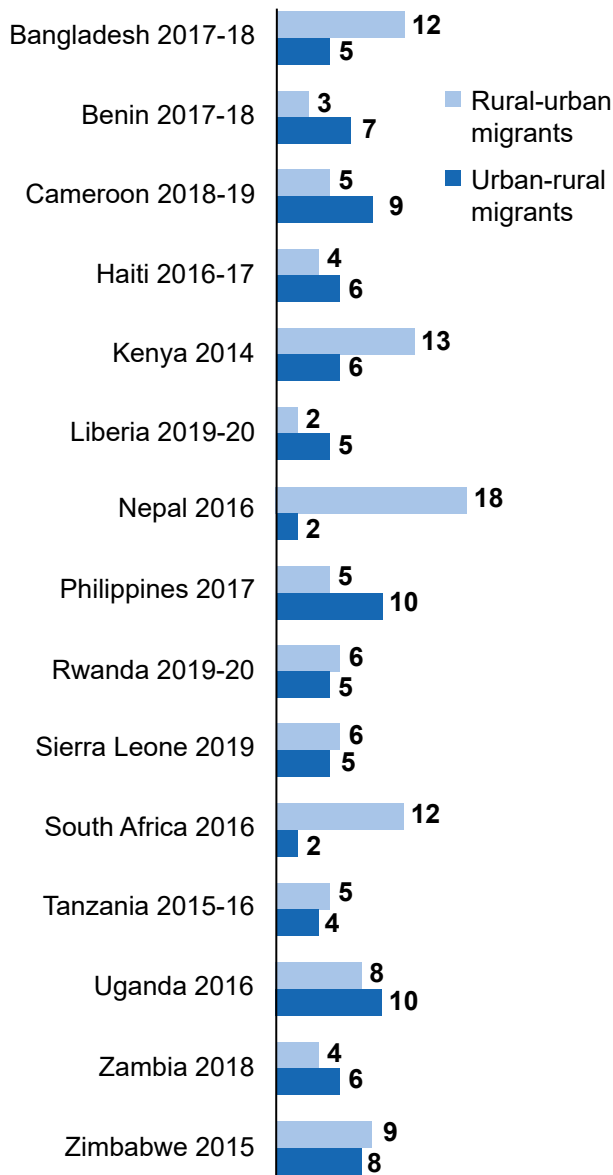
What methods were used to conduct this analysis?

This study examines the relationship between internal migration and four health outcomes:

- Attending at least 4 antenatal care (ANC) visits
- Using a modern method of family planning
- Having a major problem accessing care for self due to getting money for treatment
- Having a major problem accessing care for self due to distance to facility

Women age 18-49 are classified as rural to urban migrants, urban to rural migrants, or non-migrants. Migrants are further classified as recent (those who moved to their current residence within the last 3 years) and non-recent (those who moved to their current residence 3-9 years ago). Multivariable logistic regression was performed, controlling for other factors that may affect the selected health outcomes such as household wealth and women's education level.

Figure 1. Percent of women age 15-49 who are internal migrants.



What are the key results?

- **There are high levels of rural to urban migration in a few countries and high levels of urban to rural migration in others.** Figure 1 shows relatively high rural to urban migration in Bangladesh (12%), Kenya (13%), Nepal (18%), and South Africa (12%). However, Benin, Cameroon, Haiti, Liberia, Philippines, Uganda, and Zambia have more urban to rural migrants than rural to urban.

- **Studying migrant characteristics provides evidence of the selection process of migration.** For instance, among women age 18-24, most are recent rural to urban migrants.

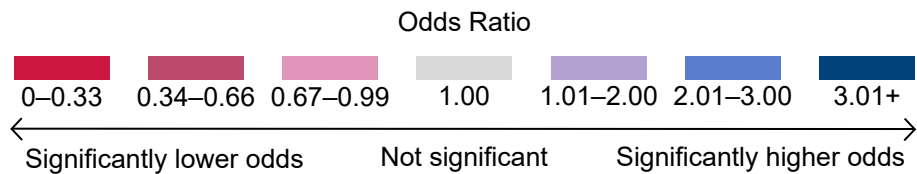
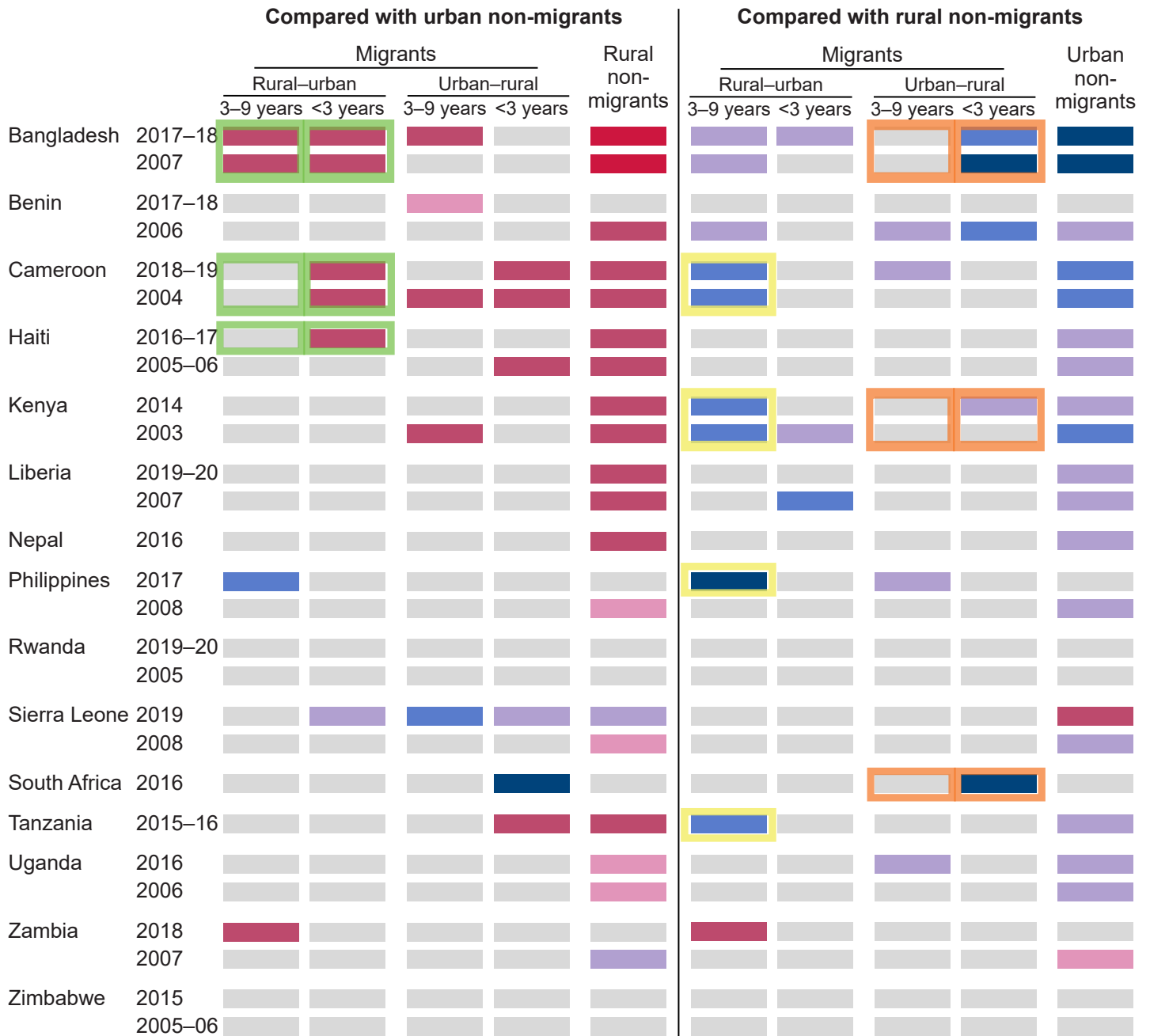
- **There are small yet significant changes in migration levels between surveys approximately 10 years apart.** Rural to urban migration increased by 5 percentage points in Kenya and decreased in the Philippines (4 percentage points). On the other hand, urban to rural migration increased by 4 percentage points in Rwanda and the Philippines and decreased in Liberia (5 percentage points).

- **Migrants differ from non-migrants in some countries.** There is considerable variation in associations between migration status and health outcomes. For instance, the odds of having at least 4 ANC visits for non-recent rural to urban migrants is roughly twice that of rural non-migrants in Cameroon, Kenya, Philippines, and Tanzania (see yellow boxes in in Figure 2).

- **There is some evidence that non-recent migrants become more similar to permanent residents over time.** In Cameroon and Haiti recent rural to urban migrants have more than 50% lower odds of attending at least 4 ANC visits compared to urban non-migrants, while there is no significant difference between longer-term rural to urban migrants and urban non-migrants, (see green boxes in Figure 2). In Bangladesh however, the difference between migrants and non-migrants in ANC visits persists even for non-recent migrants.

- **In some cases, urban to rural migrants have better outcomes than rural non-migrants.** In Bangladesh, Kenya, and South Africa recent urban to rural migrants have higher odds of ANC visits compared to rural non-migrants. However, there is no significant difference in ANC visits between non-recent urban to rural migrants and rural non-migrants (see orange boxes in Figure 2). This suggests that migrants who have stayed longer in a rural area have lost their “urban advantage” compared to rural non-migrants.

Figure 2. Adjusted odds ratios of migration status and attending at least 4 ANC visits for the most recent birth in the last 3 years among women age 18-49. (adapted from Figure 9 in full report)



For a discussion of the findings for the remaining outcomes (use of modern method of family planning, problem accessing care due to getting money for treatment and problem accessing care due to distance to health facility), see the full report.

What does this mean?

While there is a lot of attention given to urbanization and rural to urban migration, this study finds evidence of relatively high levels of urban to rural migration in some countries. The relationships between internal migration patterns and health care access are complex and vary substantially by country. In some countries there are large disparities in terms of use and access of health services found between migrants and non-migrants which in some cases have persisted for nearly a decade. Further research is needed to better understand the migrant selection process and how duration of stay influences health-seeking behavior.

Code to construct the migration measure and other variables in this analysis is available on [The DHS Program Code Share Library](#).



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