



## Full Length Article

# Access to healthcare and social determinants of health among female migrant beggars in Ibadan, Nigeria

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## ABSTRACT

**Introduction:** Migration is a social determinant of health, and a major underlying factor of inequity of access to health and disparities in health outcomes. Migrant beggars from Northern part of Nigeria are a common feature in Southern Nigeria. Not too much is known about the challenges associated with access to healthcare and social determinants of health among this group of people in Nigeria. This study aims to fill existing gaps and contribute to the efforts of stakeholders in ameliorating the perennial challenges faced by this group of people.

**Materials and methods:** The study was a descriptive cross-sectional study carried out among female migrants in the city of Ibadan. Using Open Data Kit (ODK), a semi-structured interviewer-administered questionnaire was used to collect data from respondents relating to access to health and basic social amenities, and challenges associated with these and as well as coping strategies. Data analysis was done with STATA version 15. More than a third-fifth of the respondents gave birth to their babies at home, used open defecation 189(49.6%), well/borehole 204 (53.6%) is the source of drinking water. Three hundred and fifty-six (90.8%) of the respondents sleep in open space. Respondents with secondary school level of education, had a 129% increased odds of using health facilities compared to those who did not have any formal education (OR=2.29, p=0.014, CI: 1.18-4.44). Access to healthcare services and social amenities among women beggars was poor. There is a need for stakeholders to address this.

## Background

Migration is a social determinant of health, and a major underlying factor of inequity of access to health and disparities in health outcomes (Hill et al., 2021). Although, the major driver of migration is economic factor (Mak et al., 2021; Ojedokun, 2015), however, conflict is both a major factor of economic deprivation and of migration of individuals and groups of people (Cantor et al., 2021). However, on its own, poor economic situation and chronic poverty, even in the absence of conflicts, could lead to displacement of communities and in the quest to search for means of survival migrate to other areas (Mak et al., 2021; Ijadunola et al., 2020).

Migrants are known to be vulnerable to challenges for which other population groups are, to some extent protected from (Baggio et al., 2021). Migrants are found globally in all regions of the world. However, the incidence of migration is usually from poor economic and disadvantaged areas to more prosperous locations (Cantor et al., 2021).

Migrants are known to be specifically vulnerable to exposure to certain health challenges including exposure to infectious agents to extents that are higher than the local population (Burns et al., 2021; Cantor et al., 2021) and psychological, emotional trauma experienced in the process of migration (Fouche et al., 2021).

Unlike the support rendered by the international communities to refugees who are migrants to other countries (cross-border or international migrants), individuals and groups of people who migrate from one part of a country to another part of the same country (internal migrants) as a result of displacement or for economic reasons, rarely benefit from the support of international communities and organizations (Cantor et al., 2021). Thus, internal migrants are more often than not, left with the little support derived from local organizations who are in themselves burdened by the prevailing poor socio-economic situation in the contextual environment. Compared to the local population, generally, migrants (both cross-border and internal migrants) are usually poor and have poorer health outcomes than the local populations (Cantor et al.,

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2021). This could partly be as a result of a systemic inequity of access to available healthcare services (Burns et al., 2021), lack of information about available medical aid, cultural perception of illness that influence health-seeking behaviour and (cultural) as well as language barriers (Salinas et al., 2021; Akhtar et al., 2022; Barlow et al., 2022; Baggio et al., 2021). In addition to these, real or perceived discrimination, unfriendly policies in the local communities and poverty tend to negatively affect health outcomes among migrants (Garcini et al., 2021). Likewise, loneliness and low social support and poor understanding of the health system in the host community have also been cited as factors of inequitable access to healthcare services (Akhtar et al., 2022; Ruiz-Sánchez et al., 2021). Poor access to income-generating opportunities and or, inadequate skills for available jobs are a barrier to financial independence amongst migrants (Cantor et al., 2021). In addition, migrants are far away from home, and do not have access to the even the meagre income generating opportunities they previously had at their local communities (Kamta et al., 2020). As a result, the majority of them take to begging for cash and kind by the roadside and from street-to street as a daily job (Salami et al., 2013). This situation characteristically put them in circumstances of inability to afford needed healthcare services; this is in addition to limited access to services that relate to social determinants of health such as potable water, adequate accommodation facilities, hygienic waste disposal methods among others (Mak et al., 2021; Baggio et al., 2021). Studies have reported cases of sexually related abuse especially among female migrants, with consequent health implications such as unwanted pregnancies, sexually transmitted infections and emotional trauma associated with such incidence (Burns et al., 2021). In recent years, the influx of internal migrants from the Northern to the Southern parts of Nigeria has increased (Ijadunola et al., 2020). Internal migrant beggars from the Northern areas of Nigeria is not an uncommon feature in Southern part of Nigeria; an earlier study corroborated this (Salami et al., 2013). This has been attributed to many reasons including insecurity resulting from more than a decade long insurgency and other forms of violence in the Northern part of Nigeria (Mukhtar et al., 2018; Kanu et al., 2019). Other reasons are poverty which is worse in the Northern part of Nigeria compared to the Southern part (Kale, 2012). Diseases of poverty such as blindness that renders an already poorly-skilled population group worse-off (Tafida et al., 2015) are also more common in the North of Nigeria. Not too much is known about the challenges associated with access to healthcare and social determinants of health among internal migrants in Nigeria. This study aims to fill existing gaps, and contribute to the efforts of stakeholders in ameliorating the perennial challenges faced by this group of people in Nigeria. Lessons learned would be useful as a learning curve in similar settings.

## Materials and methods

### Study design

The study was a descriptive cross-sectional study carried out among female migrants in the city of Ibadan.

### Setting

The setting of the study was Ibadan, Oyo State located in the southwest geo-political zone of Nigeria. Ibadan has an estimated population of 2,559,853. The city is located 128 km inland northeast of Lagos (former capital of Nigeria) and 530 km southwest of Abuja, the federal capital. It is located on coordinates 7°23'47"N 3°55'0"E (National Population Commission, 2013). The city has 11 Local Government Areas (LGAs), of which 5 were in the inner core area while 6 were in the peripheral and outer ring of the city. The inhabitants are mainly Yorubas, though other ethnic nationalities within and outside of Nigeria form part of the population (Llyod, 1967). Predominant professions include civil servants, businesspersons, artisans and farmers.

Christianity, Islam and traditional religions are the major faiths adopted.

### Participants

Total population recruitment of all women beggars was done at designated communities allocated to them by the Oyo State Government.

### Inclusion criteria

This includes women beggars who were at least 18 years old, trades in designated areas within the city of Ibadan, Nigeria.

### Sample size determination and selection of study participants

The minimum sample size required for adequate power to detect a statistical significance was determined from the formula for estimating a single proportion ( $Z^2pq/d^2$ ) where  $p = 51.2\%$ , proportion of migrant beggars in Ibadan who patronized the patent medicine vendors for their healthcare needs. The  $p$  was derived from a previous study conducted among street internal -migrant beggars in Ibadan by Salami and Olugbayo (2017). A minimum sample size of 381 was estimated as the required sample size for the study.

The study adopted a total population survey because the estimated number of migrant beggars in the settlements were less than 500 and very close to the estimated required sample size which was estimated. All settlement clusters were visited and study questionnaire was administered to all consenting migrant beggars. Data collection was carried out within four weeks.

### Data collection tool and collection process

Using Open Data Kit (ODK), a semi-structured interviewer-administered questionnaire was used to collect data from respondents on socio-demographic characteristics, information relating to health challenges encountered by the respondents, access to health care services and challenges on respondents, and coping strategies on health care needs. The questionnaire was validated by using it to collect data among beggars in another LGA that is about ten kilometres away from the study site. Necessary correction was done on the tool before it was used to collect data at the study sites. Trained interviewers collected data from the respondents. Interviewers who understand the Hausa language (the language understood and spoken by the beggars) were engaged to collect data.

### Data management and analysis

The dataset was exported from an Open Data Kit (ODK) to an excel sheet on a computer with a password and then exported into Stata Version 15 for analysis. Data cleaning and recoding were carried out to meet the objective of the work. Data analysis was done with STATA version 15. Descriptive analysis of variables was done using frequency and percentage for categorical data, while the mean and standard deviation was used for continuous variables. Bivariate and Univariate logistic regression analysis was carried out to determine the association and effect of selected socio-demographic characteristics and patronization of healthcare facilities among respondents using Chi-square and logistics regression respectively. The level of significance was predetermined at a  $P$ -value < 0.05.

### Ethical considerations

This was sought and obtained from the Oyo State Research Ethical Review Committee, Ministry of Health, Agodi Secretariat, Ibadan, Nigeria.

**Results**

*Socio-demographic characteristics of the respondents*

**Table 1** shows the socio-demographic characteristics of the respondents. About one hundred and eighty-eight (49%) of the respondents' age is between 35 and 69 years of age, married 243(63.8%), gave birth to  $\leq 3$  204(53.5%) number of children. More than two-fifths of the respondents had no formal education, with Hausa/Fulani 379 (99.5%) being the common ethnicity and the majority of them are from the North. More than four-fifths of the respondents speak Hausa, making between N500 and N1000 214(56.2%) a day. Three hundred and thirty-seven (88.5%) of the respondents had a manager who serves as a guardian to the beggar, but none of them ever 381(100%) remit money to their supervisor. Two hundred and sixty-three (69%) of the respondents have lived  $\leq 9$  years in Ibadan, with their reason for leaving home being because the South is more lucrative (67.7%).

**Table 1**  
Socio-demographic characteristics of the respondents.

Variables	Frequency (N = 381)	Percentage
<b>Age(Years)</b>		
$\leq 34$	112	29.4
35-69	188	49.3
$\geq 70$	81	21.3
<b>Marital Status</b>		
Single	29	7.6
Married	243	63.8
Separated	36	9.4
Widow	73	19.2
<b>Number of children</b>		
$\leq 3$	204	53.5
4-7	149	39.1
$> 7$	28	7.4
<b>Education status</b>		
No formal Education	167	43.8
Primary	141	37
Secondary	73	19.2
<b>Ethnicity</b>		
Hausa/Fulani	379	99.5
Yoruba	2	0.5
<b>State of Origin</b>		
North	379	99.5
South	2	0.5
<b>Spoken Language</b>		
Hausa	309	82.1
Yoruba	4	1
Hausa and Others	68	16.9
<b>Income per day (Naira = N)</b>		
$\leq 400$	162	42.5
500-1000	214	56.2
$> 1000$	5	1.3
<b>Have a manager/Supervisor</b>		
Yes	337	88.5
No	44	11.5
<b>Remit Money</b>		
No	381	100
<b>Years lived in Ibadan</b>		
$\leq 9$	263	69.1
10-19	55	14.4
$> 19$	63	16.5
<b>Occupation back home</b>		
Beggar	67	17.6
Farmers	25	6.6
Trader	99	26.0
Others	190	49.8
<b>Reason for leaving home</b>		
Insecurity	49	12.9
Southern Nigeria is lucrative	258	67.7
Others	74	19.4

(N1 = \$ 0.00224).

*The burden of diseases and health related conditions among respondents*

**Table 2** shows the respondents' burden on disease and health-related conditions. Three hundred and fifty (91.9%) of the respondents are not managing any form of health condition, do not have any form of health challenges after relocation 375(98.4%). Two hundred and ninety (76.1%) of the respondents are not aware of any health facility closer to their place of work. More than four-fifths of the respondents did not patronize any healthcare facilities closer to them, money (financial reasons) 123(39.9%) being the most common reason for the low patronization. More than two-thirds of the respondents make payments out of their pocket. None of the respondents had ever heard of health insurance.

*Access to health-related basic social amenities among respondents*

**Table 3** shows the respondents' access to health-related basic social amenities among respondents. Three hundred and eighty-one (100%) of the respondents had never experienced any form of sexual harassment. More than a third-fifth of the respondents gave birth to their child at home, bush 189(49.6%) is the usual place to dump waste, well/borehole 204(53.6%) is the source of drinking water. Three hundred and fifty-six (90.8%) of the respondents sleep in an open space.

*Association between socio-demographics characteristics and patronization of healthcare facility by respondent*

**Table 4** shows the association between respondents' socio-demographic and patronization of healthcare facilities by respondents. There is a high proportion of patronizing the healthcare facility among respondents that attended secondary 21(28.8%) as their highest level of education compared to those that attended primary 27(19.1%) and no formal education 25(15%) at P-value<0.05. Also, there is a high proportion of patronization of healthcare facilities among respondents that are Christian 1(100%) compared to those that are Muslim 72(18.9%) at a P-value<0.05.

*Binary logistic regression: predictors of healthcare access*

**Table 5** shows the association between respondents' socio-

**Table 2**  
Distribution of respondents' disease burden and health related conditions.

Variables	Frequency (N = 381)	Percentage
<b>Managing any Health Condition</b>		
Yes	31	8.1
No	350	91.9
<b>Health Challenges that started after relocation</b>		
Yes	6	1.6
No	375	98.4
<b>Awareness of any nearby Health Facility</b>		
Yes	91	23.9
No	290	76.1
<b>Patronizing Health facility closer</b>		
Yes	73	19.2
No	308	80.8
<b>Challenges patronising health facility</b>		
Money (financial)	123	32.3
Poor knowledge of Location	97	25.5
Belief in other health systems		161 42.2
<b>Method of payment</b>		
Out of pocket	55	75.3
Insurance	0	
Others	18	24.7
NA*	308	80.8
<b>Ever heard of health insurance</b>		
No	381	100

\* NA: participants who did not patronise health facility did not have to describe payment method.

**Table 3**  
frequency distribution of respondents access to health related basic social amenities.

Variables	N(381)	%
<b>Sexually harassed</b>		
No	381	100
<b>Place of delivery</b>		
Orthodox facility	64	16.8
Others	61	16
Home	256	67.2
<b>Waste disposal Method</b>		
Modern toilet	41	10.8
Pit latrine	151	39.6
Bush	189	49.6
<b>Source of drinking water</b>		
Well/Borehole	204	53.6
Others	177	46.4
<b>Accommodation type</b>		
Open space	346	90.8
Shacks/shops/sheds	21	5.5
Others	14	3.7

NB: There is no information about the number of women beggars who delivered while living in the street.

**Table 4**  
Association between socio-demographic characteristics and patronization of healthcare facility.

Variables	Yes	No	$\chi^2$	P-value
<b>Age</b>				
≤34	25(22.2%)	87(77.7%)	126	0.531
35-69	35(18.6%)	153(81.4%)		
≥70	13(16.0%)	68(84%)		
<b>Marital Status</b>			1.82	0.611
Single	3(10.3%)	26(89.7%)		
Married	47(19.3%)	196(80.7%)		
Separated	7(19.4%)	29(80.6%)		
Widow	16(21.9%)	57(78.1%)		
<b>Has a Child</b>			1.21	0.272
Yes	66(18.9%)	283(81.1%)		
No	4(12.5%)	28(87.5%)		
<b>Level of Education</b>			6.24	0.044*
No formal	25(15%)	142(85%)		
Primary	27(19.1%)	114(80.9%)		
Secondary	21(28.8%)	52(71.2%)		
<b>Number of children</b>			1.20	0.548
≤3	49(18.6%)	214(81.4%)		
4-7	9(16.4%)	46(83.6%)		
>7	15(23.8%)	48(76.2%)		
<b>Religious affiliation</b>			4.23	0.040*
Christianity	1(100%)	0(0%)		
Islam	72(18.9%)	308(81.1%)		
<b>Profit made daily</b>			2.90	0.235
≤400	26(16%)	136(84%)		
500-1000	45(21%)	169(79%)		
>1000	2(40%)	3(60%)		

\* Statistically significant.

demographic and use of healthcare facilities by respondents using binary logistic regression. The highest level of education attained by respondents was the only factor that was independently associated with the use of healthcare facilities (Table 5). Respondents with secondary (OR=2.29, p=0.014, CI: 1.18-4.44) as their highest level of education had a 129% increased odds of using health facilities compared to those who did not have any formal education.

**Discussion**

The study revealed that almost all the women street beggars interviewed were from the northern part of the country. Findings showed that all the women were poor, and had a very low level of education, with the majority of them making less than a thousand naira a day.

**Table 5**  
Binary logistic of associated factors affecting patronage of healthcare among respondents.

Variable	AOR*	95%CI	P-value
<b>Age</b>			
0-34(ref)	1		
35-69	0.8	0.45-1.42	0.438
≥70	0.67	0.32-1.40	0.281
<b>Marital Status</b>			
Single(ref)	1		
Married	2.08	0.60-7.15	0.246
Separated	2.09	0.49-8.94	0.319
Widow	2.43	0.65-9.08	0.186
<b>Has a Child</b>			
Yes(ref)	1		
No	0.55	0.19-1.62	0.279
<b>level of Education</b>			
No formal (ref)	1		
Primary	1.35	0.74-2.44	0.33
Secondary	2.29	1.18-4.44	0.014**
<b>Profit made daily</b>			
≤400(ref)	1		
500-1000	1.39	0.82-2.37	0.223
>1000	3.48	0.56-21.91	0.183
<b>Number of children</b>			
≤(ref)			
4-7	0.87	0.50-1.50	0.608
>7	1.37	0.54-3.44	0.507

\* AOR; adjusted odds ratio \*\*statistically significant.

Whereas, average daily income among the general population where the study was conducted was about two thousand five hundred naira which is equivalent to \$5.79 (World Bank, 2022). Healthcare facility use was poor among respondents mainly due to poor awareness and poor financial status. It is pertinent to note that previous studies have shown that most beggars on the streets of major cities in Nigeria are from the Northern part of Nigeria and or countries with common boundaries with Nigeria at its northern fringes. Reports have shown that level of poverty is the highest in the Northern part of (Nigeria) and lowest in the Southwest of Nigeria (Kale, 2012).

Extreme poverty in the Northern part of Nigeria has been partly attributed to worsening climate change that negatively affected agricultural productivity and therefore low income (Abraham and Fonta, 2018). Worsening insurgency in the Northern part of Nigeria is a major cause of insecurity of lives and properties and the attendant poverty in the affected communities (Ayegba, 2015). Insecurity and poverty are major drivers of migration (Kanu et al., 2019). Low level of formal education and associated poor skills to compete for any means of livelihood in their new environment. In a recent National Demographic and Health Survey in Nigeria, households with a low level of education are among the poorest (National Population Commission, 2013). The Southern part of Nigeria has been reported to be the economically productive and prosperous part of Nigeria, with better educational attainment and more stability in terms of security. The Southwest of Nigeria is known to have the best of all these attributes (Kale, 2012). These may explain the reasons why beggars chose to migrate to the Southern part of Nigeria and especially the Southwest where this study was conducted. As revealed in this study, migrant women beggars live in conditions of extreme deprivation and poverty which affect their health-seeking behavior. This deprivation is characterized partly by poor housing facilities, poor access to any form of water supply, and one of the most forms of unhygienic management of human wastes. The most recent survey on health and population patterns in Nigeria (National Population Commission, 2018) aver that access to social infrastructure and amenities though generally poor in Nigeria, however, it is worse among migrants (Baggio et al., 2021) as a result of many factors among which are systemic inequity of access to social amenities compared to local communities (Burns et al., 2021).

Poverty is another major factor of poor access to social amenities and



healthcare services amongst them and poverty (Garcini et al., 2021). Previous studies have cited poor access to and inadequate utilization of social amenities as one of the factors of the occurrence of avoidable morbidity and mortality such as diarrheal illnesses, respiratory tract infections, and skin diseases amongst migrants. Local migrants' situation is worsened by the lack of support from international organizations. This is unlike the support rendered by these bodies to refugees (Cantor et al., 2021). This situation will negatively impact the quality of life of migrants. This study shows that none of the respondents has ever heard of health insurance. This may not be too far from expectation; currently, the population coverage of the National Health Insurance Scheme (NHIS) of Nigeria is low at less than ten percent of the total population (Adewole et al., 2021). The Nigeria National Health Insurance is a public-private-partnership between the NHIS, the Health Maintenance Organizations (HMOs) and other health care providers (private and public). The overall objective is to secure universal health coverage and access to adequate and affordable health care. It had the mandate to achieve this (UHC) within a period of ten years from its inception (2005-2015). While the NHIS shapes the health insurance policy by licensing the HMOs that operates the health insurance business, it also accredits health care facilities to provide the benefit packages to registered enrollees. The HMOs are responsible for the purchase of health care services on behalf of the Scheme for registered enrollees. Accredited health facilities in both the public and the private sectors provide needed healthcare services to subscribers (Adewole and Osungbade., 2016). Awareness about it is also poor (Adewole et al., 2017). This has implications for health equity and universal health coverage. On the one side, health insurance penetration in Nigeria is already one of the poorest globally (Federal Ministry of Health, 2014). This is corroborated by an National Demographic and Health Survey (NDHS) report that coverage of the NHIS of Nigeria is worse among poorly educated, lowest wealth quintile, and among those who live in the Northern part of Nigeria (National Population Commission, 2013; National Population Commission, 2018). Respondents in this study fit into this classification. Worst still, the neediest, among whom are beggars, appears unaware of its existence and they are unenlightened about its role as a safety net for unhindered access to healthcare (Adewole et al., 2015).

Therefore, they relied on out-of-pocket (OOP) payments for healthcare bill settlements (Federal Ministry of Health, 2014). Studies have shown that the use of OOP is associated with delay or non-use of healthcare facilities with attendant poor health outcomes (Chuma et al., 2013, Gopalan and Durairaj, 2012). In this study, paying for healthcare services may have contributed to poor patronage of an orthodox form of healthcare services and thus instead, resort to other forms of help such as home delivery of pregnant women, potential risk of increased maternal and child morbidity and mortality. However, patronage of orthodox healthcare facilities was more likely among those with a higher level of education. This is not unlikely to be associated with the known better health-seeking behaviour among educated individuals than it is likely to be among those without western education (Abuduxike et al., 2020). Stakeholders should pay more attention to this as a factor to promote the use of the NHIS and other forms of prepayment schemes in Nigeria.

The findings in this study could be an indication of a larger social problem with huge implications for health security. The root causes of the social problems of the population need further investigations. Economic empowerment and health education seem particularly pertinent at this time. This may lift them out of poverty and reduce the inequity of access to social determinants of health. Of note, and using appropriate strategies, knowledge about health insurance and its benefits should be introduced and promoted among this population group. In a Kenya study, different and appropriate strategies were used to promote the uptake of prepayment schemes among different population groups (Nyagero et al., 2012). A similar approach should be used in this environment. It is also pertinent that the government find a lasting solution to factors that facilitate migration especially conflicts and economic challenges which are worse in the Northern part of Nigeria. Generally,

social amenities and other determinants of health such as appropriately equipped healthcare facilities should be provided. The use of these facilities must be promoted. Inclusion of, male beggars, coupled with qualitative data would have provided better study findings. This is accepted as a limitation.

## Declaration of Competing Interest

Authors have no competing interest to declare.

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