SEXUAL AND REPRODUCTIVE HEALTH CONCERNS OF MIGRANTS IN IBADAN AND SAKI AREAS OF OYO STATE NIGERIA

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ABSTRACT

This cross-sectional study was carried out to investigate the sexual and reproductive health needs of migrants. Five hundred and sixty-six migrants took part in the survey. Results showed that 62.9% were males, 48.2% were between 20-40 years; a third (32.0%) were from Republic of Benin; 20.1% reportedly had more than one sexual partner; 12.6% had ever contracted an STI and 47.9% did know the causes. Main health seeking behaviours were treatment from the Chemists (0.9%), self medication (0.5%) and traditional healers (0.2%). Outcome of these showed that only 3.7% of reported that there was healing. Not knowing where to go (46.5%), poverty (23.0%) and fear of arrest by government agents (0.9%) were main hindrances to accessing SRH services. Based on these there is a need for enlightenment campaign with emphasis on transmission route, strong advocacy and social mobilizations to improve access to SRH services and reduce transmission of STIs.

Key words: Migrants, sexual and reproductive health, Nigeria

Introduction

According to the United Nations, there are currently more than 190 million people who have migrated, whether willingly or under duress. The number of people on the move has more than doubled since 1975 as people leave their communities in times of war, conflict, or natural disaster, or in search of jobs and opportunities [1]. Significantly, the pace of rural to urban migration has dramatically increased, especially in Africa and Asia [2].

Many of the health problems faced by migrants are the product of social and environmental factors including housing and working conditions, personal security, family situation, poor integration, cultural and linguistic barriers, discrimination and stigmatisation. The sexual and reproductive health of many migrants suggests several concerns among which include poor accessibility to reproductive health information including information on HIV/AIDS and other sexually transmitted diseases. Recent migrants are less likely than other urban residents to use the available reproductive health care services. Among contraceptive users, migrants are more likely than nonimmigrant to find it difficult identifying the nearest source of modern contraceptives. This may increase the risks of HIV/AIDS and other sexually transmitted diseases. The disruption of family and community life during moves, especially in situations of poverty and crisis, also increases risky sexual behavior and exposure to STDs. In addition, safe motherhood is difficult among migrants and this may threat life during childbirth. Prenatal and delivery care often are minimal, and emergency care may not be easily available

Sexual and reproductive health intervention programmes often exclude migrants living in both urban and rural isolated areas. Few reproductive health programmes have recognized migrants as a specific group with special needs. There is usually poor assessment of migrants' reproductive health needs and how they differ from non-migrants needs. Reproductive health information and services are not usually tailored to meet the needs of migrants. These have made migrants to be particularly vulnerable to some infectious diseases such as TB, HIV/AIDS and STIs. All these have culminated in the shortfalls on available information and gaps in knowledge. This study therefore determined the sexual and reproductive health problems confronting migrants in selected communities; examined hindrances to receiving reproductive health information; documented adopted strategies being used currently; assessed the effectiveness of strategies being adopted; investigated the existing opportunities to access sexual and reproductive health care services and identified appropriate ways of making sexual and reproductive health care services available, accessible and affordable to migrants.

Methodology

The study was a cross-sectional survey carried out among migrants in an urban (Ibadan) and rural (Saki) areas of Oyo State. The scope of the study was delimited to Ibadan and Saki areas of Oyo State. Ibadan, the capital of Oyo State has multiple clusters where migrants congregate and Saki is a gateway community to the majority of international migrants into Oyo State. The migrants usually stay in Saki to acquire some language

skills, which they could use to communicate when they eventually enter into the major towns and cities.

The questionnaire for data collection was semi-structured and interviewer-administered. It was divided into seven sections: demographic characteristics; pattern of sexual behaviour; sexual and reproductive health problems facing migrants in the selected communities; hindrances to receiving sexual and reproductive health information; strategies adopted to manage existing sexual and reproductive health problems; effectiveness of strategies used; existing opportunities to access sexual and reproductive health care; ways of making sexual and reproductive health care services available, accessible and affordable.

All the migrants available during the period of data collection were surveyed. The leaders were fully mobilized and involved in the sensitization of their members on the purpose of the research. Verbal informed consent was obtained from each participating migrant before the interview was conducted. Prior to this, the research assistants were trained and the questionnaires pre-tested and standardized. The interviews were conducted during morning/afternoon hours of weekdays and weekends when the migrants were less busy. Data were analyzed using the SPSS (version 12.0) to generate frequencies and descriptive statistics.

Results

Socio-demographic characteristics

A total of five hundred and sixty-six respondents participated in the study. Of the 566 respondents in the study, 1(2.0%) was a child (1-10 age bracket), 150(26.5%) were adolescents in the 11-19 age bracket, 273(48.2%) were adults in the 20-40 age group, 104(18.4%) were between 40-59 years, 21(3.7) were 50 years and above while 17(3.0%) had no idea of their age (Table 1). Three hundred and fifty-six (62.9%) of the respondents were males while 206(36.4) were females. Reported countries of origin of the respondents were Ghana 51(9.0%), Benin Republic 181(32.0%), Niger Republic 3(0.5%), Burkina-Faso 20 (3.5%), Togo 98(17.3%) and within Nigeria 183(32.3%) (Table 1).

Respondents' duration of stay in the study area showed that 37(6.5%) had been resident in the study sites for less than a year, 155(27.4%) for 2-5years, 135(23.9%) for 6-10 years, 217(38.3%) for 11 years and above and 1 (0.2%) respondent had been resident there since birth. On the reasons for deciding to come and live in the study area, 9(1.6%) had no idea of the reason, 407 (71.9) came to live there in search of a livelihood, 73(12.9%) decided to in order to be living alone and 10(1.8%) decided to because their family moved there. Respondents' age at arrival in the current pace of abode showed that 90 (15.9%) were between the ages of 1-10 when they first came, 210(37.1%) were between 11and 19 years, 201(35.5%) were between 20-40 years, 23(4.1%) were between 40-59 years, 3(0.5%) were 60years and above, 12(2.1%) had no idea of their age at that time while 12(2.1%) said they were born there. Current living conditions showed that 43(7.6%) were living alone, 32(5.7%) were living with their parents, 34(6.0%) were

living with friends, 225(39.8%) were living with relatives while 20(3.5%) were living with their boss. Figure 1 shows the occupation of the respondents. Most 247(43.6%) were farmers and 137(24.2%) were traders. The level of education of the respondents showed that 155(27.4%) had primary education, 128(22.6%) had secondary, 37(6.5%) had tertiary, 4(0.7%) had quranic education while 3(0.5) had informal education and 235(41.5%) had none. Two hundred and sixty (45.9%) of the respondents were single, 258(45.6%) were married, 9(1.6%) were widowed, 8(1.4%) were separated while 1(0.2%) were divorced. Socialization pattern showed that 113(20.0%) of those who were married got married in the study area while 169(29.9%) did not.

Age at marriage showed that 84(14.8%) were less than 20years old at their first marriage, 125(22.1%) were between 20-30 years, 34(6.0%) were above 30 years while 27(4.8%) were not sure of their age at first marriage. Three hundred and ninety-three (69.4%) of the respondents were Christians, 134(23.7%) were Muslims while 2(0.4%) were of the traditional religion. Assessment of fertility history showed that 177(31.3%) have between 1-5 children, 72(12.7%) have 6-10 children, 25(4.4%) have more than 10 children while 113 (20.0%) have no children.

Report of the monthly income of the respondents showed that 5 (0.9%) respondents earned less than N1000 [$6.6] monthly, 33(5.8%) earned between N1000 and N5000 [$6.66 and $33.33], 38(6.7%) earned between N6000 and N10000 [$40 and $66.66], 29(5.1%) earned between N11000 and N20000 [$73.33 and $133.33], 50(8.8%) earned more than N20000 [$133.33] monthly while 22(3.9%) earned no salary as at the time of the data collection.

Sexual behavior of Respondents

Respondents' sexual behaviour was explored. Of those who were single 169(29.9%) had engaged in sexual activities. Two hundred and twenty seven (40.1%) reportedly have only one partner, 68(12.0%) have two, 13(2.3%) have three, 9(1.6%) have four while 24(4.2%) have more than four sexual partners (Table 2). Frequency of sexual activities of respondents showed that 18(3.2%) engage in sexual activities daily, 89(15.7%) weekly, 41(7.2%) once a month while 131(23.1%) said anytime. Respondents were asked their age at their first sexual experience. Thirteen (2.3%) said they were less than 10 years at their sexual debut, 254(44.9%) were between 10-20 years, 70(12.4%) were between 21-30 years while 4(0.7%) were more than 30 years at sexual debut.

Sexual and Reproductive Health Concerns among Respondents

Only 71 (12.5%) of the respondents reportedly have current sexual and reproductive health concerns. These included gonorrhea 23 (32.4%), HIV/AIDS 6(8.5%), syphilis 3(4.2%) and 39(54.9%) described various conditions such as itchy private part suggestive of infections. On past history of sexual and reproductive challenges, only 16 (2.8%) responded in the affirmative. Of these, 11(68.8%) reportedly had had gonorrhea, 4(25.0%) itching in private part and 1(6.2%) mentioned syphilis. Perception of seriousness of these disease entities varied as more respondents 3.9% perceived gonorrhea as the most serious compared with 0.7%% and 0.5% who perceived

HIV/AIDS and syphilis as most serious respectively. Women irrespective of their age were reportedly more affected by these sexual and reproductive health challenges.

Health seeking behaviour for the various sexual and health challenges faced showed that 15(2.7%) consulted friends, 5(0.9%) each visited hospitals and chemist shops (PMVs), 3(0.5%) engaged in self-medication while 1(0.2%) reportedly visited traditional healers. Reported outcome of these actions showed that no improvement was seen in 13.6% of the cases.

Knowledge of causation of the mentioned disease entities varied among respondents. A large majority 546(96.4%) of the respondents had no idea of the cause while 10(1.8%) mentioned ignorance, 9(1.6%) mentioned poverty and 1(0.2%) said being single was responsible. Hindrances to information on sexual and reproductive health issues as highlighted by respondents included poverty 40(7.1%), fear of arrest by government agents 5 (0.9%), not knowing people 3(0.5%) and not knowing where to go 2(0.4%).

Reported challenges faced in accessing sexual and reproductive healthcare services as a migrant included poverty 130 (23.0%), high cost of service 50(8.8%), discrimination 36(6.4%), proximity 24(4.2%), ignorance 16(2.8%), and harassment from law enforcement agents 5(0.9%). Suggestions for improved access to sexual and reproductive healthcare services proffered by migrants included making more health facilities available (41.3%), reduced cost of services 33(5.8%) and reduced discrimination 5(0.9%). On how these can be removed, respondents said that 37(6.5%) said more health centers should be built, 19(3.4%) said free health services should be made available, 3(0.5%) said there should be no harassment while 8(1.4%) said there should be enlightenment. On how the migrants can be reached for enlightenment, 53(9.4%) said they could be reached the media, 35(6.2%) suggested that migrants should be reached through their local associations while 2(0.4%) said through religious bodies.

Discussion

The results showed that young persons are affected by the push and pull forces that lead to migration just like the adults. This has far reaching implications for population and reproductive health issues of young migrants who have the same developmental needs common to all young people [3]. These needs as found in this study needs are affected by displacement from their homes and separation from the structure and guidance of their families. The new environments in which they find themselves are often hostile and unhealthy [4]. This may increase their vulnerability to sexual violence and infections. The high preponderance of unskilled job with its attendant low monthly income predisposed the migrants to poverty and inability to access and pay for sexual and reproductive health services as documented by the study. Furthermore, the assumption that urban migrants should have greater access to health information and services, (including RH/FP) since health services are usually concentrated in urban areas, was refuted by the findings of this study [5] as respondents have very limited access to health care.

The reported sexual activities documented by the study pointed at the type of sexual networking amongst them and their host communities. The age of sexual debut was not different from those found in non-migrant populations [6]. In addition, women were reportedly more affected by the different sexual and reproductive health challenges. This has been corroborated by studies from other regions of the world [7, 8, 9]. These findings have brought to the fore the importance of instituting health promotion activities geared towards healthy living and prevention of diseases among this group of people.

The proportion of respondents reporting sexual and reproductive health challenges is a cause for concern. This is coupled with their low knowledge of causation of the disease conditions. This has implication for preventive actions. If the cause is unknown, taking preventive action against such disease entity is farfetched. This poor knowledge influenced the inappropriate health seeking behaviour documented. This finding has shown that the migrants constitute an unreached important target for population and reproductive health education programmes. This group had to be reached if the society is going to have holistic health.

Conclusion

The study explored the sexual and reproductive health concerns of migrants in a rural and an urban area of Oyo state, Nigeria. Results showed that sexual and reproductive health concerns exist among this group in conjunction with poor knowledge of causation, inappropriate health seeking behaviour and poor access and utilization of SRH services with women mostly affected. Therefore findings from this study suggest that there is an urgent need for the design and implementation of migrant specific SRH programmes to improve this aspect of migrants' health.

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Table 1 – Socio-demographic Characteristics of Migrants surveyed

Socio-demographic Variables	Frequency	Percentage
Age		
1-10	1	2.0
11-19	150	26.5
20-40	273	48.2
40-49	104	18.4
50+	21	3.7
No idea	17	3.0
Total	566	100.0
Place of Origin		
Ghana	51	9.0
Benin	181	32.0
Niger	3	0.5
Burkina Faso	20	3.5
Togo	98	17.3
Within Nigeria	183	32.3
Others	23	4.1
No response	7	1.2
Religion		
Christianity	393	69.4
Muslims	134	23.7
Traditional religion	2	0.4
No response	37	6.5
Total	566	100.0

Fig. 1: Occupation of respondents