

REVIEW ARTICLE

Accessibility and utilization of health-care services among rural–urban migrants in Ghana: A scoping review

Godfred Otchere¹, Samuel Egyakwa Ankomah^{2*}, Adam Fusheini^{1,3}, Emmanuel Kumah⁴, and Samuel Kofi Agyei⁵¹Department of Preventive and Social Medicine, Faculty of Medicine, University of Otago, Dunedin, Otago, New Zealand²Obstetrics and Gynaecology Directorate, Komfo Anokye Teaching Hospital, Kumasi, Ashanti Region, Ghana³Public Service Department of New Zealand, Ministry of Social Development, Wellington, New Zealand⁴Department of Health Administration and Education, Faculty of Health, Allied Sciences and Home Economics Education, University of Education, Winneba, Central Region, Ghana⁵Department of Physician Assistant, Faculty of Health and Medical Sciences, Presbyterian University, Agogo, Ashanti Region, Ghana

Abstract

Since the second half of the 20th century, internal migration patterns in Ghana have been dominated by movements from rural (or northern) to urban (or southern) areas. Numerous studies report wide socioeconomic gaps between the geographical north and south of Ghana, explaining the unidirectional movement in search of better opportunities. Differences in personal health profiles, values, and beliefs mean that internal migrants face a higher risk of ill health than urban natives. Compounding this issue is the barriers that impede their access to and utilization of health-care services. We synthesized evidence from existing literature to understand internal migrants' access to and utilization of healthcare in Ghana, as well as their coping strategies. This review followed Arksey and O'Malley's guidelines for conducting scoping reviews. We searched PubMed, EconLit, CINAHL, PsychINFO, and Medline (Ovid) electronic databases for studies published from January 2012 to June 2022. In addition, a manual literature search was conducted on Google by examining the reference lists of selected articles to identify other relevant studies. The majority of the studies ($n = 12$ [75%]) focused on female migrants, while 4 (25%) included both male and female migrants. This review identified several factors affecting access to health-care services for internal migrants in Ghana. These factors included infrastructural, financial, and language barriers, as well as long patient waiting times. Significantly, these barriers resulted in increased self-medication and self-diagnosis among internal migrants, leading to overall poor health outcomes. Based on the study findings, we propose a multidimensional approach to bridging the health access gap for internal migrants. This approach involves improving health system factors such as health service delivery, health workforce, availability of essential medicines, and health finance reforms to provide quality health-care services at affordable or no cost, while considering the socioeconomic and cultural conditions of the internal migrants.

Keywords: Internal migrants; Access; Healthcare; Utilization; Ghana; Health system

***Corresponding author:**
Samuel Egyakwa Ankomah
(sankomah@kath.gov.gh)

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1. Introduction

Internal migration, also referred to in this study as rural–urban migration, has driven ongoing intensive urbanization in Ghana (Ghana Statistical Service, 2013; UNICEF, 2018; United Nations High Commissioner for Refugees, 2017). These migration patterns in Ghana have predominantly been from rural to urban areas, or in other words, from the north to the south, particularly since the second half of the 20th century (Dick & Schraven, 2018; United Nations High Commissioner for Refugees, 2017). Numerous studies have reported a wide socioeconomic gap between the geographical north and south of Ghana, which drives these internal migration patterns (Figure 1). Data from the Ghana Statistical Service show that about 80% of migration in Ghana is internal. Of this, over 4 million people (70%) settle in urban areas and cities (Ghana Statistical Service, 2021). For instance, Ghana's Population and Housing Census migration report (2023:80) highlights north–south migration from the Upper West, Upper East, and Northern Regions to the Greater Accra, Ashanti, Ahafo, Western North, and Western Regions of Ghana (Figure 1).

Migrants move in search of better working opportunities, education, healthcare, recreation, and, in some cases, to escape political instability or

environmental disasters (Hjelm *et al.*, 2012; Ziblim, 2013). Despite the benefits this migration may bring, it also exposes migrants to various forms of hazards (Abubakar *et al.*, 2018). For instance, internal migrants are more vulnerable to health issues due to differences in their health profiles, values, and beliefs compared to the host population (Wickramage & Annunziata, 2018). In general, they have poorer health outcomes than the urban natives because they often lack adequate access to and the capability to utilize health-care services, as well as other social support in their new environment (Afeadie, 2021; Amrevurayire & Ojeh, 2016). For instance, a study conducted in Ghana by Amankwaa *et al.* (2003) affirmed that the mortality rate of children under age five is higher (84.2 per 1000) among internal migrants than among urban natives (77.2 per 1000). Another study by Meyer-Weitz & Komesuor (2023) in Ghana also discovered a higher prevalence of depression, anxiety, and stress among internal migrants.

Some attempts have been made by the government of Ghana to ensure equitable access to and utilization of health-care services for all citizens through the implementation of the National Health Insurance Scheme (NHIS) (Act 650/852) (Amporfu & Grépin, 2019; Okoro, 2019). The NHIS, further, provides exemption packages

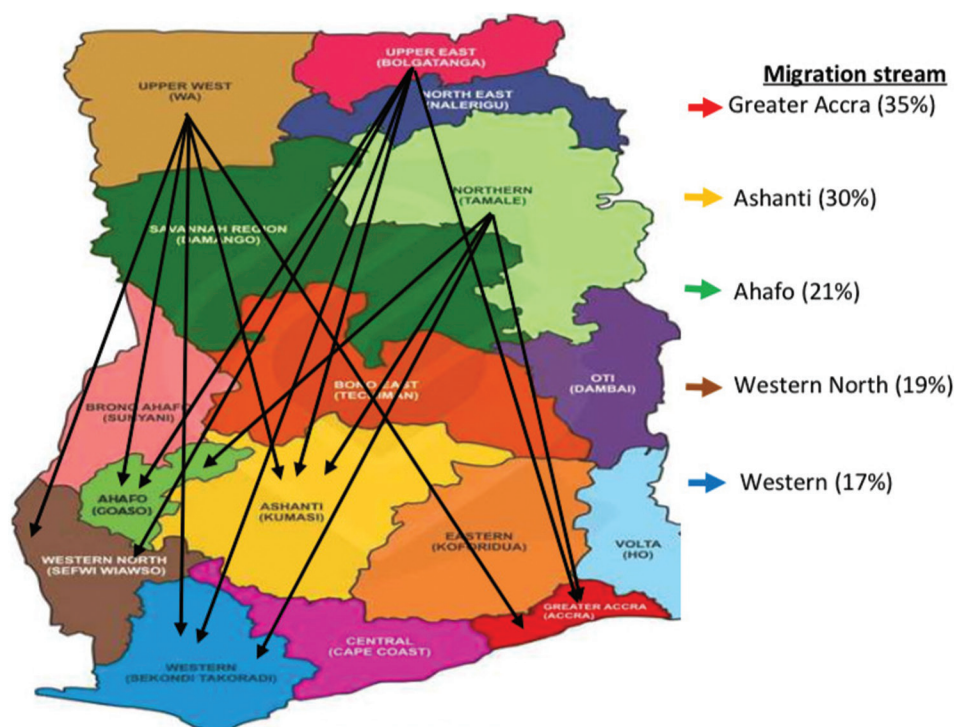


Figure 1. The north–south migration patterns in Ghana. Source: Authors' design based on Ghana's 2021 Population and Housing Census migration data (2023:80).

such as premium exemptions, free enrolment, free maternal healthcare, and free antenatal and childbirth care for vulnerable populations, including internal migrants, as specified under the National Health Insurance Regulation (sections 56 and 58) (Aryeetey *et al.*, 2015; Blanchet *et al.*, 2012; National Health Insurance Regulations, 2004). Notwithstanding, these policies and interventions to address the health access problems, socioeconomic factors such as cultural barriers, occupation, food, housing, utilities, transportation, and access to education also play a major role in determining healthcare access to and utilization for internal migrants (Doshi *et al.*, 2020). Thus, despite several interventions to improve health-care services and facilitate full-range access among internal migrants in Ghana, evidence still points to growing health inequality between internal migrants and urban natives (Akazili *et al.*, 2017; Sznajder *et al.*, 2020). This evidence, however, has not yet been synthesized to understand the various factors influencing their access to and utilization of health-care services. This review, therefore, seeks to address these gaps by systematically identifying literature on internal migrants' access to and utilization of health-care services in Ghana. The review also examines their coping mechanisms and proposes strategies to improve their health outcomes.

2. Data and methods

This review followed Arksey & O'Malley's (2005) guidelines for conducting scoping reviews, which involve five steps: (i) identify research question(s); (ii) identify relevant papers; (iii) select studies; (iv) extract and chart data; and (v) collate, summarize, and report findings.

2.1. Identify research question

The research questions were informed by the population, concept, and context framework (Ankomah *et al.*, 2021; Chambers *et al.*, 2016; Peters *et al.*, 2015), as shown in Figure 2. The population refers to internal migrants

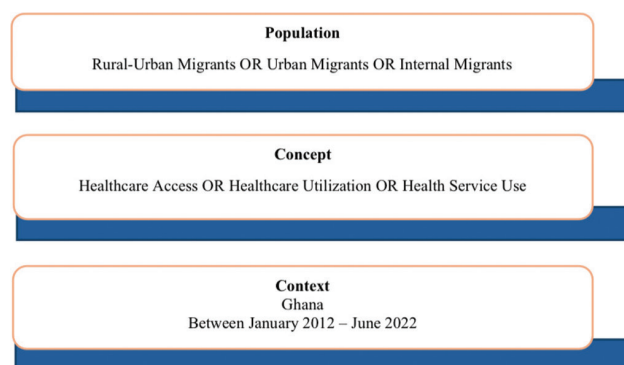


Figure 2. The population, concept, and context framework

in Ghana; the concept entails healthcare access and utilization; and the context is Ghana. The review addressed the following questions:

- (i) What are the facilitators and barriers to accessing and utilizing health-care services among internal migrants?
- (ii) What coping mechanisms do internal migrants use when faced with barriers to accessing and utilizing health-care services?
- (iii) What health system interventions and strategies could be used to improve internal migrants' access to and utilization of health-care services?

2.2. Identify relevant papers

A three-step search strategy for scoping reviews was used to achieve a comprehensive search, as recommended by the Joanna Briggs Institute (2015). First, an initial search of the PubMed database (Table 1) was conducted. Second, the search strategy developed for the PubMed database was applied to the following databases: EconLit, CINAHL, PsychINFO, and Medline (Ovid). Third, the reference lists of all eligible articles were searched and screened for additional relevant studies. The final search strategy in PubMed was conducted in June 2022.

2.3. Select studies

All article citations were exported to the EndNote Version X9 library for further screening of titles and abstracts. Duplicate records were removed electronically using Endnote. Subsequently, abstract screening was conducted, followed by a full-text screening to select eligible relevant papers by applying the inclusion and exclusion criteria:

- Inclusion criteria
 - (i) Published gray literature and peer-reviewed English language articles from January 2012 to June 2022.
 - (ii) Papers on facilitators and/or barriers to healthcare access among internal migrants in Ghana.
 - (iii) Papers showing coping mechanisms internal migrants use when faced with barriers to healthcare in Ghana.

Table 1. Search term developed for the PubMed database

Concept#	Search terms entered in PubMed	Result
1	urban OR internal migrants OR internal migrants OR migrants OR migrants	308,492
2	Utilization OR utilization OR usage OR uptake OR use OR access OR health care OR health care OR health service	5,073,467
3	#1 AND #2	99,766
4	Ghana	5,073,467
5	#3 AND #4	665

- (iv) Papers reporting on health system interventions to improve access to and utilization of healthcare among internal migrants in Ghana.

- Exclusion criteria

The following criteria were excluded from the study:

- (i) Papers not conducted in English but in other languages.
- (ii) Papers reporting on internal migrants' health in countries other than Ghana.

2.4. Extract and chart data

A data extraction form was designed using a Microsoft Excel spreadsheet with the following column headings: author, publication year, country, aim/purpose, study sample, study design, study outcomes, and main findings. This form was designed to extract relevant information from the selected articles. This process served as the foundation for appraising, analyzing, summarizing, and interpreting findings that correspond to the aim and research question of scoping reviews (Büchter *et al.*, 2020).

2.5. Collate, summarize, and report findings

We conducted a quantitative descriptive summary analysis and a qualitative thematic analysis of the selected eligible papers. This process involved identifying themes in the selected papers and summarizing the key results in a summary table, with each result under a thematic heading (Molyneux *et al.*, 2012).

2.6. Quality assessment and assurance

Two reviewers independently applied the eligibility criteria to screen the full text of the selected titles and abstracts. The eligibility criteria provided clear guidelines and consistency in the selection process (Arksey & O'Malley, 2005). This application minimized the risk of error and, thus, enhanced the credibility of the review findings (Arksey & O'Malley, 2005). The reviewers compared results and reached a consensus after each stage of the selection process, with a third reviewer serving as a tiebreaker in instances where the two reviewers failed to reach an agreement. After full screening, the data were entered into the designed data extraction spreadsheet using Microsoft Excel. The data were reported using the Preferred Reporting Item for Systematic Reviews and Meta-Analyses for Scoping Reviews (PRISMA-ScR) guidelines by Tricco *et al.* (2016:16b). The risk of bias of the eligible studies was not assessed as this review is not a systematic review. However, the quality of the selected studies was not compromised by strictly applying the eligibility criteria.

3. Results

3.1. Extent of the literature

The initial search identified a total of 932 papers, including 805 from the electronic database search and 127 from a manual search. After removing duplicate articles, 801 remained. A total of 729 articles were removed during the abstract and title screening, leaving 72 for full-text screening. The full-text screening resulted in the exclusion of 56 articles. These papers were excluded for the following reasons: lack of focus on facilitators and barriers to healthcare ($n = 28$), lack of focus on internal migrants in Ghana ($n = 19$), and not reporting on health system interventions to improve health among the internal migrants ($n = 9$). In total, 16 eligible studies were included in the final analysis. The PRISMA flow diagram (Figure 3) depicts the stages of study identification and selection.

3.2. Nature of the literature

A detailed description of the study characteristics is presented in Table 2. The publications came from the research fields of global and public health, social science, and policy disciplines. Thirteen ($n = 13$ [81%]) were original peer-reviewed journal articles, while 3 (19%) were theses. The study designs and methods from all identified sources were clearly described. A total of 5092 internal migrants were included in the 16 studies. Most ($n = 12$ [75%]) publications focused on female migrants, while 4 (25%) included a mix of male and female migrants. All 16 (100%) studies focused on internal migrants' experiences with both public and private health facilities.

3.3. Thematic findings

Several health-system and individual-level factors were identified in the included studies as barriers to accessing and utilizing health-care services among internal migrants. Summary of result is shown in Table 3.

3.3.1. Barriers to health-care utilization among internal migrants

All 16 eligible studies (Akazili *et al.*, 2018; Asaana, 2015; Baada *et al.*, 2021; Boateng, 2020; Boateng *et al.*, 2017; Lattof, 2017; Lattof, 2018; Munemo *et al.*, 2021; Nyarko & Tahiru, 2018; Owusu-Ansah *et al.*, 2016; Owusu & Yeboah, 2018; Rizwan *et al.*, 2022; Shamsu-Deen & Adadow, 2019; Sznajder *et al.*, 2020; Teye, 2019; Yiran *et al.*, 2015) reported on barriers to accessing and utilizing health-care services among the internal migrants. These barriers have been grouped into eight sub-themes, as presented below.

- (a) Infrastructural barriers to health-care utilization
Seven articles (Baada *et al.*, 2021; Boateng *et al.*, 2017; Munemo *et al.*, 2021; Owusu & Yeboah, 2018;

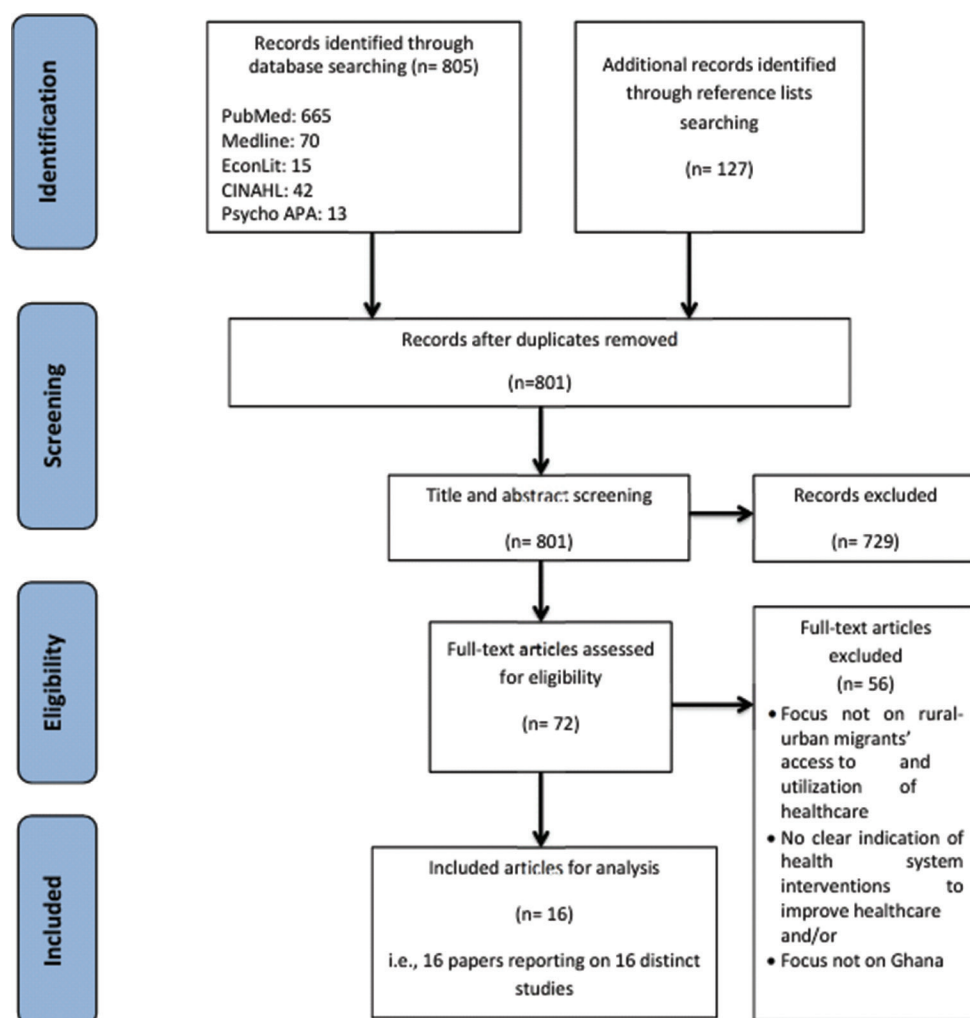


Figure 3. PRISMA flow chart summarizing search and selection of articles

Rizwan *et al.*, 2022; Shamsu-Deen & Adadow, 2019; Yiran *et al.*, 2015) identified distance from health-care facilities as a barrier to health-care utilization. Our review discovered that most internal migrants live in slum areas and, therefore, find it difficult to travel from their residences to health facilities for appropriate medical care when they are sick. For instance, a study conducted by Owusu & Yeboah (2018) revealed that health facilities were often over 5 km away from the slum areas where internal migrants live. Even in cases where internal migrants wanted to seek formal healthcare, they had to walk several hours because they could not afford any form of transport services.

(b) Financial constraints and affordability of quality health services

Most of the studies (Akazili *et al.*, 2018; Baada *et al.*, 2021; Boateng, 2020; Boateng *et al.*, 2017; Lattof, 2017; Lattof, 2018; Munemo *et al.*, 2021; Owusu & Yeboah, 2018; Rizwan *et al.*, 2022; Shamsu-Deen

& Adadow, 2019; Sznajder *et al.*, 2020; Teye, 2019; Yiran *et al.*, 2015) reported financial barriers as a deterrent to healthcare access and utilization among the internal migrants in Ghana. Findings from our review identified significant financial barriers for all the internal migrants as they were required to pay additional fees despite being enrolled in the NHIS (Akazili *et al.*, 2018). Particularly, a study by Yiran *et al.* (2015) showed that female internal migrants were asked to provide medical consumables such as gauze and other items during childbirth, despite the provision of free maternal health under the NHIS.

Furthermore, this review revealed that health facilities were inadequately stocked with many essential drugs, leading to prescriptions being issued for purchase out-of-pocket after spending hours at the health facility. Most internal migrants earn an average of \$4.9 – \$23.9 weekly (whereas formal sector workers earn \$37.3 – \$46.6 weekly) (Boateng, 2020). As a result,

Table 2. Characteristics of included studies

Author, year of publication	Study aim/Purpose	Study design	Study sample
Baada <i>et al.</i> , 2021	Explore reproductive health experiences among migrant women	Qualitative descriptive design	Interviews with 30 female migrants and five focus group discussions with ten women in each group
Akazili <i>et al.</i> , 2018	Identify factors affecting access to health-care services among informal workers in Northern Ghana	Exploratory study design through qualitative approach	68 migrants through six FGDs with a maximum of 8 – 10 in each FGD and 15 IDIs
Asaana, 2015	Examine migrant women's access to health services post-migration	Qualitative descriptive design	70 female migrants
Boateng <i>et al.</i> , 2017	Examine the factors associated with the use of NHIS among migrant female head porters in Kumasi	Quantitative cross-sectional study design	392 female migrants
Nyarko & Tahiru, 2018	Identify health-related concerns of female head porters	Qualitative descriptive study design	122 female migrants through IDIs
Owusu-Ansah <i>et al.</i> , 2016	Describe and analyze factors associated with the utilization of health-care facilities among migrants	Quantitative cross-sectional study design	465 internal migrants
Sznajder <i>et al.</i> , 2020	Explore migration narratives of migrants' sexual and reproductive lives in an informal settlement in Accra	Qualitative descriptive study design	20 migrants
Rizwan <i>et al.</i> , 2022	Explore the impact of social determinants of health among migrants	Qualitative approach	N/A
Lattof, 2017	Examine the health status of female migrants who work in the informal sector	Secondary analysis through a mixed approach	625 female migrants through IDI ($n=48$) and remaining questionnaires
Teye, 2019	Examine access to and utilization of health-care services in Ghana after migration	Mixed approach using census and survey processing System (CSPPro) data	116 migrants and 116 non-migrants through ten IDIs and one unstructured expert interview
Owusu & Yeboah, 2018	Examine factors affecting access to and utilization of healthcare among female migrants	Qualitative case study design	N/A
Munemo <i>et al.</i> , 2021	Examine family practices among female migrant women	Qualitative descriptive design	Interviews with 19 female migrants and three key informants
Lattof, 2018	Identify factors that affect female migrants' access to health-care services in Accra	Mixed methods using primary survey data	625 female migrants through semi-structured interviews (four internal migrants) and remaining questionnaires
Boateng, 2020	Investigate health-seeking behaviors of migrant female head porters in the Kumasi metropolis	Quantitative case study approaches	378 female migrants
Yiran <i>et al.</i> , 2015	Identify factors that promote or hinder access to maternal healthcare	Mixed-method approaches	70 female migrants through 70 questionnaire survey
Shamsu-Deen & Adadow, 2019	Examine female migrants' health-seeking behavior in Accra	Mixed-method using cross-sectional design	216 female migrants through survey questionnaires

Note: N/A indicates the unavailability of information regarding the study sample.

Abbreviations: FGD: Focus group discussion; IDI: In-depth interview; NHIS: National Health Insurance Scheme.

many are unable to afford the medications prescribed to them. It was also reported that doctors referred them to private laboratories for tests to be conducted at their own expense (Akazili *et al.*, 2018).

(c) Perception of attitude of health personnel
The reviewed studies documented unfriendly attitudes and misconduct by some health professionals, who were reported to be cold toward internal migrants,

particularly those who work as head porters (Akazili *et al.*, 2018; Asaana, 2015; Lattof, 2017; Munemo *et al.*, 2021; Owusu & Yeboah, 2018; Yiran *et al.*, 2015). Specifically, a study by Owusu & Yeboah (2018) disclosed that some female internal migrants were reluctant to attend antenatal clinics because they perceived health-care professionals as unfriendly toward them due to their attire. Furthermore, this review revealed that some internal migrants at times felt demeaned by health professionals due to their migrant status, indicating differences in respect and the quality of care they received. In addition, some health professionals blamed them for their illnesses, which affected their confidence in the health system (Asaana, 2015).

- (d) Adequacy of the National Health Insurance Scheme
Six articles (Akazili *et al.*, 2018; Baada *et al.*, 2021; Boateng, 2020; Boateng *et al.*, 2017; Lattof, 2017; Teye, 2019) described enrolment difficulties (such as long processing times, registration costs, and distance to the NHIS registration office) and the inadequacy of the NHIS as barriers to health-care utilization among internal migrants in Ghana. For instance, a study by Boateng (2017) found that despite the high (78.8%) NHIS enrolment among internal migrants (specifically head porters), 53.8% were unable to renew their NHIS enrolment annually, which is required to access health-care services. It was also reported that internal migrants, who are not required to pay for health-care services in the northern part of the country, are always asked to pay additional bills for health-care services in the south (Boateng *et al.*, 2017).
- (e) Linguistic barriers
This review found that most internal migrants could only speak their local dialect and lacked confidence in their ability to communicate effectively to seek health-care services (Lattof, 2017; Owusu & Yeboah, 2018; Rizwan *et al.*, 2022; Yiran *et al.*, 2015). Many migrants have difficulties with the dominant languages (Twi and English) in southern Ghana. Health professionals, on the other, often do not comprehend the languages spoken by the migrants, which affect effective communication during diagnosis and the provision of care.
- (f) Time spent at the health facility for medical care
While the availability of health services was not a problem for internal migrants in the south (urban areas), 8 articles (Akazili *et al.*, 2018; Lattof, 2017; Lattof, 2018; Munemo *et al.*, 2021; Nyarko & Tahiru, 2018; Owusu & Yeboah, 2018; Sznajder *et al.*, 2020; Yiran *et al.*, 2015) reported that long queues and unnecessary waiting times at health facilities deterred

them from seeking healthcare. These delays have influenced their health-seeking behaviors. Our review identified that long waiting hours for medical care at health facilities negatively affected internal migrants' daily productivity, as most of them work in the informal sector, particularly in the head portage business (Owusu & Yeboah, 2018; Yiran *et al.*, 2015). In addition, the articles reported that internal migrants risked losing their daily income or jobs if they had to consistently visit health facilities for medical care.

- (g) Influence of gender and sociocultural barriers
Four articles (Baada *et al.*, 2021; Munemo *et al.*, 2021; Owusu & Yeboah, 2018; Rizwan *et al.*, 2022) revealed that female internal migrants had to obtain permission from the male head of their households before accessing reproductive health-care services. Our review reported that cultural norms or customs affect women's use of reproductive health services, such as contraceptives, as they are obliged to seek consent from their male counterparts. Among the Dagaaba and Sissala of the Upper West Region (UWR), a study by Baada *et al.* (2021) described how the payment of a bride price confers a woman's reproductive rights to her spouse. It was reported that internal migrants from UWR still maintain this tradition, which limits their ability to independently seek reproductive healthcare.

Another barrier discovered was the failure of health-care professionals to consider patients' cultural values and health practices, leading to negative health-seeking behavior among these migrant populations (Munemo *et al.*, 2021). Our review identified that cultural orientation and perceptions of migrants have implications for their health-seeking behavior. Thus, many internal migrants only use formal health services when their health condition significantly deteriorates (Owusu & Yeboah, 2018).

- (h) Health illiteracy and ignorance of formal structures for the National Health Insurance Scheme
Internal migrants' level of knowledge and understanding of health information also affected their utilization of healthcare in urban areas (Lattof, 2017; Rizwan *et al.*, 2022). Most of them were unaware or uncertain about whether health insurance cards from the north (rural areas) could be used to access healthcare in the south (urban areas) of Ghana (Teye, 2019). It was reported that internal migrants were unaware of the NHIS registration costs in Ghana. For example, Boateng *et al.* (2020) revealed that some internal migrants believed that they needed to save GH¢ 80 – 100 (\$7.95 – \$9.95) before they could register with the NHIS, which far exceeds the actual GH¢ 25 – 30 (\$2.5) NHIS registration fee. In addition,

Table 3. Summary of results from included studies

Author, year of publication	Outcome (s)			Main finding (s)
	Barrier (s)	Coping mechanism (s)	Health system factors/ Possible interventions	
Baada <i>et al.</i> , 2021	(i) Financial barrier. (ii) Infrastructural and sociocultural barriers. (iii) Regarded the quality of health services as poor.	(i) Supreme being as their source of relief for their health challenges. (ii) Rely on herbs/barks.	(i) Organize periodic social programs that provide health information and resources. (ii) Equipping health workers with the necessary logistics.	Migrant women are restricted by their male counterparts to use family planning services and limited social support in their new community or society.
Akazili <i>et al.</i> , 2018	(i) Long waiting hours at the health facility. (ii) Shortage or lack of medicines at the health facilities. (iii) Difficulties to register with NHIS. (iv) Unprofessional conduct of health workers.	(i) Borrowed money and/or use of earnings from the sale of properties to buy medicines. (ii) Rely on herbal or traditional medication to treat their condition.	(i) Reforming the National Health Insurance Policy. (ii) Behavioral change among health workers. (iii) Lower NHIS registration fee. (iv) Extension of the NHIS renewal period instead of the annual renewal.	Health system challenges and poor quality of health-care services under the NHIS influence migrants' health-seeking behavior.
Asaana, 2015	(i) Poor care experiences often experienced by health practitioners. (ii) Long waiting times and/or delays when seeking care. (iii) Expensive allopathic care.	(i) Self-medicating and traditional medicines.	N/A	Financial challenges, negative encounters with health professionals, and limited autonomy to use health services.
Boateng <i>et al.</i> , 2017	(i) Physical challenges. (ii) Unsatisfied with drug prescriptions. (iii) Challenges in renewing their NHIS. (iv) Attitude of the care providers.	N/A	(i) Decentralizing NHIS operation to the district level. (ii) Delivery of NHIS services through mobile van.	Limited NHIS service coverage.
Nyarko & Tahiru, 2018	(i) Financial constraints. (ii) Limited NHIS coverage. (iii) Long waiting times at the health facilities.	(i) Resort to purchasing drugs from licensed medical dealers or pharmacies. (ii) Taking rest without seeking professional healthcare.	N/A	Seeking medical services from licensed chemical dealers and/or pharmacies.
Owusu-Ansah <i>et al.</i> , 2016	Financial constraints to enroll on the NHIS.	Migrants (61.1%) relied on drug stores, self-medication (3.3%), or consulted the herbalist (2.4%).	N/A	Most migrants (71.2%) had not been south for professional health services for some time.
Sznajder <i>et al.</i> , 2020	(i) Financial barriers. (ii) Long waiting hours prohibited taking time to seek healthcare.	Seeking medical help from pharmacies and drug stores/chemical sellers.	N/A	Financial difficulties and lack of social support affect migrants' sexual and reproductive health outcomes.
Rizwan <i>et al.</i> , 2022	(i) Physical barriers. (ii) Societal gender norms or male dominance. (iii) Poor quality of health-care services under the NHIS. (iv) High illiteracy rate and language barriers.	(i) Strong belief in traditional medicine. (ii) Religious power.	Design a health system that meets the needs of the migrants.	Access to health-care services is affected by cultural, financial, and social factors.

(Cont'd...)

Table 3. (Continued)

Author, year of publication	Outcome (s)			Main finding (s)
	Barrier (s)	Coping mechanism (s)	Health system factors/ Possible interventions	
Lattof, 2017	(i) Financial and language barriers. (ii) Stigma and discrimination. (iii) Long processing times to renew NHIS membership. (iv) Ignorant of the health-care costs.	(i) Relied on religious power. (ii) Self-medication. (iii) Social support. (iv) Seeking medical help from drug/licensed chemical sellers.	(i) Design culturally appropriate care. (ii) Higher indigent exemptions than the national average. (iii) Reform the NHIS's exemption criteria.	Reform and design culturally sensitive health systems.
Teye, 2019	(i) Challenges to enrolling on the NHIS. (ii) Financial barriers.	(i) Self-medication. (ii) Traditional healers or drug peddlers.	Robust NHIS system.	The majority of migrants (50.9%) have limited access to healthcare than the non-migrants (33.6%).
Owusu & Yeboah, 2018	(i) Financial and physical challenges. (ii) Long waiting times and disappointments of not receiving prescribed medication. (iii) Unsatisfactory conduct of health providers. (iv) Unequal distribution of health resources. (iv) Cultural and language differences.	N/A	(i) Substantial health investment. (ii) Develop mobile health clinics in slum areas. (iii) Behavioral change on the part of health officials. (iv) Intensive health awareness campaigns.	Economic, cultural, and institutional factors affect access to and utilization of health-care services.
Munemo <i>et al.</i> , 2021	(i) Poor attitudes of Family Planning Nurses. (ii) Male dominance, that is, cultural norms. (iii) Lack of physical access and operational days and time of health facilities.	N/A	N/A	Social and cultural barriers and institutional challenges affect the utilization of family planning services by migrant female head porters.
Lattof, 2018	Financial constraints and long waiting times at health facilities.	Rely on prayers to feel better.	N/A	Socioeconomic challenges and lack of social support affect the mental health of migrants.
Boateng, 2020	(i) Delays in processing health insurance cards. (ii) Financial barriers, that is, high out-of-pocket health expenses. (iii) Poor quality of care.	(i) The majority of migrants (67%) seek health medication from over-the-counter chemical sellers. (ii) Borrow money for their medical bills.	(i) Improve community participation in the District's Mutual Health Insurance. (ii) Introduce high indigent exemption. (iii) Establish mobile clinics and organize health outreach programs.	The majority of female head porters sought care from over-the-counter chemical sellers.
Yiran <i>et al.</i> , 2015	(i) Hostile attitude of health professionals. (ii) Proximity challenges, language barrier, longer waiting times at health facilities, and financial accessibility.	Use of over-the-counter medicines, drug peddlers, and local herbalists.	Establish a mobile health-care system.	Lack of health facilities in slum areas, high cost of maternal healthcare, delays and longer waiting times and strong preference for traditional medicines by migrants.
Shamsu-Deen & Adadow, 2019	(i) Proximity of the health facilities. (ii) Availability of health staff.	Drug peddlers, local herbalists, and licensed chemical shops.	N/A	The majority of migrants (75.5%) seek healthcare from traditional healers and licensed drug sellers.

Note: N/A represents the study did not examine the outcome.
Abbreviation: NHIS: National Health Insurance Scheme.

a study by Lattof (2017) revealed that the majority (88%) of internal migrants who worked as head porters were unaware of the procedures to register for health insurance and did not know about NHIS registration exemptions such as free antenatal and childbirth care.

3.3.2. Coping strategies of internal migrants for their health needs

Eleven studies (Akazili *et al.*, 2018; Asaana, 2015; Baada *et al.*, 2021; Boateng, 2020; Nyarko & Tahiru, 2018; Owusu-Ansah *et al.*, 2016; Rizwan *et al.*, 2022; Shamsu-Deen & Adadow, 2019; Sznajder *et al.*, 2020; Teye, 2019; Yiran *et al.*, 2015) reported on measures taken by internal migrants to access and utilize healthcare at their present locations. Four sub-themes were identified.

- (a) Local chemists, drug peddlers, and traditional healers
Eleven articles (Akazili *et al.*, 2018; Asaana, 2015; Baada *et al.*, 2021; Boateng, 2020; Nyarko & Tahiru, 2018; Owusu-Ansah *et al.*, 2016; Rizwan *et al.*, 2022; Shamsu-Deen & Adadow, 2019; Sznajder *et al.*, 2020; Teye, 2019; Yiran *et al.*, 2015) reported that internal migrants often resort to traditional healers, local chemists, and drug peddlers for herbal medicines to treat their health conditions instead of seeking help from the formal health-care system. For instance, a study by Asaana (2015) discovered that internal migrants carried traditional medicines with them when they migrated to Kumasi (or other southern part of Ghana) to treat ailments such as malaria, back pain, and flu. It was revealed that they preferred the services of traditional healers because they are affordable and allow for payment in installments when they do not have enough money (Akazili *et al.*, 2018; Baada *et al.*, 2021). Our review discovered that most of these traditional healers are from the north and can speak the migrants' northern dialects.
- (b) Savings, borrowing, and selling properties
Borrowing or selling properties was a common source of finance for internal migrants to pay for their health-care costs (Akazili *et al.*, 2018; Boateng, 2020). This trend was most prevalent among internal migrants working in the informal sector, especially head porters. This review identified that limited avenues for health support often resulted in dependence on community groups and programs that encourage internal migrants to save for their basic needs, including health-care expenditures. Thus, they often used savings meant for other essential needs, such as food and shelter, to cover health-care expenses.
- (c) Supreme being as their healer
Another significant finding from three articles (Baada *et al.*, 2021; Lattof, 2017; Rizwan *et al.*, 2022) identified

that internal migrants relied on divine interventions or higher religious powers when faced with health challenges. Many of the migrants sought or relied on religious powers for relief, especially when facing reproductive health challenges. They preferred to rely on religion rather than seeking help from neighbors or local health professionals in their new communities, due to concerns that local people would not care enough to help them or keep their information confidential.

- (d) Taking a rest
Another coping strategy identified was taking a rest without medication. A study by Nyarko & Tahiru (2018) found that internal migrants with health conditions would take some time off to recuperate and then return to work without taking any medication. Most internal migrants neither bought drugs nor visited health facilities for assessment. They perceived visiting a hospital for medical care as irrelevant unless their condition was critical.

3.3.3. Health system interventions and strategies

Recommendations on potential health system measures and interventions to improve healthcare access for internal migrants were identified in six eligible studies (Akazili *et al.*, 2018; Boateng, 2020; Boateng *et al.*, 2017; Lattof, 2017; Owusu & Yeboah, 2018; Teye, 2019). Based on the findings, five sub-themes were identified.

- (a) Reforming of the National Health Insurance Policy
Four articles (Akazili *et al.*, 2018; Boateng, 2020; Boateng *et al.*, 2017; Lattof, 2017) proposed that policymakers should review the pooled pre-payment mechanisms, such as community-based insurance schemes, for rural–urban migration populations to improve the enrolment of migrants in the scheme. Our review recommended implementing mobile van operations to bring NHIS services to slum areas where most of the internal migrants live. It was, further, suggested that an effective reimbursement system be put in place to promptly reimburse health-care providers. The authors argued for an extension of the annual NHIS renewal period to 5 years to reduce the financial and bureaucratic burdens internal migrants face when trying to renew their insurance each year. To complement the function of the NHIS, Akazili *et al.* (2018) suggested adopting a family health-care system, which would contain all relevant health information for each family, enabling internal migrants to access health services countrywide.
- (b) Restructuring primary health-care services and political support
To address proximity challenges faced by internal migrants, the articles argued for the establishment of

mobile health services and the construction of fully equipped health centers closer to slum areas (Boateng, 2020). Our review discovered that the majority of well-resourced health centers are situated in large residential areas, while the few available health facilities in smaller communities (slum areas) lack adequate resources, negatively impacting health-care delivery services, particularly reproductive health services (Owusu & Yeboah, 2018). This review, therefore, suggests the need for increased government investment in the health sector in Ghana. In addition, a study conducted by Boateng *et al.* (2017) examined the impact of the political environment on healthcare accessibility, especially in meeting the needs of the underserved. In their view, a clear political commitment to health equity is essential to tackle inequalities in health-care provision.

(c) Community participation and intensive awareness campaigns

To enhance the utilization of health services for internal migrants, two articles (Boateng, 2020; Owusu & Yeboah, 2018) reported the need for intensive health awareness campaigns and health outreach programs to change migrants' cultural orientation regarding their health-seeking behavior. Our review identified that the participation of the community in defining problems, planning, implementing, and evaluating community resources makes individuals feel responsible not only for their own health but also for that of others.

(d) Change in behavior of health workers toward clients

In terms of health professionals' attitudes toward vulnerable migrants, three articles (Akazili *et al.*, 2018; Owusu & Yeboah, 2018; Teye, 2019) recommended the need for behavioral change by introducing regular training programs for health professionals on the principles of healthcare and instituting a feedback system through client satisfaction surveys to improve health-care delivery services, particularly concerning patients' satisfaction. It was, further, reported that the attitude of health workers significantly influenced internal migrants' help-seeking behavior.

(e) Appropriate health technology and culturally appropriate care

Three articles (Akazili *et al.*, 2018; Lattot, 2017; Owusu & Yeboah, 2018) suggested the need for adequate health resources and equipment, as well as training of staff on culturally appropriate care techniques to work at health-care facilities. Adequate training involves identifying methods and equipment that facilities can afford to invest in, ensuring they do not contravene local beliefs and cultural practices.

4. Discussion

Most of the reviewed articles focused on internal migrants – rural – urban migrants' access to and utilization of health-care services in Ghana – examining the institutional, health system, and socioeconomic factors. Differences in the utilization rate of health-care services between different groups show inequity in access to and use of these services (Rodney & Hill, 2014).

4.1. Barriers to accessing and utilizing healthcare

Financial barriers to healthcare were commonly identified among internal migrants in Ghana. Despite the financial protection the NHIS guarantees, our review found that NHIS users, particularly vulnerable internal migrants, still had to pay some medical bills, discouraging them from seeking healthcare. It was discovered that due to internal migrants' low income levels, they struggle to meet their basic needs (such as food, shelter, and clothing) and cannot afford additional health-care expenses. The authors argued that internal migrants' inability to access formal health services was due to their low income. Similarly, evidence from the previous studies affirmed that economic status is a key social determinant of health (Adjei & Buor, 2012; Alfers, 2013; Gyasi *et al.*, 2016).

Institutional barriers such as physical inaccessibility and inconvenient opening hours at health-care facilities were other common obstacle for internal migrants to access and utilize formal health-care services. It was reported that many internal migrants live in slum areas far from health facilities. The previous studies (Apanga & Adam, 2015; Eliason *et al.*, 2014; Farmer *et al.*, 2015; Fayehun *et al.*, 2022; Ganle *et al.*, 2016; Otu, 2019; Saeed *et al.*, 2016) in other West African countries found similar results with regard to physical barriers to health facilities. This violates the WHO's recommendation of ensuring that health facilities are located within a 5 km radius of residential communities for quality health-care delivery (World Health Organization, 2018). On the contrary, Owusu-Ansah *et al.* (2016) reported that neither distance nor access to transportation hindered participants from accessing health facilities for their health needs. However, their study reported other barriers to healthcare access among internal migrants.

Another major obstacle to healthcare access identified in this review was the negative attitude and discriminatory behavior of health professionals (Sahile *et al.*, 2019). Evidence from other studies (Cooper *et al.*, 2019; Dauvrin & Lorant, 2014; Jakič & Pavlič, 2016) affirms that this negative attitude not only influences internal migrants' health-seeking behavior but also affects their confidence in the orthodox health system. The existence of poor attitudes

has further endangered the lives of patients, especially internal migrants, who are already in a precarious condition with regard to healthcare access (Cooper *et al.*, 2019).

It was, further, revealed that the absence of qualified translators increased the risk of internal migrants receiving improper care or being unable to follow physicians' instructions. This lack of translation services echoes observations in other studies, which revealed that language barriers threaten physicians' communication with their patients and affect their ability to give adequate medical advice (Floyd & Sakellariou, 2017; Woofter & Sudhinaraset, 2022). In addition to obvious cultural barriers such as language differences, there are also invisible cultural barriers, including gender influence, body language, notions of modesty, rules of conduct, gestures, and childbearing practices, which have been proven to influence a person's perception and approaches to healthcare (Woofter & Sudhinaraset, 2022). As this review finds, gender influence and childbearing practices influence internal migrants' behavior toward seeking reproductive health-care services in Ghana. Often, cultural differences are overlooked in their role in healthcare delivery, disregarding the fact that they can cause misunderstandings between patients and health professionals. These misunderstandings reiterate the importance of considering patients' diverse cultural values in healthcare delivery and planning (Ferdous *et al.*, 2020; Moyer *et al.*, 2013; Robertshaw *et al.*, 2017).

Moreover, this review demonstrates a widespread lack of awareness of NHIS guidelines and exemptions, such as free maternal healthcare for internal migrants who work as head porters. The NHIS has been one of the key drivers for promoting universal access to affordable and equitable healthcare, irrespective of socioeconomic background. However, the high level of ignorance and illiteracy poses a threat to achieving these goals and undermines the NHIS's ability to remove financial barriers to healthcare (Alhassan *et al.*, 2016). This lack of awareness highlights the relevance of health campaigns and awareness creation, as proposed by Dzúrová *et al.* (2014), who argue that there is no health equity without awareness.

4.2. Coping strategies of internal migrants for their health needs

Our review found that self-diagnosis and self-medication are common strategies among internal migrants. They rely on local chemists, drug peddlers, traditional healers, and local herbs brought from the north. Scientific evidence suggests that such practices could complicate their health status, as self-medicating may lead to drug addiction, allergy, incorrect diagnosis and dosage, disability, or premature death (De Sanctis *et al.*, 2020). However, many internal

migrants are unaware of these possible implications or are indifferent to their impact. Furthermore, most internal migrants rely on divine intervention or religious beliefs as their source of relief for health ailments. This observation agrees with scientific arguments that spirituality has a positive impact on health behaviors (Kharitonov, 2012; Unterrainer *et al.*, 2014). However, despite the positive influence of spirituality on general well-being, it may lead to undetected sicknesses without proper healthcare and may influence migrants to forego needed medical care or refuse life-saving procedures (Saeed *et al.*, 2016; Thomson *et al.*, 2015).

Moreover, internal migrants in Ghana were found to use monies from their savings or borrow to meet their health needs. This strategy is also prevalent in other African low- and middle-income countries such as Zambia, Cote d'Ivoire, and Chad (Etiaba *et al.*, 2015). Although this approach helps internal migrants pool money to cover health-care costs, it may worsen their future well-being as it leads to further impoverishment (Badurdeen *et al.*, 2013). In this regard, they compromise future financial returns and well-being, suffering food insecurity, poor nutrition, child labor, and reduced resilience against poverty.

Another coping strategy adopted by internal migrants is taking a break from work to recover from illness without taking any specific medication. A similar coping strategy is found among female migrant domestic workers in Singapore (Markova & Sandal, 2016; Van Bortel *et al.*, 2019). This strategy allows internal migrants to avoid the financial and physical burdens of accessing healthcare.

4.3. Potential interventions to improve healthcare access and utilization

A well-functioning health system is crucial for bridging health inequity gaps and achieving "Health for All" and "Healthy People 2030" targets, which seek to improve the health and well-being of all populations (Atun, 2012). This review highlights key interventions to improve access to and utilization of healthcare for internal migrants. The implementation of mobile health services and NHIS registration vans was cited as relevant strategies to help meet the needs of populations in slum and deprived communities. Findings support this argument, revealing that the use of mobile vans greatly helps to identify and meet the health needs of people in slum areas (Atun, 2012). Evidence from a previous study (Sorensen *et al.*, 2019) revealed that many health professionals lack adequate training in cultural competence in medical practice. Therefore, it is important for health managers and policymakers to prioritize this area.

Furthermore, organizing regular or periodic awareness campaigns and health outreach programs will educate internal migrants on the available structures and procedures to register and use formal healthcare. This approach aligns with the WHO guidelines on health promotion, which encourage health program managers, including governmental and non-governmental organizations, and policymakers to increase knowledge of interventions important for increasing access to healthcare (World Health Organization, 2015).

4.4. Public health implications

Improving access to healthcare is a key indicator of health system performance and an important mechanism to bridge health disparities experienced by vulnerable populations, particularly internal migrants (Cookson *et al.*, 2016). The findings will assist policymakers in building robust health systems that focus on equity and demographic adaptations to improve access to and use of affordable and quality healthcare for all populations. This argument is premised on the notion that designing effective interventions to improve migrant health outcomes could reduce long-term economic, health, and social costs (World Health Organization, 2015). It will also facilitate the promotion of migrant health and emphasize the need for more proactive measures to address the strategies internal migrants adopt to mitigate their inability to access and utilize appropriate healthcare.

Our review sheds light on the experiences of previous migrants, serving as a source of learning for future migrants regarding challenges during the migration trajectory and their effect on health, as well as information about existing structures and interventions for their health needs.

4.5. Strengths and limitations

The search limitation, from January 2012 to June 2022, may have excluded other relevant articles. A secondary limitation is that the analysis of qualitative data may be influenced by the cultural, political, and socioeconomic conditions existing at the time of data collection. Therefore, it is possible that data reinterpreted in this review may suggest different conclusions. However, despite these limitations, the search strategy for this review was designed to comprehensively assess significant public health and health sciences literature on internal migrants' access to and utilization of healthcare in Ghana.

5. Conclusion

This review examined internal migrants' access to and utilization of health-care services in Ghana. Most of the studies ($n = 12$ [75%]) focused on female migrants who

migrate for economic opportunities, with less attention given to children and male migrants. While access to healthcare is crucial for all populations, we found several factors affecting access to appropriate health-care services among internal migrants in Ghana. These factors included infrastructural, financial, and linguistic barriers, ignorance of NHIS structures, male dominance, hostile attitudes of some health staff, and long patient waiting times. Significantly, these barriers increased self-medication and self-diagnosis among internal migrants, leading to poor overall health outcomes. Suggestions on the implementation of mobile health services and NHIS registration van were cited as relevant to help meet the needs of populations, especially the vulnerable internal migrants, in slum areas. In addition, awareness campaigns and health outreach programs were highly recommended as a way to educate internal migrants on the available structures and procedures for registering for the NHIS and utilizing formal health-care services.

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Conflict of interest

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Author contributions

Conceptualization: Godfred Otchere

Investigation: Godfred Otchere, Samuel Egyakwa Ankomah

Methodology: Godfred Otchere, Samuel Egyakwa Ankomah, Emmanuel Kumah

Formal analysis: Godfred Otchere, Samuel Egyakwa Ankomah

Writing – original draft: Godfred Otchere, Samuel Egyakwa Ankomah, Adam Fusheini

Writing – review & editing: All authors

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