

UNIVERSITY OF GHANA
COLLEGE OF HUMANITIES

**FAMILY PLANNING DECISION MAKING AMONG NORTHERN
MIGRANT WOMEN IN MADINA**

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DECLARATION

I Petronella Munemo, hereby declare that this dissertation is the result of my own work conducted under the supervision of Dr. Mavis Dako-Gyeke and Dr. Alice Boateng. Acknowledgements have been duly made to authors whose works have been cited. No part of this work has been submitted in this university or elsewhere for any purpose.

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DEDICATION

I dedicate this work to my family, more especially my husband Dr. Augustine Ocloo and my sons Augustine Jnr. Tadiwanashe Ocloo and Martin Tafadzwa Ocloo.



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ABSTRACT

Even though, family planning is a reproductive health right to which every individual is entitled, for migrant women, family planning decisions are likely to be shrouded by many factors which may impede their right to decide. This study therefore explored family planning decision making among northern migrant women in Madina, Accra. The objectives of the study were to (a) explore how northern migrant women's migration status influence their family planning decisions and uptake, (b) find out northern migrant women's knowledge about family planning, (c) ascertain the socio-cultural norms and beliefs that influenced decisions and use of contraceptives among northern migrant women and (d) find out institutional challenges that hindered access to family planning services by northern migrant women. The study adopted a qualitative research design in which 22 participants, consisting of 19 head porters and three key informants were purposively selected. In-depth face-to-face interviews were conducted to collect data for the study. Findings indicated that, many head porters' decisions and use of family planning were tied to their migration status. In addition, it was found that, female head porters had limited family planning knowledge, in particular, the various methods and their benefits. Further findings revealed that, social and cultural factors inhibited effective family planning uptake by migrant women. Moreover, it was found that, institutional challenges constrained access and utilisation of family planning services by migrant women. Based on the findings of the study, it was concluded that, many head porters in Madina did not utilise family planning services. Accordingly, recommendations were offered to various stakeholders (social workers, Ministry of Health and organisations that offer family planning services) to promote family planning through education targeted at head porters, in order to encourage access and utilisation.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Family planning is a reproductive health right to which every individual is entitled. According to the World Health Organisation (WHO) (2005) it is beneficial, because it allows individuals to predict and attain their desired number of children, as well as the spacing and timing of births, through the use of contraceptive methods and the treatment of involuntary infertility. Family planning was made a fundamental human right, at the 1994 International Conference on Population and Development in Cairo, Egypt, where for the first time focus was shifted from concern with population growth, to a commitment on reproductive health and justice with specific emphasis on women's empowerment (Cates & Maggwa, 2014; United Nations Population Fund (UNFPA), 1996). One key recommendation, of the Cairo conference was for countries to ensure accessibility to information on contraceptives, as well as safe and effective family planning methods for citizens (UNFPA, 1996).

The conference in Cairo paved the way for many countries to make family planning programmes elements of nationwide, economic and social development programmes in order to harness equity in decision making, and encourage informed choice in family planning (Jaconson, 2000). Ghana was not an exception, the country has since made strides toward achieving universal access to family planning services through the introduction of several policies. One of which, was the introduction of the Road Map for Repositioning Family Planning, a policy, that re-emphasised commitment, awareness, acceptance and funding of family planning as important to the development agenda (Ghana Health Services, 2006). Another was the incorporation of family

planning into reproductive and child health services at all levels of the health delivery system, to ensure universal accessibility by Ghanaians (Eliason et al., 2014). These measures resulted in awareness and patronage of family planning services in the country although, the acceptance rate remained low (Eliason et al., 2014). Family planning acceptance rate is likely to be lower among migrants, because they have limited access to reproductive health care, and may face many impediments to their reproductive health and rights, due to their vulnerability at destination places (UNFPA, 1996).

Internal migrants in Ghana constitute more than 80 percent of all migrants, and of this figure, 70 percent move to urban areas particularly, large cities, such as Accra, Kumasi and Takoradi (Ackah & Medvedev, 2012). Many of these migrants are women from northern Ghana to cities in the south, where they engage mainly in informal sector activities like head portering, domestic work, bartending and street hawking (Adaawen & Jorgensen, 2012; Yeboah, 2010). According to Awumbila and Ardayfio-Schandorf (2008) migration from northern to southern Ghana, is becoming highly feminised, as women are moving independently, proving that the once male dominated phenomenon is showing considerable changes. Awumbila's assertion is supported by observations by the Ghana Living Standards Survey (GLSS), which reported that, there were more female migrants from northern Ghana as compared to male migrants from the same region (Ghana Statistical Service (GSS), 2008). Several reasons account for the exodus of women from northern to southern Ghana, which include; poverty, negative cultural practices, forced marriages, desire to make preparations towards marriage and better welfare prospects in the south (Awumbila & Ardayfio-Schandorf, 2008; Boateng & Korang-Okrah, 2013; Yeboah, 2010).

The feminisation of migration as a survival strategy provides employment opportunities, which ultimately improves women's living standards, and harnesses their agency (Awumbila &

Ardayafio-Schandorf, 2008). However, at the same time, due to its complex and multi-directional nature, migration has implications for the reproductive health of migrants (Unnithan-Kumar & Khanna, 2015). At destination places, migrants often face challenges associated with access to social services, including reproductive health (Awumbila & Ardayafio-Schandorf, 2008). Available evidence has shown that, migration often influences sexual reproductive health decisions, and this has made it an issue of great concern among researchers (Unnithan-Kumar, 2015). For example, migration could disrupt fertility of migrants as they experience separation from sexual partners or face other social, financial and cultural challenges associated with the migratory process, that influence access to and utilisation of reproductive health services at destination places (White, Tagoe, Stiff, Adazu & Smith, 2005). Seeing that migration often affects decisions on sexual behaviour and expectations on family planning, including conception, contraceptive practice and family size, the interplay between family planning and migration needs further exploration by researchers (Unnithan-Kumar, 2015). Thus, this study sought to investigate family planning decision making with focus on northern migrant women.

1.2 Statement of the Problem

Access to family planning has increased in many parts of the world, but remains low in sub-Saharan Africa (World Health Organisation (WHO), 2015). In Ghana, the total demand for family planning services is 51 percent, yet only 33 percent of this number is satisfied (Population Reference Bureau, 2015). This, according to the Ghana Demographic and Health Survey suggests that, many Ghanaian women still have unmet need for family planning (GSS, 2009). This could be due to the fact that, decisions related to reproduction, family size and contraceptive use are among some of the most difficult choices women, have to make (Mosha, Ruben & Kakoko, 2013).

Generally, decisions to practice or not to practice family planning are complex, and require considerable amount of power, and are influenced by several factors that impede on individuals' right to decide (Romero, Greenely, Vereas & Salas-Lopez, 2007; Olaitan, 2011). Although, there are many social and economic incentives and disincentives that affect individual decisions about child bearing and family size, there is widespread consensus that family planning requires decisions which may be multifaceted especially for women (Romero et al., 2007; UNFPA, 1996). For instance, culturally, in Ghana and other African countries, gender norms play a direct role on family planning decisions, by restricting women's participation in decision making processes, especially women, such as migrants who may be vulnerable and less empowered (Awingura & Ayamba, 2015; Bawa & Sanyare, 2013; Darteh, Doku & Esia-Donkoh, 2014; Guttmacher Institute and International Planned Parenthood Federation (GIIPPF), 2010).

Migrant women most often are confronted with norms, attitudes and practices about fertility and child rearing that exist in receiving communities, which influence their family planning choices and decisions (Schmid & Kohls, 2009). Moreover, barriers to healthcare services for migrants often arise due to financial constraints, cultural and language differences as well as lack of adequate information at destination places (UNDP, 2009). Inadequate knowledge about reproductive health services (e.g. information regarding family planning, use of contraceptives and transmission routes of HIV and AIDS) among migrant women has been reported by UNFPA (2013).

Sadly, many migrant women are not properly informed about the various methods available and how they work, which impact adversely on their decisions to utilise its services (Malini & Narayan, 2014). In addition, there seems to be inequities among populations with regard to accessing family planning services, as wealthier groups enjoy better access and use than the

poorest. For instance, migrants are likely to face even worse inequalities in accessing family planning services as compared to permanent inhabitants in settlements areas (Cates & Maggwa, 2014; WHO, 2010). In spite of the positive outcomes associated with migration, migrant groups are still considered vulnerable because they are at risk of ill health as a result of structural constraints which limit their access to culturally appropriate and affordable healthcare including family planning (Derose, Escarce & Lurie, 2007; Grove & Zwi, 2006).

While numerous efforts have been made to improve family planning usage in Ghana, there is still low usage among migrant women as compared to natives in destination areas (Gaetano, Lutuf, Zaake & Annika, 2014). Given that migration alters reproductive decisions and contraceptive use, it is essential to unearth how migrant women make family planning choices (Maternowska et al., 2010). Moreover, though much research has been conducted on migration (Adaawen & Jorgensen, 2012; Awumbila & Ardayfio-Schandorf, 2008; Yeboah, 2010) and family planning (Darteh et al., 2014; Eliason et al., 2014; Awingura & Ayamba, 2015) in Ghana, family planning remains largely unexplored among migrant female head porters. Also, since extant research, does not focus much on the interplay between migration and reproductive health, more research is needed to delve into migrant women's family planning decision making. This gap in literature necessitates this research to be carried out in order to unravel how migrant women in Madina make family planning choices.

1.3 Objectives of the Study

The objectives of the study were:

1. To explore how northern migrant women's migration status influences their family planning decisions and uptake in Madina.
2. To find out northern migrant women's knowledge about family planning in Madina.

3. To ascertain the socio-cultural norms and beliefs that influence decisions and use of contraceptives among northern migrant women in Madina.
4. To find out institutional challenges that hinder access to family planning services by northern migrant women in Madina.

1.4 Research Questions

The study answered the following questions:

1. How does northern migrant women's migration status influence their family planning decisions and uptake in Madina?
2. What knowledge do northern migrant women in Madina have about family planning?
3. What are the socio-cultural norms and beliefs that influence northern migrant women's decisions and use of contraceptives in Madina?
4. What institutional challenges hinder access to family planning services by northern migrant women in Madina?

1.5 Significance of the Study

It is hoped that findings of this study would contribute to research, policy and social work practice. Findings of the present study are expected to contribute to the discourse on migration and health. These findings would highlight the interplay between migration and family planning, and as such could be beneficial to future researchers who wish to undertake studies in the same field. Moreover, other researchers could use findings of this study, as reference material to undertake further studies that would investigate how migration influences family planning decision making among female migrants elsewhere in Ghana.

Adequate or inadequate knowledge of family planning could influence family planning decisions among migrants, therefore findings of this study would provide evidence on how family planning knowledge could influence uptake of services. Accordingly, through publication and dissemination of the findings to policy making bodies, it is hoped that, findings of this study would provide information that could influence the design and implementation of policies in the area of migration and health. Moreover, findings of the study would generate insights to serve as basis for effective educational programmes by the Ministry of Health and other stakeholders, in order to disseminate reproductive health information to migrants.

Findings on social and cultural factors that influence contraceptive use would provide evidence and facts to social work practitioners that could influence appropriate interventions. Social workers could use the findings on social, cultural and institutional challenges that impede access and utilisation of family planning services, to advocate for better access to such services by migrant women. In addition, social workers could formulate strategies in order to eliminate such barriers and promote equitable access to reproductive health services.

1.6 Study Area

Madina is a multi-ethnic and fast growing sub-urban town in the La-Nkwantanang Madina Municipal in the Greater Accra Region of Ghana. It is one of the 16 Metropolitan, Municipal and District Assemblies in the Region which was established in 2012 as part of the newly created Assemblies. Located in the northern part of the Greater Accra Region, this municipal covers a total land surface area of 70.887 square kilometres. It is bordered on the West by the Ga East Municipal, on the East by the Adentan Municipal, the South by Accra Metropolitan Area and the North by the Akwapim South District. The total population of the Municipality in 2010 was 111,926 comprising 48.5 percent males against 51.5 percent females. La-Nkwantanang Madina

Municipality is generally urban. The main economic activity in Madina is farming and trading, with Madina market as the main trading centre (Ghana Statistical Services, 2014).

The indigenous people of La-Nkwantanang Madina Municipal are Ga Dangmes, but the area is home to other ethnic groups such as Ewes, Akans, Nzema, Guans, Gonja, Dagomba, Wala, Frafra, and Hausa among others. Of the total population of 111,926 in the Municipality, 65.7 percent (73,545) are migrants who were born elsewhere in the Greater Accra Region or other regions in Ghana or outside Ghana. The high proportion of migrants in the Municipality, who are attracted from all over the country to the area in search of jobs and other economic opportunities makes the La-Nkwantanang Madina Municipality one of the cosmopolitan Municipalities in the Country (Ghana Statistical Services, 2014).

1.7 Definition of Terms

Family planning: Spacing, control of fertility and family size through the use of traditional or modern contraceptive methods.

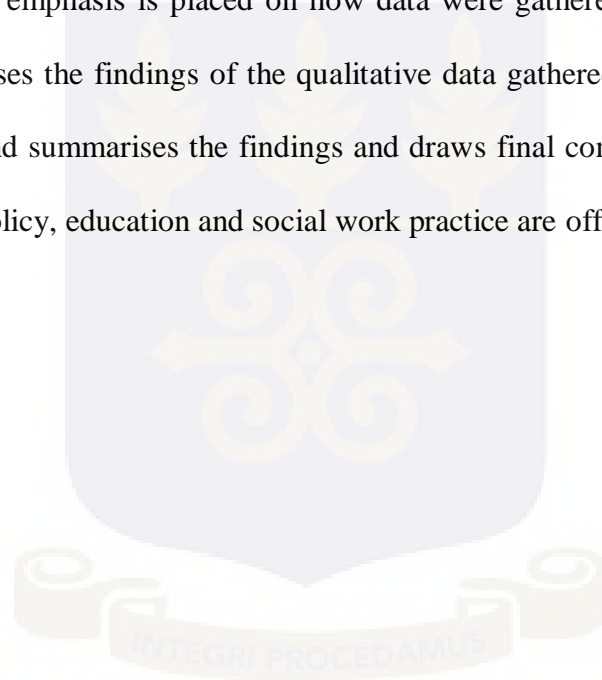
Decision making: The process of making choices among alternatives with the intention of moving toward some desired state of affairs (McShane & Von Glinow, 2013).

Contraceptives: Modern or traditional methods used to control fertility, prevent pregnancy or space the birth of children.

Migrant: A person who has moved to and stayed at his or her current place of residence for at least one year (GSS, 2008).

1.8 Organisation of the Study

The thesis is organised into five chapters; chapter one provides the introduction and orientation of the study, in which a brief background on migration, family planning and decision making is given. The problem statement, objectives, significance of the study and definition of key concepts are presented and explained. Chapter two presents a review of related literature and discusses the theoretical perspective adopted for the study. Chapter three looks at the research methodology that was employed in the study and provides justification for selected techniques that were used. Specific emphasis is placed on how data were gathered and analysed. Chapter four presents and discusses the findings of the qualitative data gathered from the field. Finally, chapter five discusses and summarises the findings and draws final conclusions of the research. Recommendations for policy, education and social work practice are offered.



CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL PERSPECTIVE

2.1 Introduction

This chapter presents a review of relevant literature on migration and family planning decision making. Literature review is necessary in any study because, it demonstrates essential theories, arguments and controversies and highlights the ways to which research in the area has been undertaken by others (Gray, 2009). The topics covered in the literature review include; (a) the influence of migration on migrants' family planning decisions and uptake, (b) migrant women's knowledge about family planning, (c) socio-cultural norms and beliefs that influence contraceptive use, (d) institutional challenges that hinder access to family planning services. Additionally, the theory of planned behaviour and its relevance to the study are discussed.

2.2 Migration and Family Planning Decisions

Migration discourses seem to suggest that migration interferes with family planning decisions during and after the migratory process, as a result of changes associated with the process (Brockhoff & Yang, 1994; White et al., 2005). For a clear demonstration on the interplay between migration and family planning decisions, the section discusses the following areas; (a) migration in Ghana, (b) family formation in Northern Ghana, (c) family planning in urban areas, and (d) women's role in family planning decisions.

2.2.1 Migration in Ghana

In Africa, rural-urban migration is very much prevalent and accounts for more than one half of city growths (Barrios, Bertinelli, Strobl, 2006). In Ghana, internal migration has been and is at the centre of many research projects. Of particular interest is the north-south migration which is fuelled by unequal distribution of development in the country (Awumbila & Ardayfio-Schandorf,

2008; Yeboah, 2010). Thus, migration in Ghana, like anywhere else in the world is due to imbalances in development which exist between origin and destination areas (UNFPA, 2013). Consequently, this has contributed to the exodus of migrants from the north to the south which is perceived to be a haven of economic success (Yeboah, 2010). Many migrants in Ghana were identified by Abdul-Korah (2008), as permanent settlers in the south with their families, whilst others remain seasonal, consisting mainly of farmers and labourers from the North migrating to the south during the dry season in search of work.

Furthermore, Mensah-Bonsu (2003) in a study on migration and environmental pressure in Ghana identified four types of migration: (a) rural-urban, (b) rural-rural, (c) urban-rural and (d) urban-urban. Rural-rural and rural-urban were identified as the most important types of migration due to the fact that, they were responsible for the rapid increase in the population of towns. In another vein, other scholars (Boakye-Yiadom & MacKay, 2007) categorised migration in Ghana in terms of international and internal movement of people. They identified the migration of well trained and educated professionals abroad to seek greener pastures, as well as that of rural youth with few skills from underdeveloped regions to cities, to engage in menial jobs.

Earlier migration discourses, viewed women as passive participants in the migratory process, who moved in the company of their spouses or to join spouses who were already settlers in the south or to stay with relatives (Awumbila & Schandorf, 2008; Opare, 2003). Nonetheless, this trend has seen significant changes, showing independent participation of women in the migratory streams towards the south in search of better economic opportunities and cultural emancipation (Awumbila & Schandorf, 2008, Yeboah, 2010). The increased migration of women from the

north to the south was also, documented by GSS (2008) which indicated that, more females (43%) migrated from northern Ghana as compared to males (37%) from the same region.

North-south female migration was also observed in a mixed methods study by Awumbila and Schandorf (2008) on internal migration, vulnerability and female porters in Accra. Structured questionnaires, focus group discussions, case histories and key informant interviews were used to collect data from 100 participants, selected through purposive sampling. Their findings ascertained that, migration to the south to work in the informal sector, particularly head portage was dominated by women 45 years and below. This finding was substantiated by Yeboah (2010) and Boateng and Korang-Okrah (2013). Using a mixed methods approach, Yeboah employed structured questionnaires, in-depth interviews, focus group discussions and case histories to collect data from 120 participants in a study on gender and livelihoods among porters in Accra. Findings of this study indicated that, majority of migrants, mostly women worked in the informal sector as head porters, though some of them engaged in other activities, such as cleaning peoples' homes and washing, to supplement their income.

2.2.2 Family Formation in Northern Ghana

Polygamy is predominantly practised in the north and large families are desired as the outcome of such marriages (Nukunya, 2003). The three northern regions Upper East, Upper West and Northern are highly patriarchal, and as a result power and decision making are vested in males. A patrilineal system, where lineage is traced through the male descent is dominant among people of northern Ghana (Nukunya, 2003). Consequently, in a patrilineal system, once married, a wife is expected to take up residence in the husband's compound (patrilocal), where she is obligated to produce many children for the husband's lineage. This according to scholars (e.g. Bawah,

Akweongo, Simmons & Phillips, 1999), explains the high fertility observed in northern Ghana, as well as the universalisation of arranged marriages among teenagers.

Moreover, given the polygamous nature of marriages in northern Ghana and the payment of bride price, giving birth to many children to maintain one's husband's lineage becomes paramount as a result of competition among wives for husband's affection (Bawah et al., 1999). These intricate issues have implications for family planning decision making and use among women. Various research (e.g. Awingura & Ayamba, 2015; Bawah et al., 1999) have shown under-utilisation of contraceptives in northern Ghana. Some of the reasons for the low utilisation of contraceptives by women in northern Ghana were identified by Bawah et al. (1999) in a study that explored the impact of family planning on gender relations in northern Ghana. Random and purposeful sampling techniques were used to select participants for 36 focus group discussions. Findings of this study indicated that, women in their reproductive ages (18-49) did not practise modern contraception, due to fear of punishment and resistance from men and other family members. Participants in this study feared that using modern contraceptives could lead to preference for another wife and in worst case scenarios, divorce (Bawah et al., 1999).

A recent descriptive cross sectional study by Awingura and Ayamba (2015) examined factors influencing the uptake of family planning services in the Talensi District, Ghana. The researchers selected 280 respondents, using a systematic random sampling technique and analysed the data using SPSS version 21.0. The authors concluded that, though many women were aware of family planning services in the Talensi district, the uptake of the service was low due to factors, such as husband's opposition and misconceptions about family planning. Reasons cited for non-utilisation of contraceptives by participants, reaffirm the notion that customs surrounding marriage, family formation and relationships between couples tend to maintain lineages, promote

fertility and protect the extended household. For this reason, women's decisions to take control over their reproductive lives imply that, they are not willing to perform their reproductive responsibilities (Bawah et al., 1999).

2.2.3 Family Planning in Urban Areas

Migration and its related changes are perceived to interfere with family planning choices during and after the migratory process (Brockhoff & Yang, 1994). This is because characteristics associated with migration for example, socio-economic factors and whether individuals are migrating alone or as couples, affect fertility directly or indirectly. Direct influences dwell on the lack of knowledge on where to get family planning services and indirectly as the migrants' routine is disrupted resulting in high or low fertility (White et al., 2005).

White and colleagues (2005) conducted a quantitative study on urbanisation and fertility transition in Ghana, which examined the way in which migration and urban residence operate to alter fertility outcomes. The study utilised data from the Kumasi Peri-Urban survey, and used stratified sampling technique to select 747 migrant women of reproductive ages. Quantitative data analysis was carried out, using Ordinary Least Squares, Poisson and Logit Models. Their findings showed that, adaptation and socialisation to urban fertility norms were significantly correlated with fertility decline. This they associated to influential reasons and everyday life constraints in urban areas, which predispose migrant women to make different family planning choices, leading to fertility decline. Findings of their survey further revealed that, the migratory process disrupted migrant's fertility only temporarily, such that recent migrants exhibited lower fertility than second generation residents. The reason for this was cited as, the absence of sexual partners who were either at the places of origin or undertaking circular migration, thus migrant women were at less risk of conception. The authors concluded among other things that,

migration into urban areas might erode traditional or cultural practices that govern sexuality, resulting in high fertility known as the disruption hypothesis (White et al., 2005).

Additionally, Majelantle and Navaneetheam (2013) reviewed various theories and evidences on migration and fertility and suggested that indeed, fertility adaptation of circular and seasonal migrants might not see significant changes, as they may have weaker motivation to adapt as compared to permanent migrants. However, according to the authors, the adaptation process takes effect over a long period of time and is gradual. Notwithstanding the above observations, migrants' fertility, to some extent mimic that of natives at the place of destination in terms of total number of children (Chattopadhyay, White & Debpuur, 2006). Chattopadhyay et al., conducted a quantitative study on migrant fertility in Ghana. Their study utilised secondary data from the Ghana Demographic Health Survey (1998-1999). Four thousand, eight hundred and forty-three women between the ages of 15-49 were selected through a stratified probability sampling technique and quantitative analysis of the data revealed that, migrant fertility at places of origin is significantly different from non-migrant fertility and that migrants adopt the fertility regime of the destination area before migrating.

Chattopadhyay and colleagues' (2006) findings point toward the selection hypothesis, which is characterised by the tendency for migrants to be selected based on individual characteristics such as education, age at marriage and employment among others. A typical example is, the likelihood of highly educated migrant women to urban areas, having fewer children than rural non-migrants who are less educated, contributing to lower fertility rates in urban areas (Goldstein & Goldstein, 1981). Moreover, increased women's participation in family decisions as they become more financially independent, leads to their ability to make reproductive decisions resulting in a change in fertility outcomes (Mosha et al., 2013). In Ghana for example, findings

from a study by Chattopadhyay and contemporaries showed a decrease in urban fertility among migrant women which was related to the increase in contraceptive use and other fertility depressing factors often associated with urban life. This, according to Masanja (2014) implies that, while traditional norms are replaced with modern ones, values and behaviours towards family planning among urban female migrants experience a shift.

At destination places, migrants become financially and sexually liberated as a result of the removal of traditional controls over sexual behaviour and access to employment. This can be viewed as a double edged sword, because on the one side, women may attain greater freedom to choose and control their fertility, but on the other side, they may engage in high risk sexual behaviours with little contraceptive use (Brockhoff, 1995; Greif & Nii-Amoo Dodoo, 2011). This is better illustrated by findings from a study on sexuality, migration and AIDS in Ghana by Arnafi (1993). The study found that, the increase of HIV and AIDS is linked to the movement of women from rural to urban areas, where due to inadequate income engage in risky behaviours resulting in exposure to infections and less use of contraception.

Variations in attitudes towards family planning exist between migrant and non-migrant women. Migrant women as noted above, due to constraints in their receiving communities social or economic may adapt to fertility patterns and family planning behaviours of women who are natives in these communities (Omondi & Ayiemba, 2003). Contrary to findings which suggest that, urban women use contraceptives more than rural women, a more recent study by Machiyama and Cleland (2014) in Ghana, which analysed five Demographic and Health Surveys from 1988-2008 suggest otherwise. Findings of their research revealed that, majority of women in Accra in particular those in the wealth quintile, did not use modern contraceptives, which they attributed to a possible reluctance in reporting use. However, the study indicated that, though

many women were not using contraceptives majority (54%), also showed an intention to use contraceptives in the future.

2.2.4 Women's Role in Family Planning Decisions

Some studies (Roger & Earnest, 2014) have determined that, both men and women make decisions on family planning issues. Roger and Earnest (2014) examined contraceptive and reproductive health of Sudanese and Eritrean migrants in Australia. The qualitative study used focus group discussions and in-depth interviews to collect data from participants, who were migrants and key informants selected using snowball and purposive sampling techniques. A thematic content analysis of the data was carried out and the authors concluded that, even though women participated in family planning decisions, the final say in that regard, rested with the men.

Despite the fact that, migrant women may not have the final say in decisions to practice contraception, it is common for them to adopt strategies that ensure some degree of control over their reproductive health. One of these strategies is to use contraceptives in secrecy especially injectables, to prevent unwanted pregnancies (Awingura & Ayamba, 2015; Farmer et al., 2015; Mosha et al., 2013; Roger & Earnest, 2014). Non-migrants women are also faced with situation in which they might have to take decisions towards contraceptive use. This is because, challenges women face with regards to family planning decision making, are to some extent universal regardless of their status (Mosha et al., 2013).

Mosha et al. (2013) investigated family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania. The study purposively selected 98 participants between ages 18-49 and utilised focus group discussions and in-depth interviews to gather data. Content

analysis of the data showed that women used family planning without their husband's consent, as a deliberate effort to protect their health and wellbeing, and that of their children. The reasons participants gave for adopting this strategy, were to ensure that, they had control to plan and space the birth of their children. Findings by Mosha and contemporaries support assertions by White and contemporaries (2005) that, migrant women who are economically active deliberately restrain their fertility by practising contraception, in order to settle and adapt into modern economic and social life in the city.

Most recently, Farmer et al. (2015) conducted a qualitative study on motivations and constraints to family planning in Rwanda. The researchers selected 159 participants through a simple random sampling technique, and used semi-structured interviews and focus group discussions to collect data. Findings of their study revealed that, participants were in agreement that, without husband's consent, contraception had to be used secretly. Women participants further stated that, family planning was a woman's issue, and that men should not interfere. Using contraception in secret is not the only strategy women resort to, in order to control fertility. Extreme measures such as abortion can also be adopted. Orner and colleagues (2010) examined, HIV-positive pregnant women's decisions regarding abortion in Cape Town, South Africa. In-depth interviews were used to collect data from 24 women, and findings revealed that, most women who were HIV positive chose abortion as a method of contraception because they felt the burden to care for children was largely theirs. This depicts the role women play in making reproductive health decisions.

In some cases, women are bold to insist on condom use from their sexual partners. Marternowska et al., (2010) conducted a study on Mexican migrant women in California. The researchers selected and interviewed 44 participants. Findings indicated that, many of the women

participants insisted on condom use from their partners, thereby showing a greater desire to take charge of their fertility. Women in the study expressed that sometimes they cross the border into Mexico just to get contraceptives, due to easy access and affordability.

Contrary to the finding that women insist on condom use from sexual partners, research findings by Darteh and contemporaries (2014) on reproductive health decision making among Ghanaian women, suggest otherwise. Their survey of 3 124 women based on the 2008 Ghana Demographic and Health Survey found that, about one-fifth of Ghanaian women could not decline a request for sexual intercourse from their partners, whilst one in four women could not insist on condom use from a partner either. In some cultures contraceptive use is seen as the woman's decision to make, because women are expected to know about contraceptives so men do not have to worry about it, however these decisions might be restricted due to less decision making power among women (Martenowska et al., 2010; Darteh et al., 2014, Roger and Earnest, 2014).

2.3 Migrant Women's Knowledge of Family Planning

Information on family planning and its various services is essential in promoting access and utilisation (Omedi & Nyauchi, 2015). Despite this assertion, family planning knowledge is generally low among many women, which ultimately influences access and utilisation. Observations have been made that, women's knowledge levels on family planning vary depending on their migration status, place of residence (rural or urban), education and economic status (Lindstrom & Hernandez, 2006; Omondi & Ayiemba, 2003; Zhang et al., n.d). For migrants, access to information on family planning is very limited (UNFPA, 2013). This affirms insights by many scholars (Gizaw & Regassa, 2011; Maternowska et al., 2010; Omedi & Nyauchi, 2015) that, many impediments faced by individuals and couples who want to practice

family planning, are associated with limited or lack of knowledge about various methods, where to access and how to use them.

2.3.1 What do Women Know about Contraceptives and its Usage?

Lindstrom and Hernandez (2006) conducted a quantitative study, on internal migration and contraceptive knowledge and use in Guatemala, to examine how migration status and duration of residence in an urban area are associated with modern contraceptive knowledge and use. The researchers used the 1999 Guatemalan Migration and Reproductive Health Survey data. Nine hundred and seventy-one respondents were randomly selected, and results indicated low contraceptive knowledge among migrants within the first few years of migration, which increased with long duration of stay in an urban area. The authors concluded that, indeed migrant women possessed limited knowledge of modern contraceptives, which ultimately affected their family planning uptake during the first years in an urban destination.

Maternowska and colleagues (2010) documented limited knowledge on family planning, in terms of various methods of contraception among Mexican migrants in California. Participants in their study only showed awareness of one family planning method; the condom, but were oblivious to other methods of contraception. This finding was substantiated by Roger and Earnest (2014) in a study on Sudanese and Eritrean immigrants in Australia. Findings of the study showed that, migrant women had fair knowledge of family planning, though the knowledge varied between age groups. Their research findings further revealed that, varying knowledge existed with regard to types of contraception, with participants exhibiting more knowledge on the condom, and less knowledge of other methods.

Similarly, Omedi and Nyauchi (2015) observed limited knowledge on family planning among their respondents in Malawi. The study, on contraceptive usage in Malawi among currently married women, used the 2010 Malawi Demographic and Health Survey data and employed descriptive and binary regression analysis to analyse the data. Findings showed lack of knowledge on particular family planning methods and where to access them, as the main reason for respondents' inability to access and utilise services.

While some studies (Maternowska et al., 2010; Roger & Earnest, 2014) established that, women have little knowledge on contraceptives and other family planning services, other findings suggest otherwise. Kaphle (2013) conducted a quantitative descriptive survey on awareness and reproductive health rights among women in Nepal. The survey used 101 women, selected through a non-probability purposive sampling technique. Results showed that, many respondents (98%) had knowledge on family planning. Findings of the study further indicated that, the majority of women (98%) were knowledgeable about birth spacing and contraceptive use, which was associated with the deliberate education of women by the government and other organisations in the country on family planning. This discrepancy could be due to the status of women, while participants in the studies by Maternowska et al. and Roger and Earnest were migrant women, Kaphle's respondents were a cross section of women, who could have included both migrants and non-migrants in Nepal, and could have taken advantage of an array of available reproductive health services.

According to Omedi and Nyauchi (2015), many women do not have adequate information on family planning and contraceptive methods, regarding accessibility and utilisation, to their benefit. The ramifications of this are that, women especially migrants, are then less able to control their fertility effectively (Lindstrom & Hernandez, 2006). This assertion is supported by

findings from a study on Mexican migrants in California, which showed that, many participants considered the condom as a means of preventing pregnancy, but did not know that it could be used for the prevention of sexually transmitted infections (STIs) and HIV and AIDS (Maternowska et al., 2010). As found in the study on Mexican migrants in California (Maternowska et al., 2010), migrants to urban areas do not immediately have improved access to information and services, but are able to accumulate adequate knowledge over time, resulting in effective use of family planning services (Lindstrom & Hernandez, 2006).

2.3.2 Rural Urban Divide and Family Planning

Place of residence is another contributing factor which influences knowledge on family planning. In China, Zhang et al. (n.d) carried out a household survey using semi-structured questionnaires, on rural to urban migrants' awareness on reproductive health. The researchers used a sample of 519 migrants of ages 18-49, who were randomly sampled using stratified and multistage techniques. Findings of their study revealed that, migrants' knowledge on reproductive health rights was low among new migrants from rural areas, as compared to those living in urban areas. The majority of migrants in the study were noted to be unaware of what reproductive rights are or what reproductive health is.

In a different context, similar findings were observed by Omondi and Ayiemba (2003) in a study that investigated the relationships between migration and the determinants of contraceptive in Kenya. The survey used a sample of 7150 Kenyan women between ages 15-49, based on the 1988/89 Kenya Demographic and Health Survey. Using cross tabulation and logistic regression analysis, it was observed that, women migrants in urban areas were more knowledgeable about contraceptives, and usage was high among this group as compared to migrant women in rural areas. The researchers attributed this to the constraints in urban areas, associated with high cost

of family maintenance, pointing to the fact that, changes in the social and economic context may limit the desire for more children among migrants, leading to higher demand for family planning. In California, lack of knowledge as a result of place of residence, was also observed in a study on Mexican migrants. These migrants were found to have limited knowledge on family planning, because in their places of origin sexual reproductive health issues are not talked about openly, hence people feel shy to make enquiries in that regard, resulting in low knowledge levels on the issue (Maternwoska et al., 2010).

While the distribution of family planning services is limited in rural areas, the opposite is true in urban areas, due to greater exposure and supply of family planning services (Lindstrom and Hernandez, 2006). As found in Guatemala, migrants from rural areas were only less knowledgeable about contraceptives and its usage, during the first years of settling in their new destinations. Their knowledge levels however, slightly increased below that of urban non-migrants (Lindstrom and Hernandez, 2006). These observations reaffirm the notion that, place of residence has an influence on knowledge on family planning and other reproductive health matters.

2.3.3 Sources of Knowledge on Family Planning

According to Lindstrom and Hernandez (2006) urban areas offer greater publicity to information about family planning, through print and broadcast media. Exposure to family planning and related matters through the media is well documented. Research (Gizaw & Regassa, 2011; Lindstrom & Hernandez, 2006) has shown that, exposure to the media exerts tremendous influence on family planning services utilisation. As observed by Omedi and Nyauchi (2015) in Malawi, women in their study who were exposed to the media (radio, television and internet)

utilised more family planning services as compared to those who were not exposed, who consequently utilised few family planning services.

Mass media, including radio was observed to have profound influence on women's decisions to patronise family planning services, particularly those who cannot read and write (Gizaw & Regassa, 2011; Omedi & Nyauchi, 2015). Gizaw and Regassa (2011) conducted a quantitative cross-sectional study aimed at identifying demographic and socio-economic barriers to family planning service utilisation in Ethiopia. Data were collected from 551 women of ages 15-49, selected through a systematic random sampling technique. Observations were made that, women who had no media exposure were about 56.7 percent less likely to use a family planning method, as compared to women who had media exposure. The radio was documented to be more favourable due to low levels of literacy among many women (Gizaw & Regassa, 2011). In addition, healthcare workers and other women (friends and family) practising family planning have been found to be useful in disseminating information on services and usage (Omedi & Nyauchi, 2015; Zhang, n.d). In Nepal a quantitative study by Kaphle (2013) indicated that, majority of respondents (53.6%) cited healthcare workers as their major source of information on reproductive health and few respondents (4.3%) cited family and friends as their main source of information.

While Kaphle's findings pointed to healthcare workers as major sources of information, Zhang et al. (n.d) found the opposite. In a study in China, friends and family were cited by respondents as important sources of information on reproductive health to new migrants in urban areas. Migrants who had social networks at destinations were found to have better understanding of reproductive health. Their findings further revealed that migrants who extended their social networks by making new friends with local residents had more knowledge on reproductive

health rights than those who maintained their hometown social networks at urban destination (Zhang et al., (n.d)). These findings validate Olaitan's (2011) view that an individual's social environment has intense influence on family planning decisions, as they are often made with reference to the choices of other people in the same social network.

2.4 Socio-Cultural Norms and Beliefs that Influence Contraceptive Decisions and Use

Numerous social and cultural norms and beliefs have been found to influence women's decisions on contraceptive use. Among these are; gender and family dynamics, religion, education and fear of side effects (Awingura & Ayamba, 2015; Mosha et al., 2013; Olaitan, 2011; Palamuleni, 2014; Schuler, Rottach & Mukiri, 2011).

2.4.1 Gender and Family Dynamics and Contraceptive Use

Despite the fact that, women's involvement in domestic decision making is increasing and recognised as influencing their capability to make reproductive decisions, the reality however, is that, in many developing countries, men are often the primary decision makers on sexual activity, fertility and contraceptive use (Mosha, et al., 2013; Dereje, Zewdie, Kaufman & Bezawit, 2015). As a result, many men in Africa and other developing countries tend to object to the practise of family planning (Olaitan, 2011).

Gender norms for instance, give women low social status which in turn, affects their family planning decision making (GIPPF, 2010). Male superiority within traditional roles impacts women's decisions on various issues, but most importantly, those regarding reproduction (Martenowska et al., 2010; Hou & Ma, 2011; Dereje et al., 2015). In other words, male dominance in decision making restricts family planning uptake by women. A better illustration of how male dominance can impact decisions on reproduction is observed in a study in Ethiopia.

Dereje and colleagues (2015) explored the influence of gender norms on family planning decision making. The qualitative study used a grounded theory approach, and employed in-depth interviews and focus group discussions to collect data from 81 participants (35 men, 32 women and 14 key informants). Findings of the study indicated that, decision making power of men and husbands on family planning as well as dominance of men in household decisions acted as barriers to family planning utilisation by women. The authors concluded that, due to men's dominance at the household level and other related factors, the role of women on family planning decision making was limited to merely accepting the decisions of men or husbands.

Schuler and colleagues (2011) examined the interplay between gender norms and family planning decision-making in Tanzania. The researchers used face-to-face interviews and focus group discussions to collect data from 108 participants. Data was subjected to thematic analysis and findings revealed that, cultural factors related to gender limited discussions on sexual matters especially in rural areas. Participants in the study expressed that, it was inappropriate for women to initiate discussions on reproductive health as these were reserved for men as heads of families, and as such, women were only expected to play supportive roles as carers and bearers of children.

As found in the study by Dereje and contemporaries (2015) in Ethiopia, given that men have the final say in reproductive decisions women who go contrary to their husbands' opposition to family planning uptake are beaten or divorced. As expressed in the views of participants, compliance with one's husband was the only way to avoid beatings and the shame of divorce. Sometimes, consequences go beyond beatings, to accusations of infidelity or promiscuity hence, women are apprehensive to insist on using contraceptives, lest they destroy their relationships, which influences their decisions and uptake (Mosha et al., 2013). Additionally, a qualitative

study in Rwanda by Farmer and colleagues (2015) found that, unmarried and young women faced stigma when they attempted to access family planning services as they were often judged and labelled as prostitutes. Findings further showed reluctance in using family planning among single women due to fear of discrimination.

In some cases, the institutions that offer family planning services are in themselves patriarchal as they require consent from men before services are rendered (Mosha et al., 2013). As documented in Rwanda by Farmer et al. (2015), some health care centres had informal and unwritten rules which required women to be accompanied by a male partner, if they wished to access family planning services. Another important issue to point out is the influence gender dynamics have on communication between couples with regard to family planning. Many couples do not discuss family planning (Martenowska et al., 2010). In California, Maternowska and colleagues (2011) observed that, couples did not discuss child birth and family planning, and that the first child was expected within the first year of a couple's union, in order to prove fertility. Women in this study expressed the desire to postpone childbirth, but unfortunately could not communicate this to their partners as culture imposed restrictions on them.

The involvement and agreement of men in decisions to use contraceptives is very important to women (Olaitan, 2011; Awingura & Ayamba, 2015). Akafuah and Sossou (2008), highlighted the role of men in family planning decision making, in a study conducted in Ghana, on attitudes and use of family planning among Ghanaian men. The study utilised a sample of 200 men who were conveniently selected, data was collected using questionnaires and in-depth interviews. Based on the findings, it was concluded that, indeed men play an important and prominent role in reproductive decision making and family planning practices, as respondents in their study showed an interest in learning about sexual matters and contraception. Thus, the higher the

partner's involvement, the more likely the woman is to make favourable decisions toward contraceptive use and family planning. The popular view still exists that contraceptive use should be agreed to by the partner or husband. Thus without the husband's approval as family head, women cannot make independent decisions to use contraceptives (Awingura & Ayamba, 2015; Mosha, et al., 2013; Roger & Earnest, 2014).

The agreement and involvement of male partners in family planning decisions is crucial as it promotes family planning uptake by women. Olaitan (2011) conducted a quantitative descriptive study in Southwest Nigeria, on factors influencing the choice of family planning. One thousand two hundred respondents were selected through a multistage sampling technique and questionnaires were used to collect data. Findings of the study revealed that, the agreement and involvement of male partners was an important determinant when choosing family planning methods. Therefore, partner or husband's consent in family planning decisions is very critical, and as such, utilisation of contraceptives without husband's support can result in dire consequences for women. This finding was re-established by Awingura and Ayamba (2015) in Ghana that, opposition and disagreements from husbands resulted in the majority of women not accessing and utilising contraceptives.

2.4.2 Religion and Contraceptive Use

Religion exerts profound influence on family planning matters, since the degree of one's commitment to the norms of any given religion impacts his or her way of life (Palamuleni, 2014). In addition, traditional beliefs significantly influence family planning issues. For example, in Ghana, mainly in the northern regions, women who practice modern contraception have been observed to fear the wrath of the gods should anything go wrong during the process (Bawah et al., 1999). This reiterates the notions that family planning practises among women in rural areas,

are highly characterised by reliance in traditions, which impact adversely on the decision to practise contraception (Omondi & Ayiemba, 2003).

Using the 2004 Malawi Demographic and Health Survey data, Palamuleni (2014) noted that, contraceptive use was low among Muslims and Catholics, as these religions value children based on biblical and Quranic principles. Catholics were found to view population increase as positive, and artificial fertility control as undesirable which accounted for low contraception among individuals practising that religion. Another study in Malawi by Omedi and Nyauchi (2015) confirmed these observations. It was found that, Muslim respondents (29 percent) were the least practisers of contraception, because the Islamic doctrine discourages artificial family planning, followed Catholics (45.8 percent).

Migrant women belonging to Islam religion were also found to have the lowest usage of contraceptives in Kenya, reaffirming the fact that, certain inequities from the Quran inhibit women to partake in decisions that affect them. On the other hand, Protestants were found to have the highest contraceptive use in the country due to the religion's flexibility in using contraception to regulate fertility (Omondi & Ayiemba, 2003). Islam is noted for restricting women in ways that affects their reproductive health decisions. Hou and Ma (2011) studied women's decision making in reproductive health in Pakistan. The survey sampled 5 061 women, from the Pakistan Social and Living Standards Measurement Survey data. Findings showed that, male dominance and traditional Islamic practices restricted women's decisions on reproductive health. They further observed that, legal restrictions and the enforcement of Purdah (seclusion of women), curtail women's ability to make decisions on family planning.

Degni, Suominen, Ansari, Julkunen and Essen (2014) also conducted a qualitative study on Somali-born immigrant women in Finland. The study, aimed at ascertaining migrant women's experiences and perceptions of reproductive health services, purposefully selected 70 women and employed focus group discussions to collect data. Findings revealed that, many of the participants who were all Muslim women did not practise contraception, citing their desire to conform to religious prescriptions. Participants in the study expressed that, contraception was forbidden in Islam, and as such, older participants discouraged young women from accepting contraceptives from healthcare workers.

2.4.3 Education and Contraceptive Use

Educational level is a crucial determinant in the utilisation of family planning services. Many studies (e.g. Awingura & Ayamba, 2015; Mosha et al., 2013) have shown the relationship between education and contraceptive use. For example, if an individual is illiterate or ignorant about family planning and its benefits, there is likelihood that she/he might not practice it. Educated women are more likely to practise family planning, specially, contraception, compared to less educated women (Awingura & Ayamba, 2015; Omondi & Ayiemba, 2003; Zhang et al., n.d). As found by Zhang et.al (n.d) in China, migrants who had higher educational level, possessed more knowledge on reproductive health rights, as compared to those who were less educated. Similarly, in Kenya, a study by Omondi and Ayiemba (2003) noted that, more than half of migrant women who had secondary education and over 80% of those who had tertiary education used contraceptives, as compared to less than 40% of migrant women with no education and those with primary education.

Additionally, in Southwest Nigeria, educational status of couples was found to determine women's attitudes toward the choice of family planning. Majority of respondents in the study

demonstrated lack of understanding by indicating that, family planning service providers, instead of helping in fertility control, rather wanted women to be barren for life, which resulted in refusal to patronise family planning services (Olaitan, 2011). Buttressing more on the influence of education on contraceptive use, in Malawi, Omedi and Nyauchi (2015) observed that women with primary educational qualifications (22 percent) were practising contraception, than their counterparts with no educational qualifications.

Not only is education of women important in decisions on contraceptive use, male partner education is of equal importance, as it is linked to high contraceptive uptake by women. This view was affirmed by Omedi and Nyauchi (2015) through their findings in Malawi. It was observed that, women who had some knowledge on contraceptives, and whose partners had some educational qualification, were more likely to use contraceptives than their counterparts, who had no contraceptive knowledge and had partners with no educational qualification.

2.4.4 Health Implications Related to Contraceptive Use

Contraceptive use and its associated health risks or concerns and side effects, such as weight gain, irregular bleeding, fertility issues, skin breakouts, headaches, nausea, cancer, birth deformities and uterine tumour have been highlighted in family planning literature (Awingura & Ayamba, 2015; Mosha et al., 2013; Rogers & Earnest, 2014; Schuler et al., 2011). In a qualitative study in Tanzania, findings showed participant's perceptions on the side effects associated with family planning, as a deterrent to the utilising of its services (Mosha et al., 2013).

A similar observation was made by Roger and Earnest (2014) in another qualitative study on Sudanese and Eritrean immigrant women in Australia that, concerns about side effects of contraceptives, discouraged women from seeking services. The researchers further observed that,

some of the participants' concerns were centred on the idea of contraceptives being unfit physically or psychologically for the user, resulting in countless unwanted side effects. However, the fear of side effects is not the only issue that deters many women from using contraceptives. As found in the study by Roger and Earnest (2014), participants cited concerns regarding the effectiveness of contraceptives, in particular the oral pill. Drawing from personal experiences of participants it was observed that, sometimes women fell pregnant whilst on contraception methods, which deterred them from using contraceptives.

Additionally, in Rwanda Farmer et al. (2015) documented that, perceived side effects of contraceptives, interfered with participants' sexual relationships as well as their ability to work. Participants stressed on excessive bleeding, low libido and vaginal dryness, which they feared could lead to their husbands' preference for other women. The authors concluded that, due to these perceived side effects, women were discouraged from using contraceptives. Researchers (Farmer et al., 2015; Mosha et al., 2013) have however, observed that, most of the side effects perceived to be associated with contraceptives are as a result of myths and misconceptions within societies, which are fuelled by rumours and misinformation within communities.

2.5 Institutional Challenges Women Face in Accessing Family Planning Services

Many challenges that women face in accessing family planning services are institutional. These include; (a) inaccessibility of family planning services and (b) shortage of healthcare staff (Awingura & Ayamba, 2015; Gizaw & Regassa, 2011; Speizer, Whittle & Carter, 2005).

2.5.1 Inaccessibility of Family Planning Services

According to Gizaw and Regassa (2011), there are always problems associated with the availability and accessibility of family planning services by women. In a quantitative study in

Ethiopia Gizaw and Regassa observed that, many respondents had difficulties in accessing family planning services, due to lack of availability of different methods, caused by inadequate supplies. They also identified limited time and lack of facilities for family planning service provision to women, as barriers to family planning uptake. These challenges are not only limited to Ethiopia, as they were also found in Ghana by Awingura and Ayamba (2015). The researchers observed that, family planning services were very limited which affected participant's decisions and choices.

Accessing family planning services could also be dependent on place of residence. Urban residents have better access to family planning services as compared to rural inhabitants (Omedi & Nyauchi, 2015; Speizer et al., 2005). In Honduras, Speizer et al. (2005) noted that, women living in urban areas had increased access to family planning information and services. The authors, in a survey on gender relations and reproductive decision making found that, access to family planning services was relatively easy at health posts, clinics and hospitals for urban women, as compared to rural women. In addition to limited services for rural women, it was observed that, rural women incurred extra costs for transportation to and fro health facilities, and endured long periods of waiting to be attended to, which affected their family planning uptake. This observation was substantiated by Palamuleni (2014) who indicated that, urban women in Malawi were endowed with an array of social services, which included information on family planning, resulting in greater access to family planning and healthcare services, as compared to rural women.

Furthermore, though family planning services might be available to women, sometimes healthcare providers are not competent in providing services, mostly to minority groups, which limit uptake of family planning services. This was evident in a study in Finland by Degni et al.

(2014), on Somali immigrants' experiences and perceptions of reproductive health services in the country. Findings of their study indicated that, though participants were satisfied with the availability of reproductive health services in Finland, they still faced challenges associated with lack of cultural competence of Finnish healthcare workers, as well as inappropriate and unfriendly attitudes of healthcare workers. The lack of cultural competency among healthcare workers was also observed by Roger and Earnest (2014) in Australia. The authors found that, lack of cultural sensitivity and competency was a huge barrier to family planning service utilisation and contraceptive use among Sudanese and Eritrean immigrants. Findings of their study further showed a lack of cultural sensitive staff and interpreter services for healthcare clinics in the study area, which deterred many migrants from accessing services.

2.5.2 Shortage of Health Care Staff

Counselling, a precondition for contraceptive use as dictated by the United Nations Population Fund (1996) is not accessible to many women. Women seeking family planning services have been found to be unable to undergo counselling due to limited time, inadequate personnel and counselling centres (Gizaw & Regassa, 2011). In a study in Ethiopia Gizaw and Regassa discovered that, there were huge shortages of health care personnel to conduct counselling on family planning. The researchers further observed that, family planning counselling in selected towns was conducted in groups, which led to discomfort among many women, who felt apprehensive to openly discuss issues with health care workers. This acted as a major barrier to family planning uptake as women could not get enough information to trigger action.

Issues of inadequate human resource, shortages in supplies and facilities are not only limited to migrants abroad. These issues are universal to all women as they were also cited as barriers to access and utilisation of family planning services in Rwanda by Farmer et al. (2015). The study

on motivations and constraints to family planning revealed that, due to shortages in healthcare workers, women seeking services had to wait for long hours, and often had short appointments with service providers, which resulted in insufficient family planning counselling. Furthermore, it was established in the study that, supply shortages resulted in limited methods being offered to women, thereby limiting their choices.

Finally, language a major component of culture, used to express feelings and emotions can be a barrier to access and utilisation of family planning services among migrants (Roger and Earnest, 2014). In a qualitative study in Australia, it was discovered that, migrant participants did not utilise family planning services because many clinics and hospitals had male doctors and interpreters, which prevented women from explaining their issues fully. Thus, cultural and linguistic barriers pose great challenges for many migrants, due to their inability to communicate their needs appropriately, which affects uptake of family planning services (Lindstrom & Hernandez, 2006).

2.6 THEORETICAL PERSPECTIVE

Qualitative research often adopts a lens within which to view the phenomenon under study (Creswell, 2007). This is important as it helps the researcher to understand the research problem. For that reason, the theory underpinning this study is the theory of planned behaviour.

2.6.1 Theory of Planned Behaviour (Icek Ajzen, 1991)

The theory of planned behaviour is an extension of the theory of reasoned action which was found to have some shortfalls in explaining behaviour. This theory posits that, people's attitudes influence their behaviour through a process of deliberate decision making (Kassin, Fein & Markus, 2011). It focuses on a person's intention to behave in a certain way. An intention is the

likelihood that a person will behave in a particular way in specific situations even if they may actually not do so. This theory was found to be useful in many studies such as those that promote healthy behaviours (e.g. McConnon et al., 2012; Sparks, 1994) like disease prevention, safe sex practices and birth control (Kassin et al., 2011).

2.6.2 Major Assumptions of the Theory of Planned Behaviour

According to the theory of planned behaviour, the best predictor of behaviour is intention, which is the cognitive representation of a person's readiness to perform a given behaviour. It is considered to be the immediate antecedent of behaviour. This intention is determined by three factors namely; (a) attitude towards a specific behaviour, (b) subjective norms and (c) perceived behavioural control (Ajzen, 1991).

2.6.2.1 Attitudes

Attitudes toward a particular behaviour are influenced by beliefs about the outcome of behaviour (is the outcome likely or unlikely) and evaluation of the potential outcome (is the outcome good or bad). The important aspect of attitude is determining whether or not it is positive, negative or neutral. Only specific attitudes toward the behaviour in question can be expected to predict that behaviour (Ajzen, 1991). In this study, migrant women's attitudes towards family planning could be mixed as it is likely that some would consider and evaluate it as good and positive, and as such, would practise contraception or intend to practise contraception in the future. Also, it is possible that some migrant women would evaluate family planning as bad and negative, owing to the negative effects they may perceive to be associated with it. These could result in the unwillingness to practise contraception.

2.6.2.2 Subjective Norms

These are influenced by a person's perception of the beliefs of those around him or her who include; parents, friends, partners among others, whether or not they would approve or disapprove of the behaviour. Here an individual's motivation to comply with these views is considered, thus sometimes social pressures to conform often leads people to behave in certain ways that may be at odds with their inner convictions (Kassin et al., 2011). To predict someone's intentions knowing these beliefs could be as important as knowing the person's attitudes. In this study, there is likelihood that, migrant women could make family planning decisions in reference to family planning perceptions of significant people in their lives. The desire to conform to religious and cultural norms that govern family planning could compel migrant women to make family planning decisions, based on these norms regardless of their inner convictions.

2.6.2.3 Perceived Behavioural Control

This refers to people's perceptions of their ability to perform a given behaviour. In other words, how, much an individual feels that the behaviour is within his or her control. For example, when people lack confidence in their capability to engage in some behaviour, they are unlikely to form an intention to do so. It is likely that, migrant women in the study could perceive themselves as powerless and unable to make independent family planning decisions, or autonomous and able to make independent family planning decisions, which could influence their uptake.

2.6.2.4 Intentions and Actual Behaviour

Ajzen (1991) identified predictors (i.e. attitudes, subjective norms and perceived behavioural control) which lead to intentions. More favourable attitudes and subjective norms, coupled with greater perceived control result in stronger intentions to perform a particular behaviour (Ajzen, 1991). Migrant women could show favourable attitudes toward family planning based on their

evaluations, which may lead to stronger intentions, resulting in utilisation of its services. On the other hand, migrant female head porters could have unfavourable attitudes toward family planning, which may lead to weaker intentions, resulting in non-utilisation of services.

2.6.3 Application of the Theory of Planned Behaviour to the Study

In applying the theory of planned behaviour to the study, it helped the researcher to explore how migrant women arrive at family planning decisions, in terms of whether to practise it or not. Again, the theory helped to better explain how the environment represented by other people's perceptions, such as husbands, boyfriends, family and friends among others influence migrant women's decisions on family planning.

With regard to socio-cultural beliefs and how they influence contraceptive use, the theory helped to shed more light on the interplay between these beliefs and the subjective norms (for example how the person was socialised) of a person to persuade decisions on whether to use contraceptives or not. Also, the theory helped in explaining how religion and migrant women's desire to conform to religious norms, influenced decisions on contraception. Finally, the theory helped to explain whether northern migrant women perceive themselves as capable of making decisions to practice family planning and if they followed through with these decisions.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methodology adopted for the study. It provides an explanation of how the study was conducted. The research methodology discussed consists of study design, target population, study population, sampling techniques, sample size, methods of data collection, data handling and analysis and ethical considerations.

3.2 Study Design

According to Gray (2009), a research design is the overarching plan for the collection, measurement and analysis of data. It allows the researcher to gain a deep, intense and holistic overview of the context under study; often involving interacting within the everyday lives of individuals, groups, communities and organisations (Gray, 2009). The researcher therefore, adopted a qualitative research design as the approach of inquiry. This provided an opportunity to explore and gain a rich understanding of northern migrant women's family planning decision making in Madina.

A qualitative research design was appropriate for this study because according to Onwuegbuzie and Collins (2007) the goal of qualitative research is not to make generalisations about a population but to obtain insights into a phenomenon, individuals or events. It is based on this assertion that, the researcher does not wish to make generalisations to the entire population of northern migrant women in Accra. Additionally, a qualitative design is ideal for this study based on the assumptions by Corbin and Strauss (2008) that, all of the concepts related to a given occurrence have not been identified, are not fully developed or are poorly understood such that further exploration is necessary to increase understanding.

3.3 Target Population

The target population for the study was northern migrant women of reproductive age, living and working in Madina market and family planning providers working within the Ghana Health Services and Non-governmental Organisations that offer family planning services.

3.4 Study Population

The study population included migrant women living in Madina and working within the market, key informants who are officials from Ghana Health Services and Marie Stopes International (An organisation that provides sexual and reproductive healthcare to under-served women around the world). Key informants were important to the study because, they were regarded as people who were knowledgeable about the inquiry setting, and can provide insights and knowledge which can prove particularly useful in helping an observer understand what is happening and why (Patton, 2002).

Migrant women and key informants encompassed the study population from which knowledge and information on family planning decision making was sought. Participants were presumed to be knowledgeable about family planning decisions and use due to their unique characteristics. Individuals eligible to participate in the study included; (a) northern migrant women working as female head porters in Madina, (b) migrant women between ages 18-49, (c) migrant women from northern Ghana who had resided in Madina for a year or more (d) officials from family planning clinics in Madina and surrounding areas as well as Marie Stopes International.

3.5 Sampling Technique

Purposive sampling is a technique in which the researcher deliberately selects a study population due to qualities, such as knowledge and lived experiences, regarding the subject matter and the

willingness to participate (Creswell, 2009). The study therefore used purposive sampling to select participants who fitted the researcher's criteria. Purposive sampling was adopted because it is often associated with qualitative research, as it seeks to obtain insights into particular practices that exist within a specific location, context and time (Patton 2002). Also, purposive sampling was ideal, because it allowed the researcher to deliberately sample study units that were presumed to be in possession of the information the researcher was looking for (Creswell, 2009).

Migrant women were selected to participate in the study through the distribution of information leaflets to gatekeepers belonging to an organisation that works closely with them in Madina market. Gatekeepers were useful because they helped the researcher to gain access to the research location and also facilitated the data collection process. Information about the research was provided to those who wished to participate in the study to contact the gatekeepers at the Positive Action for Porter Girls Agency (PAPG) situated in the market place. A date was set for an informational session at PAPG with possible participants, to share details about the study.

The criteria for those eligible to participate in the study were explained and the migrant women were encouraged to ask questions. Afterwards, those who qualified wrote their names on a sign-up sheet provided by the researcher and were later interviewed at a place and time that was convenient for them. Key informants were invited to participate in the study through formal letters which were sent in person to their offices. This was followed by an exchange of phone calls and e-mails back and forth to verify participation and finally dates and venues for interviews were set according to participants' convenience.

3.6 Sample Size

A sample size according to Onwuegbuzie and Collins (2007) should primarily be informed by the research objectives, research questions and subsequently research design. Additionally, scholars (Bryman, 2012; Creswell, 2007) assert that, for a research based on qualitative inquiry 15-30 participants are sufficient and that, each unit in a qualitative study produces so much information, thus in order to undertake thorough and meaningful data analysis, sample sizes need to be kept reasonably low. Based on these assertions, the researcher targeted 30 participants at the onset of the fieldwork.

Guest, Bunce and Johnson (2006) contend that data saturation occurs within the first twelve interviews. Of the targeted 30 participants, 22 were interviewed, consisting of 19 migrant women, two key informants, who are family planning providers and one key informant from Marie Stopes International. Thus, data collection from participants ended at 22 because saturation had been achieved, as no new themes were observed.

3.7 Data Source

The main source of data was primary, which the researcher collected from migrant women and key informants from family planning clinics in Madina and Marie Stopes International. Primary data were collected by using a semi-structured topic guide with specific topics and themes that needed to be explored.

3.8 Methods of Data Collection

In-depth interviews (IDIs) with migrant women and key informants were used to collect data for the study. In-depth interviews were useful because they allowed the researcher to question participants about their feelings, motives and interpretations of events and to probe the responses

given by participants (Green & Thorogood, 2009; Singleton & Straits, 2010). Each interview lasted between 45 minutes to one hour. Permission was sought to use a voice recorder to record the in-depth interviews as this enabled the researcher to attend to the interviewees (Lofland, Snow, Anderson & Lofland, 2006). The in-depth interviews with migrant women were conducted in both Twi and English languages at the PAPG office in Madina market, and the days for the interviews were Monday, Tuesday and Thursday. These days were ideal because they are not market days, and as such participants could avail themselves for the data collection. Some of the interviews with migrant women were conducted in Twi by a research assistant in the presence of the researcher. This is because the researcher is not conversant with Twi. Key informant interviews were conducted in English, during working hours in their offices.

3.9 Data Handling and Analysis

Data collected from the field were kept and treated as private and confidential. Field notes and audio recorded data were transcribed and entered onto a computer protected with a password only known by the principal researcher. The data that were stored on external drive was also kept safely and secure. Qualitative analysis of the data was then carried out using Creswell's (2009) thematic framework for qualitative data analysis. Data from the field were first transcribed and organised then field notes were typed. The researcher then sorted the data and proceeded to search for patterns and arranging them into different categories based on the objectives of the study. The process was subsequently followed by thorough reading of all the data.

Reading through the data enabled the researcher to make sense of what the participants were saying thus dictating the tone of ideas. The data then went through the coding process which involved the organisation of material into sections of text, identification of recurrent words, concepts or themes and labelling them. Themes were then generated and these were presented as

the major findings of the study. Finally, an interpretation of the meaning of the data was carried out by relating the findings to the reviewed literature.

3.10 Ethical Considerations

Discussed below are the ethical issues that were considered during the research, these are; (a) informed consent, (b) confidentiality and anonymity, (c) plagiarism, and (d) credibility and trustworthiness.

3.10.1 Informed Consent

Informed consent is a basic ethical tenet of scientific research on human populations. Participants must understand that their participation is voluntary, and must be provided with enough information about the research to make informed decisions about whether to participate or not (American Sociological Association, 1997). The purpose and objectives of the study were clearly discussed with participants in a language they were conversant with to get their consent. Consent was obtained both orally and in written form, from participants. Participation in the study was voluntary and participants were assured of their freedom to withdraw from the study at any time.

3.10.2 Confidentiality and Anonymity

Confidentiality is an important issue when doing research and later when writing (Corbin & Strauss, 2008). The researcher has an obligation to ensure that confidential information is protected. Guaranteeing anonymity by assuring confidentiality is every researcher's obligation (Lofland et al., 2006). To safeguard these, participants' identities were kept anonymous. The interviews did not require participants to provide their names, and as such, numbers were used in presenting findings of the study.

3.10.3 Plagiarism

The researcher ensured that, data were handled in an ethical manner by acknowledging authors of all information. This implies that plagiarism, which according to Singleton and Straits (2010) is the appropriation of another person's ideas, results or words without giving proper credit, was avoided.

3.10.4 Credibility and Trustworthiness

Credibility and trustworthiness ensure that findings are accurate and consistent which is important in convincing readers of the authenticity of the research (Creswell, 2009). For this study, peer review or briefing as suggested by Creswell (2009) was used to validate findings. Findings of this study were presented to reviewers whom Creswell termed the “devil’s advocates” who are members of faculty in the Department of Social Work, University of Ghana who had the opportunity to query methods that were adopted for the study, meanings and interpretation as well as comments to enrich the research.

3.11 Limitations of the Study

Interviews for the study were conducted in both English and Twi. There are possibilities that data were lost through translation of original responses from Twi into English as it was difficult finding exact meanings of some words and phrases in either language. For example, it was very tricky for the translator to translate the word family planning in the local dialect; eventually he had to explain the concept of family planning in a sentence. In transcribing the data, an assistant was employed to transcribe Twi interviews and as a measure to prevent misinterpretation of participant’s voices, a translator was employed to play the audios and verify authenticity of the transcribed data.

CHAPTER FOUR
PRESENTATION OF FINDINGS AND DISCUSSION

4.1 Introduction

The study sought to explore family planning decision making among northern migrant women in Madina, Accra. Presented in this chapter are; the demographic characteristics of participants, influence of migration status on family planning decisions, migrant women's knowledge of family planning, socio-cultural norms and beliefs influencing decisions and use of contraceptives and institutional challenges that hinder access to family planning services by migrant women. Findings are presented in a narrative form with direct quotations from participants and discussions are made. Also, the findings are discussed in relation to reviewed literature and the theory of planned behaviour.

4.2 Socio-demographic Characteristics of Participants

Twenty-two participants were selected to participate in this study. These included three key informants and 19 migrant women working as head porters in Madina market. Two key informants were family planning providers working in family planning units at clinics in the La-Nkwatanang (Madina) District as well as Family Planning Regional Resource Personnel for Greater Accra Region, the other key informant was a Youth Coordinator at Marie Stopes International, Ghana and works on the 'kayayei' project which, offer family planning and other reproductive health services to female head porters.

Migrant participants were asked questions related to their age, number of children, marital status, religion and educational background, place of residence and place of origin. The age range of migrant participants was 18-34, 11 were married, one divorced, five were single parents and two were not married. Out of the 19 head porters, 17 had children and the number ranged from one to

five. In terms of place of origin, all the migrant participants migrated from the Northern region and were Muslims. Specifically six migrant participants were from Janga, six from Tamale, two from Nasia, three from Walewale and two from Tumu. Concerning place of residence, four of the migrant women were living in rented rooms with their spouses, two with relatives and 13 lived with other head porters from the same region. Regarding participants' educational background, 15 had no formal education, three had completed Senior High School and one had completed Junior High School.

4.3 Migration Status, Family Planning Decisions and Uptake

Female head porters expressed views on how their migration status influenced their decisions and use of family planning services. Migrant participants living with spouses in Accra were found to be using contraceptives, whilst migrant women who had left their spouses in the north were not using contraceptives. Discussed under the influence of migration and family planning decisions are two themes namely; (a) migration and family planning uptake and (b) future intentions to practice family planning.

4.3.1 Migration Status and Family Planning Uptake

For many participants in the study, duolocal living arrangements between their spouses, resulting in infrequent sexual intercourse influenced decisions and use of family planning services in Accra. Participants in the study cited the desire to work and earn money as their main reasons for coming to Accra. Consequently, husbands and children were left behind in the north so that the women could concentrate on their daily economic activities:

I migrated to Accra because of money, which I will send to my mother and father. My mother is separated from my father and has left my father's house. Where she is now, she has to build a new house so that she can live in comfortably.....I have given birth already

therefore I do not need any more children. Currently, the father of my children is not on - the scene that is why I do not have any need for family planning... I am not practising family planning (Head porter 4).

Another participant revealed that, the unavailability of her husband influenced her decision not to practise family planning, since she is rarely intimate with him:

I decided to migrate to Accra, to work and earn money so that I can support my family, especially my mother and siblings. My husband is also here in Accra but he works elsewhere so we do not live together. We only have time for ourselves to be intimate when we go to the north to visit... I decided against using contraceptives because my husband is not living with me... I even fear using contraceptives because my sister in-law lives with me in the 'kayayoo' room and if I should do it she will report to my husband (Head porter 2).

A participant, who was a seasonal migrant, had this to say concerning this issue:

I left my husband and children in the North and I decided to migrate to Accra to work and earn money. I constantly move between Accra and north, so because of that, I do not use any family planning. I just use the natural method. With my three children I did not use any family planning method. After giving birth to my first child, I came to live in Accra for three years before going back to the North. When I went back to the north, I conceived again before returning to Accra (Head porter, 9).

Some of the participants were of the view that, in the absence of a sexual partner there was no need to practise family planning:

I migrated to Accra to work as a 'kayayoo' in order to earn money, and to also learn a trade. I was staying with a man in the north, but I left because I am too young to start -

giving birth. I have not been practising family planning, because I do not see the need since I am not living with a man at the moment (Head porter, 11).

An informant further attested that, the absence of a spouse and the fact that, migrant women came to Accra to work, influenced their decisions and use of family planning services:

The 'kayayei' in particular do not patronise or utilise the services we provide, because they say their husbands are not here, they came to Accra to work, so they are not interested in men here. Even when we go to them, at the market, only one or two of them may be willing adopt a family planning method (Key Informant 3, Madina Poly-clinic).

For this participant, the constant movement back and forth between Accra, Kumasi and the north influenced her decisions regarding family planning:

I am married with two children, but I left my husband and migrated here to look for money. I move between Accra, Kumasi and the north... Due to my movements, I do not use any contraceptives as I am never with my husband long enough to require it. I once decided to use contraceptives, but then my sister called me to come to Accra and work, so I decided against it since my husband would not be around (Head porter, 13).

Though she used contraceptives at some point in her life, this head porter revealed that she abandoned it after migrating to Accra:

Economic difficulties pushed me to migrate to Accra to work and earn money, so that I can go back and take care of my family. I left my husband and children in the north. Since giving birth five years ago, I have been on the pill. When I was coming to Accra, I stopped because I am I knew that, I would not be sleeping with any man (Head porter, 15).

Participants who wished to continue with their education did not see the need for family planning, as their main priority was to work and earn money to fund their educational aspirations. This is what one of them attested:

The reason I migrated to Accra was to work and earn money to sponsor my nursing career... I finished Senior High School and I want to go further with my education. At the moment my mind is occupied with my future career, the last thing on my mind is being sexually involved with a man. For that reason I decided not to use family planning (Head porter, 10).

Female head porters, who migrated to join their spouses in Accra, were using contraceptives, as shown by this participant's comment:

I migrated to Accra to join my husband who was already here, and also to work. I have been in Accra for about eight years now, with my husband and two children. When I arrived, I saw how difficult life was in Accra, we were buying everything. I pleaded with my husband to allow me to use contraceptives and he agreed. I then started using the three month injections (Head porter, 12).

Migrant women living with spouses got encouragement to practise family planning. A migrant woman made this comment in that regard:

I live in Accra with my husband and children, we decided to settle here for some time, so that we could work and get money. When my last child was seven months old, my husband advised me adopt family planning. As a result, I chose to use the injection, which I take every three months. Had it not been because I am on injection, I would have been pregnant already (Head porter, 19).

Though she did not live with her husband in Accra, this participant's decision to use family planning was influenced by fears that her husband might cheat on her.

I have been in Accra for eight years, and I live with my other sisters in the 'kayayoo' room. I migrated to Accra because of economic difficulties back in the north. My husband is in the north, this is my second marriage. Because of the fear I have that my current husband will cheat on me, I decided to practise family planning. Anytime I am going to the north I go for the six months injection to prevent myself from getting pregnant (Head porter, 18).

4.3.2 Migrant Women's Intentions to Practise Family Planning

Knowledge about family planning did not translate into usage among many of the participants. Many head porters expressed that, they had never practised family planning, but intended to adopt it in the future. This is because they perceived it as an opportunity to gain more independence to engage in their daily activities. Abandonment and neglect by spouses were cited as big motivators in decisions to adopt family planning:

Regarding the circumstances that led to the birth of my first child, I have learnt a lesson. I have become very wise and I am now ready to go for family planning. However, I will let them explain the various types available to me, before I decide on which one to adopt (Head porter, 4).

Due to painful experiences in relationships and the burden of caring for children as a single parent, this head porter thought it wise to consider family planning:

I have two children now, but there is already pain in me, so I do not even want to give birth. But if I should get a responsible man who wishes to settle down in marriage, I may consider using contraceptives. After my first child, I sent him to live with my parents, I -

was not using any contraceptives, and before I knew it I became pregnant again so I will definitely use contraceptives in the future to prevent a similar situation from happening (Head porter, 5).

The pursuit of education was viewed as very important by this participant, which resulted in her desire to adopt family planning:

I know about the importance of family planning, I have heard about it several times from different people. Even though I do not use contraceptives now, I will definitely adopt it; I have already gone to the clinic to make inquiries. It is even a must for me, since I want to be an independent woman and do not want anything to interrupt my studies. (Head porter, 10).

For this participant, since she was contemplating going back to the north, she was seriously considering adopting family planning in order to ensure protection from unintended pregnancy:

...Like I said before, I left my hometown after staying with a man for some time, because I felt I was too young to get married. I have not practised family planning, but since I am considering going back to the north I will definitely adopt a method before I leave, because I do not know my fate, whether the man will come and demand that I return to his house or not (Head porter, 11).

Hardships encountered in caring for children influenced this head porter's intentions to use contraceptives in the near future:

Since I have two children now, I plan to use contraceptives in the future, so that I would limit the number of children. Sister, the way I suffered with these two children uhmm!, I cannot explain. I have decided to go for the injection, I have heard that it is good, at least my suffering will lessen (Head porter, 13).

After using natural contraception without much success, this head porter was ready to adopt modern contraceptives as she believed that would help to prevent unwanted pregnancies:

I have been practising the natural method, where I abstain from sex during my fertile period. After my first child, I was advised to adopt family planning by relatives but I ignored the advice, I had so many concerns about it, then before I knew it, I got pregnant with the second child. The natural method did not work completely for me, so now I am ready to try the pill or injection so that I can get my peace of mind (Head porter, 1).

As a single mother raising two children on her own, this participant was ready to utilise contraceptives in order to properly care for her children:

I do not use family planning at all, some of us the very families we come from, do not accept it, and so if you should go ahead and use contraceptives, it will bring problems for you. One of my friends is doing it secretly, so I will do the same so that I can protect myself. As it is now, I am a single mother with two children, I have a boyfriend who comes to visit once in a while, since I am sexually active, I would want to adopt family planning in order to prevent further pregnancy before we get married (Head porter, 7).

Though she was not single in the correct sense, this participant considered herself single, since her husband had travelled and had not been in touch for years. However, according to her, once the husband returns she would go for contraceptives until she is sure about his intentions:

I do not know whether I have a husband or not, I will say that for now I am single because I am raising my child on my own without his support. He travelled and I have not heard from him since then, he is yet to return, so I do not see the need to use family planning. Once he returns I will definitely go for the injection, because it is easy and -

cheap. I will not even tell him that I have done it because I am not sure about his commitment to the marriage (Head porter, 14).

4.4 Migrant Women's Knowledge of Family Planning

Female porters who participated in the study showed limited knowledge on the benefits of family planning as well as the various methods available. The limited knowledge participants exhibited contributed to the non-utilisation of family planning services. Participants had deficiencies in their knowledge on various family planning methods, however many of them showed awareness of mainly the injectable and IUDs. Findings for this section are presented under the following themes; knowledge on the benefits of family planning and its various methods and migrant women's sources of knowledge on family planning.

4.4.1 Knowledge about the Benefits of Family Planning and its Various Methods

Migrant women working as head porters in Madina market were asked what they know about family planning, its benefits and some of the methods available. Many of the participants exhibited limited or lack of adequate knowledge on family planning. Participants were able to cite some of the benefits associated with family planning as child spacing, prevention of unwanted pregnancies, ability to limit the number of children and prevention of STIs like HIV/AIDS. Few participants who had some formal education expressed more knowledge than those who had no formal education at all:

I know that family planning helps to prevent unwanted pregnancies and allows women to space the births of their children as well as care for children properly. In terms of various methods available, I know there are some types for five years, three years, one year and even three or four months but I do not know which ones exactly. I think the five -

year one is a needle they insert into your body and whilst it is there, it prevents pregnancy (Head porter, 4).

This participant was unaware that some of the family planning methods, such as the condom help in preventing HIV/AIDS and other STIs:

I have heard about family planning, what I know is that if you want to space your children, you use family planning. It is also good because it prevents individuals from contracting STIs and other diseases. I know about the condom, that's all (Head porter, 8).

Commenting on migrant women's lack of knowledge on family planning, a key informant from Marie Stopes International, had this to say:

The level of knowledge female head porters have on family planning is not adequate... Where they come from, access to information for women is very limited... They might have heard something called family planning and might know one or two types but regarding the kind of information which could trigger action, no, they do not have that (Key informant 1, Marie Stopes).

To help shed more light on family planning and its various methods, an informant offered some background information on methods and procedures available:

...We have long term and short term methods. The short term methods comprise of the injectables which include Depo-Provera (three months), Norigynon (one month), and then we have the contraceptive pill which you take orally every day. Examples of contraceptive pills are Microlut and microgynon (Key Informant 2, Abokobi Health Centre).

Apart from the short term methods, a family planning provider also talked about long term methods:

Long term methods come in three types namely; Implanon and Implanon NXT (which are both for three years), Jadelle (five years) and IUDs (Intra-Uterine Devices) which are inserted in the uterus. IUDs come in two types; Copper T (10 years) and Mirena (five years). We also have sterilisation; vasectomy for men and BLT (Bilateral Tuber Libation) for women (Key Informant 2, Abokobi Health Centre).

Contrary to the information provided by key informants on various methods and how they work, head porters who were interviewed exhibited limited or lack of sufficient knowledge on family planning methods and how they work:

They say family planning helps to prevent unwanted pregnancies, but personally I think that, every individual should know what to do, to prevent pregnancy. As for the methods available, I cannot really tell, I have heard about the injectables and the condoms but I have not seen them with my eyes, I do not know how they work. With the injectables, there is three months, six months, one year and two years (Head porter, 9).

Drawing from personal experiences of how family planning benefited her, this head porter shared insights on the methods she had tried:

From my personal experience family planning has helped me in the sense that, It could have been difficult for me to have a child who is crawling, and be pregnant at the same whilst I still go about with my daily activities at the market. I am using the pill and it has benefited me a lot... I also know about the injections both the three months and six months. I also heard about IUDs but I have not seen some before. As for the condom I have not heard about it (Head porter, 15).

Another participant attested to the benefits of family planning based on personal experience, but was not sure about how the IUD worked:

Personally, I pleaded with my husband, that I wanted to practise contraception and he husband agreed. But as a woman if you want to prevent your husband from cheating, you have to use contraceptives, so that you will not have too many children to look after, then you can have time for yourself... As for the methods I know about the pill, injection and IUD. I am currently on the oral pill and I know how it works but I am not sure how the IUD works (Head porter, 12).

A participant, who heard about family planning from her parents, had this to say:

I have heard about family planning from my parents, they have been talking about it. I also heard that if you are sexually active and not ready to give birth, you adopt family planning in order to prevent unwanted pregnancies. I understand we have 3 months, 6 months injectables and there is also the IUD but I do not know how it works. I do not know about the condom (Head porter, 11).

Providing proper care to children by channelling available resources to address their needs was one of the family planning benefits cited by participants:

Family planning helps nursing mothers to take care of their children properly and it prevents women from getting pregnant frequently. I was told by friends about the injection, that it is good. I know that there are the 3 months, 6 months and 1 year injections. Apart from that, I do not know any other method (Head porter, 13).

Though she attested that, family planning was beneficial, this participant did not know various methods of family planning because the father of her child was not around:

Family planning is beneficial because it helps women to take good care of their children. It also helps in birth spacing. I do not know the different methods or types. When I gave birth to my child, the father travelled so me I do not know, when the nurses come to educate us on family planning at the car park, I don't go because my husband is not here (Head porter, 14).

Another participant further confirmed that, family planning was beneficial, though she knew little about the various methods available:

I have heard about family planning. I hear people chatting about it. That it helps in child bearing and spacing as well. When you give birth to too many children, it comes with more suffering. So family planning helps in that regard. I know about the IUD, injection and the pill from some of my sisters who used them. I also heard about the condom but I have not seen it before (Head porter, 16).

Despite the fact that, she had heard about family planning and its benefits, this participant, lacked adequate information on the various types or methods:

I heard that family planning helps in child spacing and protection against unwanted pregnancies. As for the types or methods, I do not know much about them, I heard about the injection and the IUD, but I do not know exactly how they are used (Head porter, 17).

Some participant especially, those who had formal education exhibited enough knowledge on the benefits associated with family planning:

I know quite a lot about family planning. Some organisations sometimes gather us at the car park and tell us about it. There are a lot of benefits associated with family planning.-

It helps women to space the births of their children, determine the number of children they want as well caring for children adequately. Family planning also promotes the wellbeing of women. Every woman is entitled to family planning whether married, single or cohabiting. There are various methods available it depends on the woman to decide which one to adopt (Head porter, 6).

In addition, another participant stressed on the issue of informed consent to enable women to make informed decisions:

Family planning to my understanding are methods used to prevent or if you like to control child birth. Family planning helps by preventing unwanted pregnancies, its benefits are long term. It comes in different types namely; injectables, pills, condoms and IUDs. The choice of which one to use depends on the individual. For the woman, it is good to be educated and counselled before you adopt any method, even though people still use it anyway and anyhow. The nurses have a role to play by providing adequate information to women for them to make better choices (Head porter, 10).

This participant also expressed knowledge of the male and female condoms:

Contraceptives help in preventing unwanted pregnancies, which for me is better than having an abortion. They also help in child spacing, which ensures healthy children. I even know some of the methods such as IUDs, injectables (three months, six months and the rest) and the condom; we have the male and female one (Head porter, 18).

A head porter, who witnessed the benefits of family planning first hand, from her madam, had to say:

Family planning has benefits, it can happen that, you give birth and the man deserts you, when the child grows, the man will come back for the child, so if you do not want to be -

in that situation it is better to practise family planning. I used to have a madam who was very rich. They had three children. I got to realise that the woman was able to take good care of the children and attend to their needs because she was on family planning, so she used to advice me to practise family planning (Head porter, 2).

4.4.2 Migrant Women's Sources of Knowledge on Family Planning

The main source of knowledge on family planning was cited as healthcare providers particularly nurses at the clinic during antenatal and post-natal visits. In addition, some of the participants indicated that customers, family and friends who use contraceptives as well as programmes in the market helped them to gain knowledge about family planning.

4.4.3 Nurses at Healthcare Posts

Nurses at the clinic provided most of the knowledge that migrant women had on family planning. Antenatal and post-natal visits were cited by participants as the best opportunity to engage in family planning discussions:

I learnt about family planning mostly during post-natal visits where the nurses educated us about it (Head porter, 4).

Still commenting on the clinic as the major source of information on family planning, this participant said:

When we go for antenatal and post-natal visits the nurses tell us about family planning. I only heard about it through the education at the clinic (Head porter, 9).

Clinics all over the country offer family planning education. Some migrant women were able to access information on family planning in the north, before migrating to Accra:

I heard a lot about family planning in the north. Anytime when went for weighing at the hospital, the nurses talked about it and they encouraged nursing mothers to adopt family planning (Head porter, 13).

Another participant had this to say concerning the same issue:

I heard about family planning and how it could help me from the nurses at the weighing clinic. When we go for post-natal, we ask a lot of questions about family planning, and the nurses tell us more. They often call for meetings to discuss family planning, and at these meetings the nurses often ask for those who have complications with the family planning and they address the complaints (Head porter, 19).

4.4.4 Programmes on Family Planning

Programmes organised by clinics and other organisations such as Marie Stopes International have been a great source of knowledge on family planning for head porters in Madina. Programmes are often accompanied with music, speakers and sometimes incentives. This is a way of enticing migrant women to attend:

Nurses from the poly-clinic sometimes organise us in a meeting at the car park and tell us about family planning (Head porter, 5).

A participant revealed that, organisations and some healthcare workers organised programmes for head porters:

I have heard about family planning here in the market at the car park, organisations and some health workers, sometimes organise programmes for us to provide education on family planning. They usually use loud speakers and music (Head porter, 1).

A migrant woman, who was recruited to represent head porters at a family planning workshop in Achimota, had this to say:

I was selected to go to Achimota for a programme by an organisation that came and took us there to educate us on family planning. They provided us with everything; meals and other gifts. I learnt a lot about family planning there. We were told to share the knowledge we got from the workshop with our colleagues after the workshop (Head porter, 18).

An informant, who was the head of a family planning unit in Madina, had this to say regarding the provision of family planning education to female head porters through programmes:

We do outreach programmes for the 'kayayei', sometimes we organise a durbar for them. We sensitise them about the importance of family planning. Sometimes too, we have a - radio station in the market so we go there to give talks. I am a northerner so sometimes I go and speak about family planning in the northern language at the station. I also go to Omar FM to speak about family planning in Dabgani, but the head porters rarely call to ask questions, just a few uhmmm (Key informant 3, Madina Poly-Clinic).

4.4.5 Customers, Friends and Family

Customers, friends and family who have used family planning were cited by participants as important sources of information on family planning:

Customers do give a lot of information on family planning, sometimes when you are carrying someone's load they advise you about family planning and its benefits. If you tell them that you are not using family planning, they encourage you to practise it (Head porter, 1).

For this participant, her madam was instrumental in sharing family planning information with her:

I used to have a madam living with the husband, they were rich. They had three children. I got to realise that the woman was able to take good care of her children and attend to their needs because she was practising family planning, so she used to advise me to adopt it (Head porter, 2).

As colleagues', migrant women shared experiences of using family planning with those who had not used, they even devised ways of hiding it from their husbands, as indicated:

We discuss family planning a lot amongst ourselves, those who have practised it, share their experiences with one another, and also educate those who have not used it, but are afraid. We even discuss how to hide family planning uptake from our husbands, especially if they are not in support. Because we are in Accra, we do not feel shy to talk about it (Head porter, 12).

Family members, who had used contraceptives, shared their experiences with other family members who were non-users. In this participant's case, her sisters were helpful in providing information about family planning:

It was my sister who went started using one of the family planning methods; it was the IUD that is how I got to know about family planning. I also got to know about the pill through my other sister who was using it. I also heard about the injection it was another sister who did the four year one (Head porter, 16).

4.5 Socio-Cultural Norms and Beliefs that Influence Migrant Women's Decisions and Contraceptive Use

The main issues brought forth by participants in the current study as inhibitors of family planning uptake were (a) partner consent, (b) fear of side effects of contraceptives, (c) religion and culture, and (d) association with promiscuity.

4.5.1 Spousal Consent

Participants expressed views that, men as heads of households should be the ultimate decision makers, as such their consent was considered important before decisions to use contraceptives are made. Spousal consent was cited by many participants as a factor influencing contraceptive uptake. Participants had this to say:

As a woman you have to talk to your husband, you then go and see the health worker. After that you go with your husband to finally select the method you want if the man refuses for you to use contraceptives, then you have to comply (Head porter, 5).

When women get support from their spouses it is easier for them to use contraceptives. This participant got encouragement to use contraceptives from her partner:

In some cases it is the man who would encourage you to adopt family planning, so that you can take good care of the children. In my case, I got support from my husband, he even suggested a method for me. If you want to use contraceptives, it is important to consult your husband, and explain to him how it can benefit all of you (Head porter, 2).

While some women get support and encouragement to practise contraception from their spouses, others are discouraged from doing so. One participant had this to say in that regard:

Some men oppose contraceptive use, by saying that they want to have a lot of children because they think their parents could not give birth to a lot of children. In my case, my -

husband said I should not do it because it is not good. Women should ask permission from their husbands before using contraceptives, and if the husbands do not agree, there is no need to practise contraception (Head porter, 17).

Citing religious obligations to honour and obey one's husband this participant said:

In Islam, if you are married, your husband is your everything. You have to consult him and if he disagrees, you do not have to go ahead and use contraceptives. Personally, I have not asked my husband for permission, in case I do, and he says no, I would not do it (Head porter, 3).

A participant narrated how the use of contraceptives without a husband's permission, could result in serious marital problems:

As a woman before using contraceptives, you need to consult your husband because if you do not discuss with him, and you start using contraceptives, any complications that arise will result in problems in your marriage. If you are not lucky, you can be sent - packing out of the house. In my hometown one woman started using contraceptives without telling the husband, as I am speaking to you now she is in her father's compound, when the husband found out, he threw her out of their marital home (Head porter, 8).

According to a key informant, disobeying husbands or boyfriends' objections to contraceptives is one factor which contributes to intimate partner violence among head porters:

Many female head porters do not get spousal consent. The husband or boyfriend warns them against using contraceptives. Decisions to use contraceptives without spousal consent by 'kayayei' contribute to intimate partner violence. As a result, lack of partner consent is a key factor that inhibits uptake of family planning by female head porters (Key informant 1, Marie Stopes International).

Commenting further on spousal consent and its importance, a participant disclosed:

Husband's permission is important, if you consult your husband and he gives you the approval, then you can go ahead and use contraceptives. But if he disapproves, you do not have to use contraceptives because it can result in divorce. If your husband disapproves then you stop, you know up north, if you disregard your husband's advise, you will be in trouble, he can decide to divorce or even beat you up. My sister in-law was beaten seriously by her husband when he found out she had inserted the IUD. He ordered her to go and get it removed if she wanted to stay in the marriage (Head porter, 9).

Sharing a stakeholder's perspective on the issue of partner consent, one key informant revealed:

Partner consent is the primary key. For the migrant women especially, they are really in a deplorable situation we try our best to help out. Sometimes they come for counselling, but then they will be thinking that if my partner finds out he will beat or divorce me. - They have so many fears about what their partners will do in case they find out that they are using family planning (Key Informant 2, Abokobi Health Centre).

Another participant further revealed that, divorce and beatings are some of the consequences of disregarding a husband's objection to contraceptive use:

A woman should seek permission from her husband before using contraceptives, because if she does not tell him, it can result in marital problems. Some of the men can send you packing, or if there are complications he will tell you that you did not inform him when you were going for a contraceptive method, which can even result in him beating you. If you ask your husband there is no way he will disagree, he will obviously agree (Head porter, 14).

According to a head porter, she took the decision to use family planning because of her wellbeing and that of her children. Her husband refused her request to use contraceptives, so she went behind his back to utilise it:

You see! Women are very stubborn so they hide and practise family planning because they carry the burden of caring for children. For the woman, if you want to use contraceptives, tell your husband, if he agrees then you can adopt a method but if he refuses, you have to do what you can as a woman, because if you do not take care the burden will be on you. For me, when I wanted to use contraceptives I told my husband and he refused, so I went behind him and got the pill and was taking it (Head porter, 15).

A participant who had the view that, women should take it upon themselves to decide on contraceptive use, had this to say:

As a woman you have to seek your husband's consent before using contraceptives, you cannot do something behind him. If you want to practise family planning, consult your husband so that if any complications arise, he can support you. If he does not agree, at least you have told him. Since you know that it will benefit you as the woman, you can then go ahead and practise family planning. As for me, if my husband refuses to grant me permission to use contraceptives, I will still go ahead and do it (Head porter, 11).

Though partner consent was considered important by migrant women, one participant stated that women should go ahead and use contraceptives if their spouses are not supportive of their decisions:

Before using contraceptives you need to study your man. If you study him and he is the type that can support family planning then you can go ahead and ask permission, but if -

he is not that type then you just have to go and do your own thing and practise contraception (Head porter, 1).

This participant felt that women can only disregard their husbands if they are ready to face the consequences of being disobedient:

Before using contraceptives you have to consult your husband, because if you do not, and a problem arises as a result of the contraceptives, you may have problems in your marriage, you can be divorced. If you tell him and he refuses, and you are ready to face the consequences of disobeying him, then you may go ahead (Head porter, 16).

According to another participant, it is good to be patient and to wait for one's husband until he grants consent to use contraceptives:

Husband's consent is important, there are some cases that if you tell your husband he will agree others too, he will not. So if your husband does not agree, you have to be patient and wait until he approves (Head porter, 18).

4.5.2 Misconceptions about the Effects of Family Planning

Many head porters talked about irregular bleeding, infertility, weight gain, death, cessation of menstrual cycle and injury to their partner's manhood as negative effects of using contraceptives.

This informant shared insights from experiences, gathered through working with head porters at his organisation, he said:

If a woman starts using contraceptives and she experiences bleeding, she becomes alarmed and tells everyone who comes around that, the bleeding is associated with this particular contraceptive. The fears spread like wild fire and before you know it, all her friends and family would never like to use contraceptives. Sometimes, even their partners tell them that, when you go for contraceptives especially the ones inserted in the uterus -

the device will pierce their manhood during sexual intercourse (Key Informant 1, Marie Stopes International).

Negative personal experiences of using contraceptives could deter further uptake, as revealed by one participant:

I went for the three months injection. Please, to be honest with you, after doing it, I did not have my menses for that three month period. I also suffered from severe lower abdominal pains. Because of this experience, I decided to use the pill instead. The bitter experience, I had scared me from going for another injection. Since adopting the pill, I have not experienced any bad effects (Head porter, 12).

Contraceptives were associated with weight issues, as indicated by this migrant woman:

I heard of someone who had the IUD inserted, that she gained so much weight. So she was warned to go and remove it if she did not want it to affect her womb (Head porter, 2).

For this participant, the negative effects of contraceptives could be as serious as death:

There is this incidence where one woman did family planning here in Accra, and went back home. She got sick, but did not mention that she did family planning until the sickness became serious. She then went to the hospital complaining of abdominal pain, after finally disclosing that she did family planning, she died (Head porter, 7).

Participants believed that, contraceptives could result in infertility. One migrant woman commented on this issue:

Some of the men especially up north, advice us not to do use contraceptives, because they claim it would make us infertile, they warn you that, if you hide and use contraceptive secretly, they will know because you will not be getting pregnant (Head porter, 4).

Birth complications, such as bleeding were cited by this head porter as some undesirable effects of using contraceptives:

What I have heard in addition is that, the IUD when you get it inserted for a year, it results in complication during child birth when you finally decide to get pregnant, and even some people complain that it makes them bleed. As for me I fear that contraceptives might affect me like how it affected other women who bleed nonstop and are unable to give birth after they stop using (Head porter, 13).

4.5.3 Religion and Culture

Religion and culture were found as factors that could influence contraceptive use among migrants. Also, the cultural obligation of having large families was cited by participants as another factor that could influence contraceptive use. Concerning religion, an informant noted Catholics and Muslims as less likely to use contraceptives due to their religious beliefs:

Catholics do not favour having contraceptives. They prefer natural methods. Muslims women are prohibited from exposing their bodies to people other than their husbands. In fact, Muslims do not like the idea of you invading their privacy. So most Muslim head porters I have worked with do not favour contraceptives. They may be fine with practising family planning, but not comfortable discussing it with you. How will they explain for example, how the IUD was inserted into their uterus, it is a serious issue (Key informant 1, Marie Stopes International).

Citing personal experiences from her work with female head porters, an informant shared insights on how Muslims, fear being found out by their partners that they accessing family planning services:

Most of the female head porters, especially the Muslims are very secretive and most often do not want to practise family planning. When they do, they do not want their partners to even know about it, because it can generate into a lot of problems for them. Sometimes they ask you to keep their cards for them. They have various means of hiding their cards or hiding their uptake from their partners. In that case, they do not want to use methods that their partners can easily find out, mostly they come for the injectables especially Depo, because with this one there would not be any evidence of the woman using family planning (Key Informant 2, Abokobi Health Centre).

A participant revealed that, culturally, some men might desire large families, which could influence family planning uptake:

The only thing I know is that, some men marry many wives and desire to have a lot of children because they are traditional leaders. So that may influence (Head porter, 5).

Commenting further on the issue of large families, this participant disclosed:

In the case where the man wishes to have many children, he will oppose, if the woman wants to use family planning. Some husbands will never agree to contraception and this affects the woman (Head porter, 12).

4.5.4 Education

Some participants felt that education was a crucial determinant of contraceptive use, as educated women could be better equipped with information resulting positive decisions:

But if the woman is educated it encourages contraceptive use because the woman will be better informed (Head porter, 3).

Education could open doors for better understanding of family planning, this participant attested:

Education influences contraceptive use, the one who has been to school will surely be more knowledgeable about it than a person without formal education (Head porter, 4).

This head porter talked about how education could empower women to make decisions on the number of children to have:

As for education it is important because it influences decisions on what family planning method to adopt. It empowers women with information that could help them decide on the number of children to have (Head porter, 5).

4.5.5 Association with Promiscuity

Participants shared views that, accusations of infidelity often accompanied the use of contraceptives. These accusations were cited to emanate from family, husbands, friends and even community members. Married women and single unmarried women were not expected to use.

The of use contraceptives was associated with prostitution and infidelity:

This whole idea of being promiscuous when one uses contraceptives. There is the belief that you are promiscuous when you use contraceptives, so it discourages many head porters from accessing services. I have witnessed so many instances, where women were accused of being prostitutes and were thrown out of their marital homes by their in-laws just because they used contraceptives (Key informant 1, Marie Stopes International).

Another informant indicated that, sometimes fellow women criticised those who seek family planning services:

Female head porters' inability to patronise family planning is mostly cultural, because when they migrate to Accra, they always move in groups and once they see that you are practising family planning you are in trouble. They will criticise you and say that you came to Accra to flirt with men that is why you have are using family planning, they will then go and report you to your husband (Key Informant 2, Abokobi Health Centre).

Commenting further, on how other women could discourage head porters from accessing and utilising family planning services, this informant disclosed:

All those head porters who migrated here, left their husbands in the north, so if a sister or friend knows that the husband is in the north, and they are seen accessing services at the family planning clinic, they ask them why they are doing it? And you know in the north the perception is that when you do family planning it means that you are a - prostitute that is what they have in mind. If you do family planning it means you want to go behind your husband and sleep around (Key Informant 3, Madina Poly-clinic).

A key informant revealed how other women could discourage head porters from accessing and utilising family planning services:

We organised a programme for them here with Marie Stopes International, we gave them some t-shirts and money and gathered them outside on the benches. We then said they should come in the consulting room one-by-one and choose a family planning method, ooh! Nobody was willing to take the service. They did not want their friends to know about their uptake because it would be reported to their husbands in the north. Some -

friends will even say that eei!, you came Accra to do family planning it means you want to flirt with men (Key Informant 3, Madina Poly-clinic).

4.6 Institutional Challenges that Hinder Access to Family Planning Services by Migrant Women

Participants who were key informants cited poor family planning provider attitude and lack of physical access as major inhibitors of family planning uptake by migrant women. Group counselling was not cited by key informants as hindering access to family planning services by migrant women.

4.6.1 Poor Provider Attitude

Key informants were in agreement that, poor attitude of healthcare providers towards migrants contributed to low patronage of services. Healthcare providers were noted to be unfriendly, judgemental and lacked good customer service skills thus did not provide a conducive environment for migrant women to request for services:

Then perhaps for me the most painful thing is the way they are treated, when they go to the hospital to take up family planning services. The attitude of the workers, the way they treat head porters, does not encourage patronage of family planning services. In some cases, they are treated with disdain as if they do not deserve access to such services (Key Informant 1, Marie Stopes International).

Healthcare providers were noted for ignoring the reproductive health needs of migrant head porters:

Attitudes of family planning providers are a major issue. Many head porters are young even though they may be married and have children. Our culture frowns upon young people coming in at their own volition to access family planning services, because it -

implies that, they are spoilt. It is important to understand the cultural and religious backgrounds of these migrants so that we can be sensitive to their needs. The way health care providers sometimes talk migrants deters them from coming to the clinics for services (Key Informant 2, Abokobi Health Centre).

4.6.2 Lack of Physical Access

Physical access in terms of proximity, opening and closing times as well as days of opening was cited by key informants as another challenge that inhibited family planning uptake by migrant women. Access to family planning services by female head porters was noted to be depended on the operating hours of many facilities as well as the distance to these facilities:

We also have problems with proximity in terms of accessibility, sometimes the facility is far from head porters, so they cannot come to us, and even accessibility in terms of closing times. Our times of opening and closing are not conducive for many migrant women. Some would like to come in the evenings, but here is the case that we open from - 8am to 4pm, what can we do about those people? We therefore tend to sometimes extend our opening and closing times just to cater for their reproductive needs (Key Informant 2, Abokobi Health Centre)

Distance to facilities was cited as a major hindrance to access and utilisation of family planning services by migrant women, according to an informant:

Often times they do not have physical access to the facilities. The nearest facility around Agbobloshi where we work with head porters is the USSHER clinic which is far away from where 'kayayei' work. They therefore cannot readily access services when the need arise (Key Informant 1, Marie Stopes International).

On the contrary, one key informant insisted that physical access was really not the challenge, but rather, the attitudes of migrant women towards family planning in general:

As for the 'kayayoo' in particular, we decided to even open on Saturdays and Sundays here at Madina Poly-clinic, but we do not see them. Their working days are Monday to Saturday and they rest on Sunday that is when they visit friends, relatives and do other things. So if you want to see them unless Sunday, so we decided to open the clinic on Saturdays and Sundays because of them, but they don't come (Key Informant 3, Madina Poly-clinic).

4.6.3 Group Counselling

Key informants provided information which indicated that, in Accra at least group counselling was not a challenge because focus was on individual counselling only. Key informants indicated that, family planning counselling was done for couples or individuals who wished to practise it and family planning education in general, was provided in groups:

Counselling is something that should be done in privacy and confidence in order to encourage women to talk openly. Here we have the counselling room; if you go out there you see the clients on the bench going in one-by-one. I am here with my colleague, our procedure room is behind there, and clients come here individually as well. If we are giving health talks, yes, we do it in groups. We do not do group counselling because, some of the women will never talk due to shyness (Key Informant 3, Madina Poly-clinic).

Another key informant attested that, fears of being reported to partners prevented successful group counselling:

At this facility we do group education at the CWC (Child Welfare Clinic) and ANC (Ante-natal Clinic) but we conduct counselling individually. In a group we just give general -

education about family planning, because in a group you find majority of women not contributing because they are shy, or do not want the others; friends or neighbours to know that madam so and so is using family planning. Women fear to be reported to their partners, so they will never partake in group counselling (Key Informant 2, Abokobi Health Centre).

4.7 Discussion of the Findings

Findings of the study indicated that, migrant female head porters' migration statuses were closely connected to their decisions and use of family planning. Female head porters who migrated alone without a spouse and those who were undertaking temporal migration were found not to utilise family planning services in Accra. Many head porters in the study, had migrated independently, without their spouses to work and earn an income. Separation from sexual partners as a result of migration, also accounted for the non-use of contraceptives among the participants. They viewed separation from spouses or having no spouse at all, as a method of family planning leading to disregard for contraception. Similar findings were observed by White et al. (2005) in Ghana, that the absence of sexual partners who were left in places of origin, accounted for migrant women's lack of motivation to use contraception. Additionally, this current finding supports the disruption hypothesis which states that, temporal migrants experience a disruption in fertility which can result in low usage of family planning services (Majelantle and Navaneetham, 2013).

On the other hand, female head porters living with spouses in Accra were using contraceptives. This is possibly due to the fact that, social and economic barriers in Accra made it difficult to cater for families adequately leading to contraceptive use, in order to control fertility. These findings are in line with those of Chattopadhyay et al. (2006) and White and colleagues (2005) in Ghana, which observed a difference in family planning choices among migrant women, as a

result of depressing factors associated with urban living. The present study also supports the adaptation hypothesis, which suggests that, migrants gradually adapt to family planning norms of receiving communities, as traditional norms are replaced with modern ones leading to low fertility characterised by contraceptive use (Majelantle & Navaneetham, 2013).

Furthermore, the findings of the study revealed that there was an intention, among many migrant female head porters to adopt family planning in the future, owing to its positive outcomes. Some participants cited the burden of catering for children, personal experiences of divorce, abandonment and neglect as big motivators, for their intentions to adopt family planning. These findings suggest that, migrant women were becoming aware of their responsibility to take charge of their fertility and reproduction system. These findings corroborate findings by Mosha et al. (2013) in Tanzania, White and colleagues (2005) and Machiyama and Cleland (2014) in Ghana. Mosha et al. (2013) and White and colleagues (2005) showed that, women sometimes deliberately take efforts to control their fertility in order to improve their general health and wellbeing and that of their children. Machiyama and Cleland (2014) observed that, though majority of women in their study were not using contraceptives, 54 percent indicated an intention to use contraceptives in the future. Present findings also conform to the theory of planned behaviour (Ajzen, 1991). Migrant women's intentions to adopt family planning were based on their evaluations of the outcome of practising family planning. They evaluated family planning as beneficial, which explains their positive attitudes, leading to stronger intentions to practise family planning.

With reference to migrant women's knowledge of family planning, findings of this study observed limited knowledge of family planning; its benefits, methods and how it works among migrant female head porters. Many of them had general awareness of family planning and its

benefits, even though it was inadequate to trigger contraceptive use. Low levels of family planning knowledge were found in a study among migrants in Guatemala, which showed limited knowledge of contraceptives among migrants, during their first years in an urban destination (Lindstrom & Hernandez, 2006).

Additionally, the participants were found to be familiar with some family planning methods, but were not aware of all the methods available and how they work. Many participants exhibited knowledge of the IUD, pill and injectables, however, there was little mention of condoms even though they are widely talked about. This finding substantiates observations by Rogers and Earnest (2013) on Eritrean and Sudanese immigrants in Australia, which showed varied knowledge levels with regard to types of contraception among their participants, who exhibited more knowledge of the condom, but knew little about other methods of contraception.

The findings of this study documented healthcare providers at healthcare centres, such as clinics and hospitals, family, friends and customers as well as programmes as sources of information on family planning for migrant women. Many participants learnt about family planning at clinics during antenatal and post-natal visits where nurses deliberately provided education. Additionally, some of the participants indicated that customers, family and friends played a crucial role in disseminating family planning information. Moreover programmes organised in the market by various organisations and other stakeholders provided family planning information to migrant women. These findings are consistent with evidence from other studies on migration and family planning (Kaphle, 2013) and (Zhang, n.d) in Nepal and China respectively, which ascertained the fact that, healthcare workers, family and friends who use contraceptives were considered important sources of information on reproductive health. Lindstrom and Hernandez (2006) also

observed urban areas as offering greater publicity to information on family planning through programmes.

In this study, lack of partner consent emerged as an impediment to migrant women's access and utilisation of contraceptives. Female head porters had fears and were against the use of contraceptives without permission from their husbands. Many of them expressed that the use of contraceptives without partner consent, could result in divorce, beatings and neglect. Male dominance in family planning decisions was identified as a major barrier to family planning utilisation in Tanzania (Schuler et al., 2011). In addition, the findings substantiate those by Awingura and Ayamba (2015), Dereje and colleagues (2015), Roger and Earnest (2014) and Mosha et al. (2013) in Ghana, Ethiopia, Australia and Tanzania respectively, which showed lack of husband's consent as a barrier to family planning uptake by women. Their findings also documented incidences of divorce and abuse among women who used contraceptives without their husband's support. The present findings also conform to the theory of planned behaviour (Ajzen, 1991), migrant women's perceptions of the beliefs of spouses on family planning, were found to influence decisions and utilisation of family planning. Migrant women's motivations to comply with beliefs of their significant others led to weaker intentions towards family planning.

In addition, migrant women were found to have concerns about the adverse side effects of contraceptives on their health and fertility. They cited instances where women died, gained weight, bled irregularly, had physical injuries, experienced fertility problems and in some cases cessation of the menstrual cycle, as a result of using contraceptives. These occurrences put fear in many head porters, such that, they were weary of using contraceptives. Interestingly, for many participants, these fears were as a result of rumours from friends and family. This finding verifies qualitative observations by Rogers and Earnest (2014) and Mosha et al. (2013) that, concerns

about side effects of contraceptives discouraged women from seeking services. Furthermore, Farmer and contemporaries (2015) and Mosha et al. (2013) asserted that, most of the side effects perceived to be associated with contraceptive use are as a result of myths and misconceptions within societies that are fuelled by rumours.

Religion and culture were also identified as inhibitors of family planning uptake by migrant women, with Catholics and Muslims emerging as less likely to use contraceptives. Key informants noted, Muslims as being secretive about their bodies, such that women are prohibited from exposing themselves to persons other than their husbands, which influenced family planning uptake. All participants in the study were Muslim women from the Northern Region of Ghana, which could explain the low family planning uptake among them. This finding conforms to those by Hou and Ma (2011) in Pakistan, Omondi and Ayiemba (2003) in Kenya and Palamuleni (2014) in Malawi, which identified Catholicism and Islam as religions that have the lowest usage of contraceptives. Islam was particularly noted to limit women's participation in reproductive health decision making due to prohibitions by the Quran (Hou & Ma, 2011).

Furthermore, contraceptive use among migrant female head porters was found to be associated with promiscuity and infidelity, which largely influenced their family planning uptake. Participants opined that, such allegations made it difficult to access and utilise family planning services, as this could have ramifications for their marital statuses. Many head porters resided in rented rooms with other head porters, whilst their partners lived elsewhere in Accra or the north. Participants were therefore apprehensive of friends, family members and husbands getting wind of their contraceptive uptake, which could result in accusations of prostitution and infidelity. These observations corroborate evidence from a qualitative study in Tanzania by Mosha et al. (2013) that, contraceptive use was associated with infidelity or promiscuity, which led to divorce

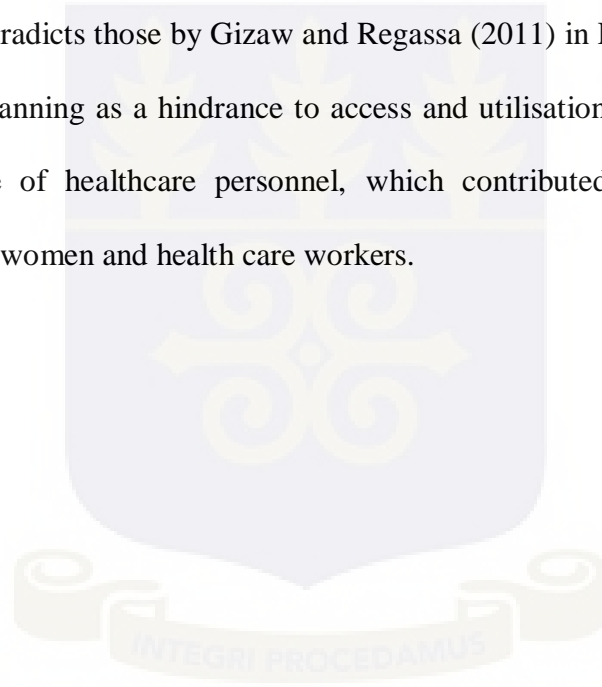
among married women. Also, findings by Farmer et al. (2015) in Rwanda, identified stigmatisation and labelling of young and unmarried women as prostitutes, when they attempted to access family planning services. In addition, education was found to have an influence on contraceptive use.

Furthermore, the findings of the study unearthed institutional barriers, such as poor provider attitude and lack of physical access to family planning services as challenges that hindered access and utilisation of family planning services by migrant women. Poor provider attitude was found to be a major barrier to access and utilisation of family planning services by migrant women. Even though, female head porters were found to have limited time to visit healthcare facilities for family planning services, the attitudes of healthcare providers also contributed to their reluctance to seek for services. The present study documented, how some family planning service providers treated migrant women with disrespect, characterised by insults and unfair judgements. This finding contradicts evidence by Palamuleni (2014) and Speizer et al. (2005), which showed easy access to family planning services at health posts for urban dwellers, as they are endowed with an array of social services family planning included, resulting in greater access and utilisation. On the other hand, the present finding corroborates those by Farmer et al. (2015) in Rwanda, which documented ridicule, stigma and judgements toward younger and unmarried women who attempted to access family planning services.

In addition, lack of physical access in terms of proximity, opening and closing times as well as days of opening were found to be constraints in access and utilisation of family planning services by migrant women. Many facilities that provide reproductive health services to migrant women were found to be far from where the participants resided, closed early and did not open on weekends and, as such were not accessible. Given the long hours female head porters work, it

implies that, visiting healthcare posts is virtually impossible. Similar findings were observed in a study in Ethiopia by Gizaw and Regassa (2011) that, huge shortages in personnel and other facilities such as clinics, limited family planning providers' capabilities to meet demand for services as they could not operate with scarce resources.

Finally, counselling, particularly group counselling was not found to be an issue that warranted concern for female head porters' inability to utilise family planning services in Accra. Evidence from the study indicated that, counselling was done individually with couples or individual clients. This finding contradicts those by Gizaw and Regassa (2011) in Ethiopia, which observed counselling on family planning as a hindrance to access and utilisation, as it was often done in groups due to shortage of healthcare personnel, which contributed and affected effective communication between women and health care workers.



CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter outlines the summary of the findings and conclusions arrived at based on the findings. It also provides recommendations for policy and implications for social work practice.

5.2 Summary of Findings

The study investigated the following objectives; (a) to explore how northern migrant women's migration status influence their family planning decisions and uptake, (b) to find out northern migrant women's knowledge about family planning, (c) to ascertain the socio-cultural norms and beliefs that influence decisions and use of contraceptives among northern migrant women and (d) to find out institutional challenges that hinder access to family planning services by northern migrant women.

It was found that, many of the migrant participants were Muslims from the Northern Region, married and between the ages of eighteen and thirty-four. Many of the participants had no formal education and lived in shared rented rooms. Female head porters' migration status influenced their decisions and family planning uptake. Many female head porters were found to have migrated independently. The absence of sexual partners as a result of migration, was viewed by migrant women as a form of family planning, and as such, resulted in non-utilisation of family planning services. On the other hand, migrant women, who were living with their spouses, were found to be using contraceptives. That is, they appeared to have adapted to urban family planning norms and behaviours which are characterised by contraceptive use.

Though many of the migrant women were found not to be practising family planning, they showed an intention to adopt it in the future, because of the positive benefits associated with it. Family planning knowledge among migrant women was limited which influenced their decisions and uptake of services. Participants exhibited general awareness of family planning and its benefits, but showed limited knowledge on the various methods and how they work. Sources of knowledge for migrant women were identified as healthcare workers, family, friends, customers and programmes at the market.

Lack of partner consent emerged as a barrier to contraceptive use by migrant women. They expressed that it was difficult utilising the services without partner consent. In addition, fear of side effects of contraceptives deterred many participants from seeking the services, even though some of these fears were just misconceptions. It was also found that, cultural and religious factors limited women's participation in family planning decisions. Further findings of the study had shown that, many migrant women disregarded contraceptives due to fears of being accused as promiscuous. Education was also found to influence family planning by migrant women.

Further analysis of data indicated several other institutional challenges that hindered family planning uptake by female head porters. Poor provider attitude was found to be a major deterrent to access and utilisation of services by migrant women. It was also found that, lack of physical access in terms of location and operation hours of many healthcare facilities that serve migrant women was a challenge to access and utilisation of family planning services.

5.3 Conclusions

From the findings and discussion, it was concluded that, many migrant women working as head porters in Madina, do not use family planning. Several reasons account for this, which include

duolocal living arrangements, separation from sexual partners as well as other limiting factors (limited knowledge on family planning, social and cultural and institutional challenges) that constrain uptake of services. In addition, migrant women's limited knowledge on family planning influences their receptiveness to contraceptives. Though it was established elsewhere, in Kenya (e.g. Omondi and Ayiemba, 2003) that, being a migrant significantly increases the probability of contraceptive use, the case was found to be different among northern migrant women in Madina, possibly due to the nature of migration they engaged in.

Even though healthcare posts play a crucial role in disseminating information on family planning, there appeared to be a discontinuity in the process through which further information is disseminated to migrant women. This result in pockets of information being omitted which are vital in empowering migrant women to make informed choices. Furthermore, conclusions are drawn that, female head porters were weary of using contraceptives. This is because, lack of adequate information implies that, their fears and unanswered questions are not properly addressed, resulting in low family planning uptake. Socio-cultural norms and beliefs on family planning were also concluded to be major impediments to migrant women's ability to access and utilise contraceptives. Institutional challenges could also frustrate migrant women's efforts to access and utilisation of family planning services.

5.4 Recommendations

Since access to appropriate family planning is essential for the wellbeing of women and communities, it is important that measures be taken to enhance its accessibility to female head porters. Given these observations, institutions particularly Ministry of Health must address challenges and ensure accessibility of services to underserved population. The following recommendations for policy and social work practice are therefore given:

Non-utilisation of family planning services due to poor provider attitude and lack of physical access was observed in this study. Reproductive health concerns among migrants should be considered, not only as a matter of academic interest but for national policy in general. It is necessary for the government (Ministry of Health), policy makers and other stakeholders, such as Marie Stopes International who have an interest in reproductive health, to take measures that ensure universal access to sexual reproductive health services and reproductive rights as agreed in accordance with the Programme of Action of the ICPD (1994) and the Beijing Platform for Action.

The Ministry of Health and other organisations that offer reproductive health services should recognise the importance of implementing policies to improve migrant women's access to reproductive healthcare. Policies should take into consideration underserved populations such as migrant female head porters, as well as adolescents as they have equal rights to reproductive health as any other Ghanaian. It is further recommended that, outreach services, particularly door to door be promoted for female head porters. Organisations, such as Marie Stopes International, which have the capacity to provide mobile services to women particularly migrants, should be encouraged to do so by recognising and rewarding their work.

In addition, there is need for the government to make a commitment to put up Community-based Health Planning Services (CHPS) compounds around market places, to ensure accessibility to services by migrant women working as head porters. Moreover, these compounds should operate at times that are convenient for female head porters. Other healthcare facilities specifically family planning clinics, within catchment areas of migrant female head porters and other marginalised groups of women, could extend their working hours to cover weekends and possibly nights to promote access to family planning services.

Moreover, to further address the issue of poor provider attitude, the Ministry of Health should commit to providing training on best practices to service providers, so that they could better serve diverse populations with diverse needs. Service providers could be sensitised to be “kayayei” friendly and their facilities should be structured to accommodate migrants’ needs. A special team of trainers could be deployed to various health posts, such as Madina Poly-clinic to monitor and train providers. This training and education should be continuous and take place over a period of time in order to ensure a complete change in behaviours.

5.5 Implications for Social Work

According to Rapoport (1970) social work profession has a strong compatibility with family planning, as the outcomes which are to enhance, strengthen and preserve family life are central concerns of social work practice. Social workers have numerous roles to play, such as advocates, empowerers, brokers and educators. Underserved populations, such as female head porters are often voiceless, and require someone to speak on their behalf, they are also often times alienated from reproductive health services. Social workers as advocates could collaborate with healthcare workers, and be the mouthpiece for migrant women, in order to ensure that they get access to reproductive health services that are affordable and best suited to their needs. Also, social workers could partner healthcare institutions and take measures to eliminate institutional challenges, such as poor provider attitude that impede access to family planning services by migrants.

Migrant women constitute a minority population with a different cultural background; therefore social workers who work in healthcare institutions could sensitise healthcare providers to be culturally sensitive. Social workers could help train healthcare workers to be able to recognise cultural differences that may impede access and utilisation of family planning services by

migrant women. Interventions could be designed that affirm migrant women's right to self-determination, thus encouraging their freedom of choice in family planning decisions.

According to UNFPA (2013) family planning contributes to sustainable development and promotes gender equality by making women more autonomous in decision making. Despite this, many women, including migrants, still lack decision making power, as such it beholds on social workers to help empower women by providing information at family planning workshops and other programmes. Using the person in the environment approach, social workers could explore other factors that constrain family planning uptake by migrant women, such as lack of partner consent and other religious and cultural factors and design appropriate interventions to address these issues.

The study identified lack of adequate knowledge on family planning as a barrier to its utilisation. Based on this finding, it is recommended that, social workers as educators, could embark on sensitisation programmes, whereby both men and women are educated on the importance of family planning, and how it could help build healthy families and communities. The type of education to be given should be strategic and purposeful and should target behaviour change. Creating awareness through educational campaigns targeted towards men to be supportive of women's decisions to practise family planning, would be mostly useful in addressing issues of partner consent. Many migrant women were also found not to be using contraceptives due to misconceptions about associated negative effects. This implies that, the education should focus on demystifying some of these misconceptions.

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APPENDICES



APPENDIX I
INFORMATION FOR RESEARCH PARTICIPANTS

Research Title: Family Planning Decision Making among Northern Migrant Women in Madina, Accra.

You are invited to participate in a research on the above topic aimed at ascertaining family planning decision making among migrant women who live and work in and around Madina market.

About the Researcher

Petronella Munemo is an M.Phil (Social Work) student at the Department of Social Work, University of Ghana. Her broad research interests are in gender and migration; reproductive health; children's welfare and other gender related issues.

Purpose of the Research

This study is aimed at exploring family planning decisions of migrant women in Madina, specifically looking at how the migration process impacts decisions on family planning choices, the knowledge migrant women have on family planning, factors that influence contraceptive use and institutional challenges migrant women face in accessing family planning services. The study is solely for academic purposes and will contribute to the award of a Masters Degree in Social Work.

Participation

Your participation in this study is voluntary, as such you have the right to withdraw anytime you feel any discomfort during the data collection process. If you decide to withdraw from the study the data provided by you will be destroyed.

Risks and Benefits

You may feel exposed about revealing sensitive information during the study. Confidentiality is highly guaranteed for you to feel free to talk to the researchers.

The study will be beneficial in that it will enhance Social work knowledge and understanding of migrant women's family planning choices and the challenges they face in making these choices.

This will contribute to policy changes that may improve the empowerment and wellbeing of women, children and families by making family planning services easily accessible.

Confidentiality

All personal identifying information about yourself will remain confidential and will not be included in the final write up. Any quotations to be used in reporting the findings will not include names or any identifying data to ensure anonymity. All recordings and transcripts will only be accessible to the researcher and assistants. The findings will be submitted as part of the researcher's Masters Degree thesis and may be published as articles in journals.

Contact

If you have any questions about the study or the procedures involved, you may contact me on 0246892050.

Consent

I have read or I understand what has been read to me. I have received a copy of this form and have agreed to participate in this study

Participant's Signature..... Date.....

Researcher's Signature..... Date.....

Consent to use quotations

I consent to the researcher using my quotes in reporting the findings.

Participant's Signature..... Date.....

APPENDIX II

TOPIC GUIDE FOR MIGRANT WOMEN AND KEY INFORMANTS

SECTION A: Migration and its Impact on Family Planning Choices.

- Could you please tell me about yourself? (Age, where you come from, your journey from place of origin to present location, duration of stay)
- What is your family composition (Marital status, Do you live with spouse, children, relatives)?
- What brought you to Accra?
- How has migration from the north to Accra changed the way you make decisions on family planning?
- What type of family planning (if any) were you practising before you migrated and why?
- In what ways have your views on family planning changed since moving to Accra?
- What do you think is the role of women in making family planning choices (contraceptive use, child spacing and number of children)?

SECTION B: Women's Knowledge of Family Planning.

- Where did you first hear about family planning (contraceptives, fertility)? **(Probe)**
- In what ways would you say coming to Accra has enhanced your knowledge on family planning?
- Can you please tell me if you know more about family planning now than before you migrated?
- Do you think women in Accra are more knowledgeable about family planning as compared to women in the north? In what ways? **(Probe)**
- Can you tell me the major source of your knowledge on family planning methods and services particularly on where and how to access them?
- What do you think are the benefits of having adequate knowledge of family planning?

SECTION C: Factors that Influence Contraceptive Use.

- Why do you think women use contraceptives?
- What do you think about contraceptive use?

- Would you say that these (as mentioned above) have any cultural or religious basis?
(Probe)
- Can you discuss reasons you feel women should be compelled to use or not to use contraceptives?
- Do you think women should seek permission from partners or relatives before using contraceptives? Why do you say so?

SECTION D: Institutional Challenges Women Face in Accessing Family Planning Services

(Key Informants).

- What kind of work do you do with migrant women working as ‘kayayei’?
- What formal family planning services are available for migrant women working as ‘kayayei’?
- How often do they utilise these services (as mentioned above)?
- From your experience working with ‘kayayei’, what are some of the reasons given for non-utilisation of contraceptives
- Can you please tell me what challenges migrant women face in accessing family planning services?
- What do you think are the reasons for the existence of these challenges?
- In what ways do you think these challenges can be addressed?
- What do you think are the consequences of inadequate family planning services and education among women, particularly migrants?