

UNIVERSITY OF GHANA

CENTER FOR MIGRATION STUDIES

**HEALTH SEEKING BEHAVIOUR AMONG RURAL-URBAN
MIGRANT SLUM DWELLERS AT MADINA IN THE
GREATER ACCRA REGION**

BY

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DECLARATION

I hereby declare that this dissertation is the result of my original work and that no part of it has been presented for a similar work in this university or elsewhere and was conducted under the supervision of Dr. Mary Boatema Setrana and Dr. Ebenezer Niikoi. I must however admit that I did make use of references from various sources which I duly acknowledged.

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DEDICATION

To my family, wife Victoria Afeadie, and children Seyram R. Afeadie and Klenam B. Afeadie

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LIST OF ACRONYMS

BBC - British Broadcasting Corporation

GSS - Ghana Statistical Service

HIV/AIDS - Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome

HSB - Health Seeking Behaviour

IOM - International Organisation for Migration

ISSER - Institute of Statistical, Social and Economic Research

IP's – Informal Providers

NGO - Nongovernmental Organisation

STI's – Sexually Transmitted Infections

TB - Tuberculosis

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNDESA - United Nations Department of Economic and Social Affairs

UNHCHR - United Nations High Commission for Refugees

UNICEF- United Nation's Children and Education Fund

UNOWA - United Nation's Office for West Africa

WHO - World Health Organisation

ABSTRACT

Rapid urbanisation, largely due to rural-urban migration, has not only led to increased city slums but has also led to an increase in health related challenges for the rural-urban migrant slum dweller. Health seeking behaviour among these sub-populations can only be achieved when policies designed take contextual issues into consideration. Although, considerable amount of research on the health seeking behaviour of slum dwellers exist, studies on the contextual exploration of rural- urban migrant slum settlements are relatively few. This study aims to investigate health seeking behavior among rural-urban migrant slum dwellers at Madina. The Health Belief Model (HBM), which is health specific behavioural cognitive model (Taylor et al., 2006; Orji et al 2012), was adopted and modified to help understand the health seeking behavior among rural- urban migrant slum dwellers, and how interventions by health planners can be achieved in slum settings such as the case of Madina in the Greater Accra Region. The conceptual framework suggests that to avoid a mismatch between context environments and health programme interventions, there is the need for planners i.e. government and other stakeholders engaged in health programme interventions, to carry out a contextual exploration of specific environment situation to be able to know the exact health seeking behaviour patterns of the specific slum communities in order to formulate need based policies that lead to expected lifestyle behaviours. The study adopted the mixed method research design approach. Questionnaire and interview guides were used to collect data from rural-urban migrant households through the simple random technique and purposive sampling respectively. A total of 241 questionnaires were retrieved from the respondents representing a response rate of 100%. Eight (8) key informants and health officials were interviewed. The findings of the study show that various diseases in the slum were attributed to poor housing units and work conditions. However, few cases or no cases of disease attack were reported at places of origin. The study also found that health seeking behaviour was observed at various places of origin as compared to the slum. Additionally, the study indicates that though there were a few challenges in health seeking behaviour before migration, these challenges were more pronounced in the slums. The financial constraints in accessing health care compelled them to resort to various coping strategies to overcome their health challenges in the slum. The study also highlighted the absence of a policy to promote health seeking behaviour. Hence, policy responses were raised to help address the challenges of health seeking behaviour, key among them is the need to embark on health education programmes both at places of origin and the slum.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND OF THE STUDY

Globally, about 54 percent of the world's population are urban residents, a billion of whom are estimated to be living in slums conditions (UN-Habitat, 2016). According to the International Organization for Migration (2015), sub-Saharan Africa is home to 61.7 percent of slum dwellers. In Ghana, as of 2001, the slum population was estimated to be around 4.5 million. This number has increased to 1.83 percent per annum and evidenced in key cities of the country. This figure reached 4.9 million in 2010 and 5.3 million in 2014 (UN-Habitat, 2016).

Like slums in other parts of the world, Ghana's urban slums serve as home to many internal and international migrants and are characterised by overcrowding, insanitary conditions, unsafe buildings, deprived access to basic facilities such as health services, sanitation and clean water (Owusu et al., 2008). Though urbanisation is occurring at a rapid pace, Ghana's housing deficit currently stands at 1.7 million units and a minimum of 170,000 housing units will have to be built annually to salvage the situation (Daily Graphic online, 2014). This phenomenon is mainly as a result of rural-urban migration. The motive behind the large movement from the rural-urban areas is due to the better living conditions and the relative improvement of different facilities in the urban areas compared to the rural areas (Habtmu, 2015). Rural-urban migration involves the movement of people from the rural areas into the cities, often the metropolitan cities of a country. This change of residence is often connected with the migration of labor and a career change from primary to second or third sector - not necessarily, though, as it can refer to the migration of people who are not working in agriculture or farming as well (Todaro, 1976). Rural-

urban migration is, therefore, a critical component of urbanisation (Tacoli et al., 2015). One of the major challenges faced by countries that are undergoing rapid urbanisation is the spread of diseases. This is because there is inadequate basic infrastructure, social and economic inequities in urban cities, a situation which leads to severe health problems (Vlahov et al., 2006).

The World Health Organisation (2005, 2006), notes that many infectious diseases such as worm infections and diarrhea easily spread through contaminated water and the unavailability of water poses a major challenge to families in maintaining basic hygienic conditions in their home environment. The challenge, therefore, in many urban areas is how the health situation and the living conditions of such underprivileged populations can be improved (Dahlgren & Whitehead, 2006).

Efforts directed at slum improvements in the past were as a response to outbreak of contagious diseases that were believed to have originated in slums. There is abundance of literature linking housing deprivation with ill health later in life; even during the 1950s, morbidity rates in urban UK were higher than in the rural areas. Slums in Bangladesh, for instance, have child mortality rates much higher than in rural areas. Some small cities in Brazil, a middle-income country that contains areas indistinguishable from the HICs on all social measures, have mortality rates more typical of LDCs. Stunting rates for children in urban areas with low socio-economic scores are similar to rural averages in many less developed countries. Millions of people who live in slums suffer unhealthy living conditions, resulting in shorter life and chronic illness. The poorer general health of slum dwellers and the lack of access to medical attention increase their likelihood of dying from epidemic diseases such as AIDS and tuberculosis, while poor sanitation exposes them to waterborne diseases (Dahlgren & Whitehead, 2006).

In most developing countries, disproportionately more health services are demanded and received by better-off people than the poor. The inability of most poor people to access health care (mainly due to the lack of financial resources) exacerbates their poor health condition, a situation caused by poor diet and poor living conditions. In some countries, people from the slums may not even be entitled to attend public health clinics, because they may not have a registered address (Dahlgren & Whitehead, 2006).

Interestingly, while, most of the slums in the cities may be located close to health care facilities, residents are deprived of access to these facilities thereby leading to negative economic and health consequences (Agyei-Mensah and de-Graft Aikins, 2010). Attempts at addressing some of these challenges in Ghana and the world, have led to the introduction of some targets and policies, prominent among them being target eleven (11) of the Millennium Development Goals which aims at improving the lives of at least 100 million slum dwellers world wide by 2020 (UN-HABITAT, 2006a). The Sustainable Development Goal (SDG) three (3), which seeks to improve health remains a global priority during 2016-2030, this is to focus on ensuring healthy lives and promoting well-being for all at all ages (WHO, 2016).

The MDG's and SDG's are both expected to bring improved health outcomes of rural – urban slum dwellers as well. This makes it necessary that healthcare policies are formulated in a way that brings about positive health outcomes for such underprivileged populations. Health seeking behaviour in their communities becomes an important step towards finding cure for any disease among any population (Prince and Hawkins, 2007). According to Ahmed et al., (2000), health seeking behaviour refers to any activity carried out by individuals who perceive themselves to have a health problem or ill for the purpose of finding appropriate remedies. It is more or less the

summation of the characteristics of the individual, the environmental conditions in which the person lives and the interaction that goes on between the individual and environment. It also takes into consideration issues of whether, when, and from where care is obtained for an illness (Chomi et al., 2014). There is therefore health differences in terms of rural settings and the urban slum settlements with regards to how such groups engage in health seeking behaviour. Therefore, knowledge about health seeking behaviour among the rural- urban migrant slum dwellers is crucial not only to ensure the well-being of such population but also to provide need based health service delivery. Using a mixed method approach, this present study sought to investigate the health seeking behavior among rural –urban migrant slum dwellers in Madina in the Greater Accra Region of Ghana. The study adopted and modified the Health Belief Model (HBM), which is health specific behavioural cognitive model (Taylor et al. 2006; Orji et al 2012) to help explain health seeking behaviour among rural – urban migrant slum dwellers.

1.1 STATEMENT OF THE PROBLEM

Some of the adverse effects of the increase in urbanisation are urban sprawl and the emergence of slums and other informal settlements which are common phenomenon in most cities of developing countries. This occurrence is largely attributed to rural - urban migration (Davis, 2004). Slums have developed and grown in many different parts of Ghana over the years. In the Greater Accra Region of Ghana alone, a report by the Population Division of the United Nations Department for Economic and Social Affairs (2009) indicates that nearly one-third of the population are slum dwellers. According to Afrane (2010), one of the migrant communities in Ghana popularly referred to as ‘Zongo,’ and newly emerging squatter communities largely contribute to the rapid expansion of slums. Old Fadama, and Nima among others, are some of the examples of slums communities in Accra. Other rapidly growing slums such as Madina are also

found in low income suburbs of the region (GSS, 2010). A major problem often faced by these slum communities is the episode of diseases due to the poor living conditions which raises a major concern. This is because in most circumstances, slum dwellers find themselves in a vicious cycle of economic and psychological poverty. The extremely excruciating situation they find themselves in makes it difficult for them to afford many essentials of life; they experience grave deprivation pushing them into a state of despondency (Unger 2007; UN-Habitat 2003; Sheuya 2008).

The poor housing situation coupled with the dirt and squalor and lack of financial resources contribute to the presence and spread of varied infectious diseases in slums, affecting women and children mainly (Unger 2007; UN-Habitat 2003; Sheuya 2008; Sverdlik 2011; WHO, 2005; Zulu et al., 2011). According to (Zulu et al., 2011; Skordis- Worrall 2011; Mathews et al., 2010; Halder et al.2009; Bulatao et al 2003; Mathews et al 2005), high cases of maternal mortality, high vulnerability to HIV infection, high unmet need for family planning and developmental challenges in children and adolescents are just a few of the many negative results of poor access to health in city slums. Besides, these sub- population are also exposed to unhealthy lifestyle factors such as physical inactivity, obesity, harmful diets, alcohol and tobacco use due to high unemployment rates and poverty (Rahman et al., 2011). Knowledge about health seeking behavior among these populations is therefore essential to provide need based health outcome. However, this is often ignored and even where this knowledge exists, there is often a mismatch between specific community needs and programme priority due to context environment variations which render programmes unproductive (Singh et al., 2014).

According to Maneze (2014), most migrants who have moved to new locations may consider health seeking behavior a lesser priority because they have many settlement issues and also seek for better economic opportunities and because of this, they rather adopt various coping mechanisms to overcome their health challenges. As a result, health promotion interventions fail to get the desired acceptance of the community. These issues make health seeking behaviour practices very complex and therefore need contextual exploration (Singh et al., 2014). Although, a considerable number of studies have been conducted on health seeking behavior of slum dwellers. Studies on the contextual exploration of rural- urban migrant slum settlements are relatively few. Therefore, this study seeks to bridge the knowledge gap by investigating the health seeking behavior of rural–urban migrant slum dwellers.

1.2 AIMS AND SPECIFIC OBJECTIVES OF THE STUDY

The aim of the study is to investigate the health seeking behaviour of rural- urban migrant slum dwellers in Madina before and after migration. In order to address this aim, the following specific objectives have been set out;

1. To find out the morbidity profile among the rural – urban migrant slum dwellers before and after migration
2. To examine health seeking behaviour among the rural-urban migrant slum dwellers before and after migration
3. To examine the challenges associated with health seeking behaviour before and after migration
4. To investigate any coping strategies adopted by these migrants to overcome their health challenges

5. To assess existing policies aimed at the health seeking behavior of the rural- urban migrants slum dwellers.

1.3 HYPOTHESIS TEST

The study was guided by the following working hypothesis

H0: There is no significant difference between the type of house used in slum settlement and a disease one is likely to suffer

H1: There is a significant difference between the type of house used in slum settlement and a disease one is likely to suffer

H0: there is no significant difference between diseases suffered before migration and after migration to the slum.

H1: there is significant difference between diseases suffered before migration and after migration to the slum.

1.4 JUSTIFICATION

The study contributes to the limited research works on migration and health, especially in the Ghanaian and African context. The study provides insight into the contextual issues regarding rural-urban migrant slum dwellers' health seeking behavior patterns which is relevant for health planners and other relevant stakeholders in Ghana and other developing countries. Evidence from this study gives morbidity profile and health seeking behavior practices for the different socio-economic strata among the rural-urban migrant slum dwellers. This data is useful for formulating and implementing targeted strategies which are responsive to the needs and priorities of the rural-urban migrant slum dwellers. Finally, the methodology and findings are a source of

reference material for both students and researchers interested in the health seeking behaviours of slum dwellers and /or migrants.

1.5 DEFINITION OF TERMS

Rural -urban migration: In this study, the term refers to the movement of people (especially the youth) from locations that are rural in nature and which are mostly deprived of development to urban centres for the purpose of better economic other opportunities in response to low agricultural productivity, poverty and lack of social facilities.

Seasonal migration: This refers to migration to urban centres for temporary employment especially in the informal sector due to the seasonal failure on the agriculture calendar in order to supplement house hold income at that time of the season.

Rural-urban migrant slums: This used in this study to describe a very low class settlement within the city which is unplanned and is inhabited by different ethnic groups with low socioeconomic status who have moved from different parts of the country. These areas are densely populated and lack basic social infrastructure and facilities such as hospitals, schools, road networks and housing units.

Health seeking behavior: It is often defined as a series of remedial actions taken by an individual to rectify a perceived illness. It also considers the way people utilise wide range of health care systems including both formal and informal care providers in their respective economic, demographic, socio-cultural circumstances.

Urbanisation: the process by which towns and cities experience movement of people from the rural to urban areas. In other words, it refers to the steady increase in the population of the urbanite and the way in which these changes are adapted by society.

Health: the state of an individual that allows him or her to adequately cope with all the daily demands of life as well as the absence of disease and impairment.

Disease: It refers to any condition which is as a result of a disorder of a structure of function in an organism that cannot be attributed to any external injury. In most instances, it is considered a medical condition which is associated with symptoms and signs.

Informal employment: It is made up of different categories of informal enterprises which provide various employment opportunities to people mostly with low socioeconomic background and whose activities are not monitored by government. Many of these types of employment offer unprotected and unsecured places of work for employees.

Communicable diseases: communicable diseases, also referred to as infectious diseases, and are caused by microorganisms such as virus, fungi and bacteria parasites and are easily transmitted from an infected person to a non-infested person through contaminated water, food or through a bite.

Non- communicable diseases: a medical condition that is not transmissible from infectious agents to non-infectious person.

Chronic diseases: The term refers to diseases of an individual that last for long periods of time and progress slowly.

Morbidity: A state of having a disease or a symptom of a disease or the amount of disease prevalent among a given population.

Self-medication: The practice whereby an individual uses a substance to self-administer treatment for psychological or physical conditions. Such substances are normally over the counter drugs or misuse of drugs to treat common health condition.

1.6 ORGANISATION OF CHAPTERS

The whole study was set out in five chapters. Chapter one introduces the thesis by providing background information of the topic, statement of the problem, objectives of the study, significance of the study, the study hypothesis and organization of chapters. Chapter two discusses the relevant literature and the conceptual framework for the study. The third chapter looks at the research methodology focusing on the study areas, sampling procedures, data collection and analysis used for the study. Chapter four discusses morbidity profile and health of the respondents. Chapter five discusses health seeking behavior and its associated challenges, coping strategies adopted by migrants to overcome health challenges and existing policies aimed at the health seeking behavior of the rural- urban migrant slum dwellers in Madina. Chapter six, the last chapter looks at the summary of the major findings, conclusions as well as research and policy implications of the study.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

In order to address the research objectives of this study, this chapter seeks to review literature on migration, urbanisation and health. It attempts a review of existing literature on theoretical perspectives on health seeking behaviours and empirical evidence within each framework. The chapter then continues with the health conditions of rural-urban migrant slum settlements and rural communities, socioeconomic conditions of rural-urban migrant slum communities, morbidity profile of the rural-urban migrants slum dwellers, health seeking behaviours among rural-urban migrant slum dwellers, barriers to health seeking behaviour among the migrant slum dwellers, coping strategies adopted to overcome health challenges and policy responses aimed at health seeking behaviour.

2.1 CONCEPTUALISING MIGRATION, URBANISATION AND HEALTH

Migration patterns have varied enormously between countries and have not only been as a result of stages of structural transformation but also on individual and household characteristics. Mostly, young people have accounted for the majority of migratory movement (Gingsbury et al. 2014; Awumbila et al 2015; Msigwa 2013). Of the total number of migrant worker groups, one-eighth are young people aged between 15-24 who are on the move mainly for better economic opportunities (UNICEF, 2014). Data collected in 150 countries indicates that more than a quarter of young men and women are eager to relocate to other countries (ILO, 2014a). This situation can also be said of internal migration (Potts, 2008). There is a strong desire among young people to migrate from their rural areas to the urban centres for better employment opportunities that are non-agricultural in nature (Ginsburg et al., 2014; Awumbila et al., 2015). Other studies have also

indicated that in rural Morocco, for instance, rural youth are often on the move to the urban centres to look for better economic prospects (UNICEF, 2007). In Ghana, as a result of the economic slump which the country experienced between the 1970's and 1980's, most Ghanaian families saw migration as a survival strategy to help them cope with the difficult economic conditions at the time (Awumbila, Kwankye and Anarfi, 2011). Recently, the independent migration of women and girls to the urban centres due to monies remitted back home from female migrants working as head porters (*Kayayei*) and domestic workers in most market places in the cities is becoming very common (Awumbila *et al.*, 2008, 2011a). The situation has arisen because most rural areas lack educational facilities and decent livelihood opportunities for young men and women, so the expanding informal sector in the urban areas becomes attractive for most of the rural youth (Deshingkar and Grimm, 2005).

In the light of this, the youth look for seasonal employment to supplement income in periods of the year when agriculture work fails. The desire, therefore, is to migrate to urban centres for a long period because of the expected income and high returns (Harris and Todaro, 1970). However, since migration comes with cost and not every type of migration can be afforded by the poorest because of their limited resources, networks, market intelligence and skills (IOM 2005; WB 2011b). Seasonal migration becomes the only option for the landless, poor households (UNDP, 2009; WB, 2007). Proponents of the New Economics of Labour Migration (NELM), argue that migration serves as part of household strategy that is intended to maximize the utility of members and driven by insurance motives in developing countries. To them the environment poses a number of economic risk which lead to income insecurity thus making it possible for most of the youths to use migration as a diversification strategy. Therefore, the solidarity from the migrants and the household of origin is assured in a way of contractual agreement in which

remittances play a significant role to those families (see Lucas and Stark 1985; Stark 1991). As the migrants move mostly to the urban areas where expectations are to be met, they move alone without accompaniment and the likelihood of independent migration increases with age. In most cases, the rural youth do not have the skills necessary to compete in the formal markets in the urban centres of destination (WB, 2011b) and as a result, the migrants end up in slums (McKay and Deshinkar, 2014). This creates a situation whereby the rural youth are compelled to do low-income hazardous work, which most often poses a threat to their health (WB, 2011b).

Thus, migration is a significant contributor factory to urbanisation, the search for social and economic opportunities as well as environmental deterioration force people to be on the move. Studies on urbanisation in Ghana have suggested that the main pull factor of internal migration are employment and other opportunities which enhance a person's standard of living and which, however, cannot be found in the Northern and other deprived parts of Ghana (Awumbila *et al.* 2011b; Black *et al.*, 2006; Kwankye *et al.*, 2009; Mensah- Bonsu 2003). When the unemployment situation in the formal sector worsens, the cities are in a better position to provide alternative livelihood to the large informal labour markets (Songsore, 2003a).

Migration within countries continues to increase at alarming rate. Although, international migration is increasing, rural-urban migration accounts for greater share of human population movements (UNDP, 2009). It is obvious that better economic and other prospects of the cities offer a lure of urban life for the youth, who are not only unemployed but are also ill, curious and hungry thus driving movement to the cities (BBC, 2007). While rural-urban migration is the main factor in the rapid pace of urbanisation, natural population growth in towns and cities also contribute to the situation (Satterthwaite 1996; Potter and Lloyd-Evans, 1998; Songsore 2003; UNOWA, 2007). The rapid pace of rural- urban migration can be partly attributed to the fact that

most of the people who migrate to the urban centres are young people and this inevitably contributes to the high rates of natural increase in the urban areas, a situation that lead to high levels of unemployment resulting to urban poverty. Besides, urban poverty is an outcome of poor living conditions (Beall, 2000a). Ghana, however, is no exception to the rapid pace of urbanisation with its attendant challenges as it pertains in many sub-Saharan African countries. The effects of rapid urbanisation on Ghana's urban cities manifest in socio-economic, environmental and institutional challenges for most urban residents and local authorities. Millions of Ghanaians living in cities are living in densely populated and insanitary conditions and they also lack access to most basic services such as water, sanitation and health care (ISSER, 2007).

According to Ghana's development blue print, the Growth and Poverty Reduction Strategy, 2006-2009 (GPRS II), in 2001, about five million Ghanaians (representing about 58 percent of the total population) are slum dwellers and this figure is increasing at a rate of 1.8 percent per annum (NDPC, 2005). Evidence of slums is found in most of Ghana's largest cities, and this is also pronounced in the secondary cities as well. There is an increase in urban poverty and slums, poorly planned urbanisation patterns pose a major public health challenge. This is facilitated by the presence of urban slums which happens to be a home to an estimated 828 million people, being one third of the world's population. Among the urban poor is evidence of insecure shelter in overcrowded slums where there is lack of access to basic facilities and social inclusion is very common (Berger, 2006). Overcrowding and poor accommodation lead to the spread of communicable diseases such as cholera, malaria, dengue fever, tuberculosis and pneumonia. Insanitary conditions and the lack of access to potable water and safe food contribute to many reported cases of diarrhoea among slum dwellers. For example, the sanitation situation in the

Accra Metropolitan Area in Ghana, was reported to be very serious as provision of toilets facilities was related to the wealth of a household. Pit latrines were found in households with low income, while, flush toilets were common among the wealthy households (Boadi, 2002). In a related study, Boadi, (2005), found that in Ghana, garbage, waste water and human excreta were usually deposited in open spaces, streams and surface drains. In Tamale, one of Ghana's major cities more than 90 percent of all urban poor store solid waste inside their house for at least 24 hours before taking them outside (Osamanu, 2007). The absence of structurally sound and ventilated homes further puts the health conditions of slum dwellers at a risk of climate change related weather including heat waves and storms. Road traffic injury and physical inactivity related risks like obesity are associated with urban sprawl (WHO, 2017).

Urbanisation can be helpful in improving the health status of people. For example, because there are many hospitals and health centres in urban areas, people who reside in these places have unlimited access to health care provided they can afford it (Kirdar, 1997). It has been observed that in countries such as Sweden, the Netherlands, Singapore and Japan, there have been improvements in the last 50 years in mortality and morbidity in highly urbanised circumstances. Though the issue of health hazards remains a new health challenge that has become an issue over the years (McMichael,1999), healthy urban living conditions are attainable only if the financial resources are used for the right purposes and supportive political structures are put in place (Galea & Vlahov, 2005).

One major feature of most urban settings is the issue of inequality in urban settings, and is a true reflection of inequalities in social, economic and living conditions (WHO, 2001a; Marmot, 2006). In some developing countries such as Cuba, Sri Lanka, Kerala and India as far back as the

1960s and 1970s, attempts to develop a more equitable society based on the socialist ideology received were successful in improving health equity and public health in those selected countries and places. However, the mainstream models for social and economic development in the 21st century failed to focus on social equity (Vagero, 2007).

What this means is that, though improving the health status of the urban poor remains a major challenge, it is also important because health inequality does not only lead to poverty in economic terms, but also leads to the loss of opportunity, capability and security (Wratten, 1995; Rakodi, 1995; Satterthwaite, 1997; Sen 1999; Kawachi & Wamala, 2007a,b). In other words, the absence of these material conditions, political engagement and psychosocial resources rather facilitate poverty at the individual, community and national levels. This implies that poverty should not only be seen in terms of one's income, that is a dollar per day, but it should also include social conditions which in some circumstances referred to as relative marginality. This intend contribute to ill-health of the marginalised as a result of chronic depression and feelings of bitterness, stress, desperation and hopelessness (Polit, 2005).

However, a gap in literature is the failed attempts on part of government to embark upon programmes of health education at various places of origin and most especially the destination. Giving the fact that health seeking behaviour might not necessarily be tied up to one's income. Unfortunately such programmes are non-existent and even when they exist, they are not effectively implemented. Suffices to say that the lack of such programme contribute to the poor health associated with urbanisation.

2.2 SOCIO- ECONOMIC CONDITIONS OF SLUM COMMUNITIES

According to Singh (2016), in most cases, the social status of slum dwellers is very poor. Most slum – dwellers live in marginalized sections of society that contain poorly- built structures where access to the basic amenities of life is difficult. They are often engaged in low level economic activities such as tailoring, construction, alcohol retailing, cleaning of houses, rag keeping, auto driving, rickshaw pulling, herding of goats, sheep, fowls and some illegal activities. This, coupled with the high illiteracy rate makes it difficult for the slum dwellers to work in any formal employment and are therefore, unable to earn any meaningful income let alone purchase the basic needs of life. According to Prasad et al., (2013), occupation plays a key role in the socioeconomic status of people. It affects other elements such as the living condition of the population and development and progress. Socio-economic status depends upon the living standard of individuals, living standards also depend on the income of family, and it is very useful in the improvement of the life of an individual or society. Occupation in turn depends on educational level, employment facilities in their periphery and skills.

Sajjad (2014) argues that the rate of unemployment among slum dwellers is very high. The high unemployment rate among slum-dwellers compel them to work in daily wage employment. Such daily wage employments are mainly in the informal sector and offer them minimum returns. Major businesses operated by slum dwellers include street vending, selling of handicrafts and petty shop keeping. Apart from creating job insecurity which in turn leads to financial problems, irregular employment leads various forms of social evils and crimes. Highlighting on the ordeal that slum dwellers undergo in the cities, Asiedu and Agyei- Mensah (2008) note that in Accra, for instance, poor street traders are always running away from the city officials just to avoid arrest. In addition, to the challenge of working in the informal sector which is characterised by

unhygienic environments and over working hours, with low incomes as compared to their counterparts working in the formal economy put the slum dwellers in devastating conditions. Another example is a study conducted by Prasad et al., (2009), on the living conditions and socio-economic conditions of slum residents of Mankhurd, Mumbai, with indicators related to socio demographic characteristics including age group, occupation, educational level, cast, religion, marital status, household size, wealth quartile and age at marriage. In this study, for the calculation of the working profile, various aspects such as work profile (Salaried and daily worker, own business and others etc), working status, work hour and time taken to get to the workplace were considered. Findings from the study illustrates poor living conditions of the slum dwellers. In order to calculate the housing amenities index, the following were taken into consideration: ownership of house (own or rented), source of light and source of water and toilet.

In a study on the socio-economic and demographic characteristics of Chennai slum residents in East India, for the calculation of the socio-economic conditions, different types of indicators were used, namely demographic characteristics, literacy level, types of houses, number of people in room, ownership pattern, drinking water facility, availability of electricity, availability of separate kitchen and types of fuels used for cooking, radio and television facility and drainage facility. On the basis of the above indicators the study concluded that the social status and the living conditions of Chennai slum residents is very poor (Chandramouli, 2003).

Similarly findings Sen (2015), found that the socio-economic conditions of slum dwellers in the Basirhat Municipal Area in West Bengal was found to be very poor based on socio-economic characteristics such as educational level, age, male- female ratio, occupational status, family size and annual income. Education plays an important role in the socioeconomic characteristics of

households. In spite of this, formal educational facilities are lacking in most slum communities. This has created a situation in which the majority of slum dwellers lack formal education though some NGO's and organisations try to provide them with some form of informal education.

However, Housing the Masses (2010), in their study on Old Fadama, the largest slum in Ghana which is inhabited mainly by migrants from the rural north of the country who earn their living from businesses transactions within the slum itself and are mostly engaged in informal sectors of the economy, partly disagrees with assertions mostly portrayed in most literature that earnings of poor urban communities are always bad. According to them, though the earnings of slum dwellers in the informal sector are often meager and irregular, some of them still earn more than some civil servants. A study conducted by Awumbila, Owusu and Teye (2014) of migrants in two slum communities in Accra suggests that significant proportion of the migrant's slum residents were earning adequate incomes. The migrant slum residents were engaged in e-waste business (salvaging materials from discarded electronic and electrical equipment and selling them later). This particular type of occupation was mainly carried out by migrants who were mostly male from Northern part of Ghana, Niger and Nigeria.

According to Prakash et al., (2010), a variety of e-waste activities made up of collection, recycling, repair, refurbishment and trading of metals are very common in slums. The study indicated that despite the risks involved in the chain of e- waste activity, the business is very lucrative as it provides a daily earning of GHC 15 (about USD 7.50 at the time of the study), for those involved in scrap collection. Those engaged in e- waste refurbishment and happen to be higher in the labour hierarchy earned between GHC 40 and 200 (about USD 20 and USD 100 respectively). These earnings, when compared to the salaries of both lower and middle level officers in Ghana's public service. The earnings are also better than what these migrants slum

dwellers were earning back home before they migrated to the slums. Also, on an individual cases as highlighted in a similar study, migrants scrap dealers from Nigeria could earn as much as GHC1, 000 (about USD 500) on a good business day. When these earnings are compared to what they were earning before they migrated, it is clear that migration has improved their earning capacity.

Awumbila, Owusu and Teye (2014) further add that though the jobs and livelihoods that slum dwellers are engaged in are usually demeaning when compared to other high income earners in the urban economy, they are able to save the little money they earn, which helps them to support the families they have left behind in their places of origin. It must, therefore, be acknowledged that the economic activities of poor migrants in informal urban settlements shows that they provide valuable services to the formal sector and are part of an urbanising Africa. The movements of these youths from the rural areas to the cities in which they strive to make a living though often considered a contributing factor to urban poverty, they work hard to ensure that portion of urban wealth are redistributed to deprived rural areas where they came from.

The regulating nature of the informal sector which most of the migrants find themselves in the cities add up to worsen their socioeconomic status. This makes it difficult for them to seek good health outcomes, a gap that has been identified in literature.

2.3 HEALTH CONDITIONS OF MIGRANT SLUM SETTLEMENTS AND RURAL COMMUNITIES

Generally, it is believed that slum dwellers have worse health conditions such as morbidity, mortality and health risks when compared to other populations (Riley et al., 2007). Another uncritical belief that has been accepted is also that slum populations after all are better off than

their rural counterparts. In addition, it is also acknowledged that all slums are not equal and variations in health status among slum population groups are as evident as variations across rural communities (Agarwal et al. 2005). Therefore, the incidence of periodic specific sickness and economic situations predictably holds an inverse relationship among rural residents. The high prevalence of malnutrition among rural residents can be attributed to their living conditions and nutritional status (Begum, 1997). There are various opinions about life in slums. While, some consider it an opportunity to transition to middle class groups, others see it as poverty trap. Although, some people consider life in a slum as an opportunity to transition to middle class groups, others describe it as a poverty trap. Although satisfaction/ dissatisfaction among slum residents could be affected by many economic, social and environmental factors as well as the initial reasons for moving in to the slums, existing evidence suggests that most slum residents in low and middle-income countries are not satisfied but have to stay in slums (Mudege et al. 2011). Other studies have also suggested that the descriptive evidence of consistent differentials in morbidity and mortality provides enough evidence that urban poverty is a complex mix of material and social deprivation for developing countries and that both elements have complicated and possibly synergistic effects on the health of the individual and groups (Stephens et al., 1997; Stephens 1995; McMichael., 2000).

The belief that urban slum residents have better access to health care relative to rural populations further stultifies any sense of injustice slum dwellers may be suffering. But recent data from Kenya and Bangladesh disagree with the view that slum residents are better off in terms of health as compared to their rural counterparts. The basis for this challenge is borne from the fact that some of those studies have not been representative of slums. Furthermore, the lack of appropriate data on slum-specific health indicators has made it difficult to clarify whether staying in a slum

is health- enhancing or damaging to the residents (African Population and Health Research Center, 2002; UNICEF 2010). Although answering these fundamental questions has been characterised by cross-sectional data limitations, the ability to draw health outcomes by comparing urban slum and rural populations sheds light on potential pros and cons slum dwellers may have relative to a group that is by and large accepted as being more vulnerable to poor health outcomes. In a more general study conducted by Mebratie et al., (2013), on health care seeking behaviour among residents of rural Ethiopia, results suggest that there was existence for strong preference for modern health care among the population under study. The study further indicated some variations across socioeconomic status by which the rich households two to three times more likely to seek modern care as compared to the poor households. This inequality also has an effect the choice of health care provider, and the timing of seeking care. Households in the lowest consumption quintiles are generally more likely to resort to lower level care and postpone seeking care compared to better off households.

Attempt to understand the health condition of both rural and urban slum residents have left some gap in literature. The study suggests that a more detailed assessment of health conditions of both areas needs to be taken into consideration before conclusions are made. For instance, in rural settings, the presence and support of family members alone can guide an individual on healthy lifestyle choices which promote health seeking behaviour. On the other hand, though the activities of lay health care providers, which are common among urban poor settlements, are often not recognised due to the questionable nature of their care provision, the role they play in the health outcomes of slum residents cannot be underestimated.

2.4 MORBIDITY PROFILE OF MIGRANT SLUM DWELLERS

Generally, it is believed that health is wealth and that healthy people are capable of building healthy nations (Goswami et al., 2013). However, the health situation among slum residents depicts a different picture. According to Goswani et al., (2013), the inability to consume healthy and nutritious foods contributes to a high level of malnutrition among slum women and their children. In one of Ghana's district hospital report, respiratory illnesses and diarrhea infections were recorded and were among the leading causes of outpatient hospital visits after malaria. Crowding in housing units is associated with communicable diseases such as respiratory infections and tuberculosis (Krieger et al., 2015; Arku et al., 2011). The lack of potable water and poor waste disposal both contribute to diarrhea transmission infections. Studies indicate that the lack of sanitation facilities is more common among slums and deprived poor communities compared to towns and cities in most places of Ghana (ISSER, 2010-2011).

In his book, *Urban Poor*, Singh (1980) reports about water borne diseases among slum residents. He observed that the most common diseases in slums are diarrhea, gastrointestinal diseases, water diseases, oral diseases and parasitic worms/infestation. Nijama et al., (2003) have also profiled morbidity cases among slum children and identified malaria, diarrhea, typhoid and other such diseases and attributed them to the improper living conditions of slum dwellers. Sigh and Rahman (2002), notes that slum dwellers in developing countries suffer regular attack of malaria due to poor environmental conditions. In most slums of Nairobi Province, malaria has been cited as a common epidemic though no measures have been taken by authorities to resolve the issue (Yazoume, 2007). Dysentery, malaria and viral infection were also cited as some of the most common diseases in the slums of Coimbatore, Tamilnadu. Knowledge in disease prevention

among most slum settlements was rather weak and also contributed to the spread of many many diseases among slum dwellers.

Misra et al., (2003), reported that Injection Safety Awareness and health related knowledge among slum residents located close to Nehru Place (Ambedkar Camp) in South Delhi was very weak. In this study, about 51 percent of the participants' demonstrated knowledge about transmission of diseases spread through used syringes. Among Chennai slum residents, awareness and attitude towards AIDS was very poor. Only 67 percent of males and 55 percent of females had knowledge about its mode of transmission. In their responses about the mode of transmission, 34 percent males and 50 percent females reported AIDS as a hereditary disease (Kalasagar et al., 2006).

What this means is that there is the need for government to address TB, HIV/AIDS, and vector borne diseases in informal settlements and also to improve health services for the urban poor (David et al.,2007). Among under 5 years old children of Gokalpuri slums of Delhi, attack rate of Acute Respiratory Infections (ARI) and Acute Diarrhea Diseases (ADD) were 14.6 percent and 7.73 percent respectively. Poor sanitation and lack of potable water for residents served as contributing factor (Gupta et al., 2007). According to Rahman (2006), there is a strong link between environmental conditions and the outbreak of diarrhoea. For example, among the urban poor of Aligarh City the incidence of diarrhoea was reported to be 96 percent with open defecation, buying prepared cheap food from vendors and the use of manual latrines being the main contributory factors. The same applies to that of children in slums which were found to be 32 percent compared to 13 percent in Nairobi as a whole and 17 percent in rural areas (Kilmani et al., 2007). In profiling diseases among slum dwellers. Riley et al., (2007) notes that there is

also evidence of chronic non- communicable diseases such as hypertension, diabetes, injuries, rheumatic and heart diseases among slum dwellers. Karn et al., (2003), finally conclude in a study that income, literacy, sanitation and personal hygiene have impacted on the morbidity of the slum populations. This study further proved the effect of environmental and socioeconomic factors on the health status of slum residents. Poor environmental conditions and the lack of access to basic amenities which are often blamed on the high morbidity among slum dwellers as reported in most literature leaves a gap in this study.

The hazardous nature of the work that most of these slum dwellers are engaged in also contributes to the poor health outcomes. Health seeking behaviour takes into consideration actions taken by a person to prevent diseases. However, since the main motivation for coming to the city is for economic gains, these slum dwellers are forced to take up any task that can earn them a living and which indirectly affect their health.

2.5 THEORETICAL PERSPECTIVE ON HEALTH SEEKING BEHAVIOUR

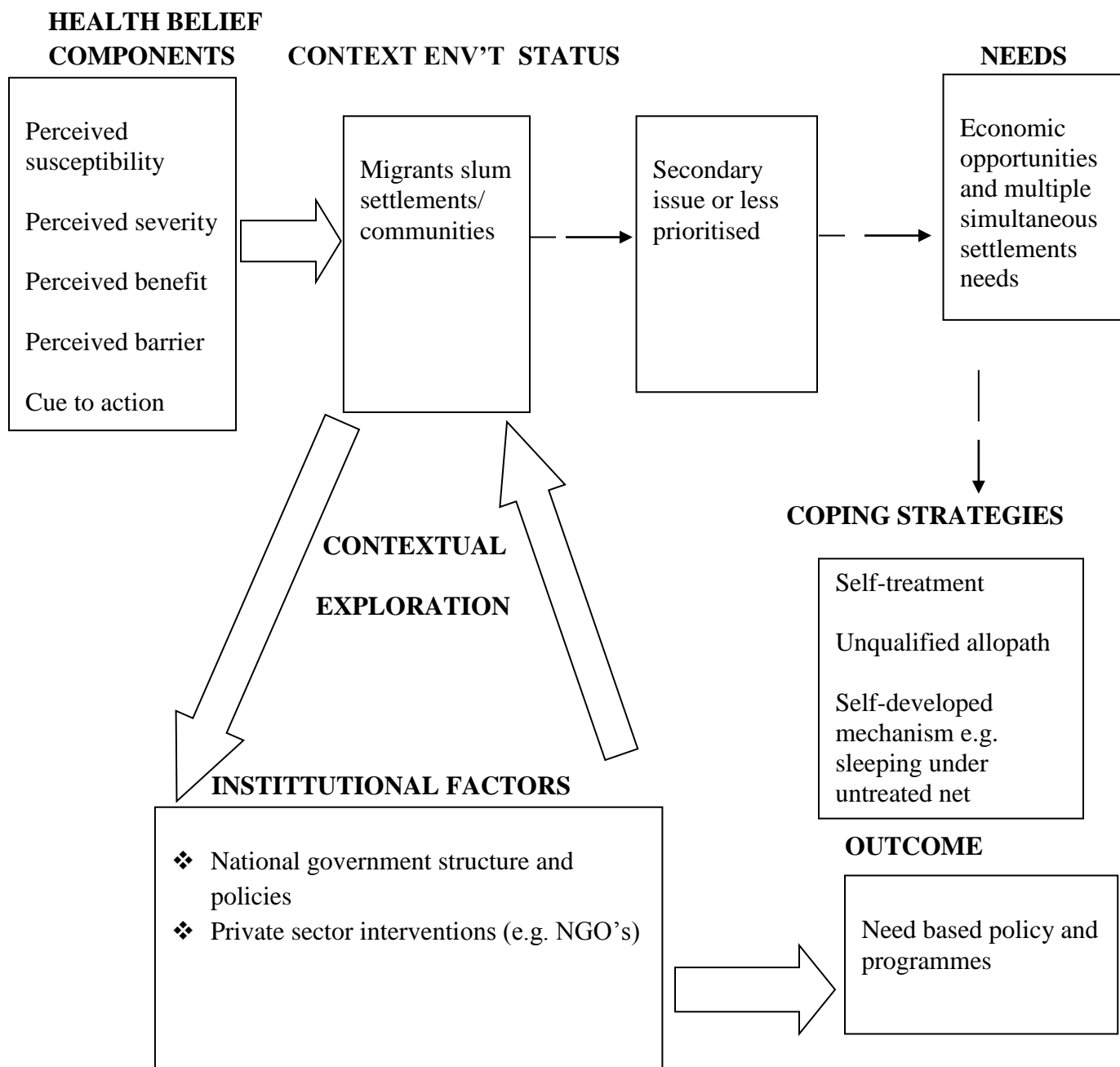
Literature reviewed indicates that a number of models can be used for understanding health seeking behaviour. Behavioural change theories and models such as the Health Belief Model (HBM) Berry (2004), Theory of Reasoned Action (TRA) Fishbein (1975), Theory of Planned Behaviour (TPB) Ajzen (1991), and Transtheoretical Model Prochaska (1997) have been widely applied in public health to help explain health seeking behaviours (Hausmann et al. 2003; MacKian 2003). The use of these theories and models have helped to identify and understand people's health seeking behaviour beyond their knowledge, attitudes and practices (Hausmann et al., 2003). For the purpose of this study, the Health Belief Model (HBM), which is health specific behavioural cognitive model (Taylor et al. 2006; Orji et al 2012), was adopted and modified to help understand health seeking behaviour for different types of diseases and how

interventions by planners and other support agencies can be achieved among rural – urban migrant slum settings as in the case of Madina in the Greater Accra Region. The model is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. HBM was first proposed by Hochbaum, Rosenstock and Kegels in the US public health services. HBM is therefore based on the idea that the behaviour of people or individuals are more likely to change and treatments adherence (Janz et al.1984; Turner et al 2004; Olsen 2008)

The health belief components, as indicated in Figure 2.1, is based on the idea that people are more likely to change their behaviour and adhere to treatment if i) they perceive that are at risk of contracting a disease (perceived susceptibility), ii) they perceive that the disease is likely to have an unfavourable outcome (perceived severity), iii) they perceive the proposed health behaviour to be effective and practical (perceived benefit), iv) they perceive the barriers to adopting the behaviour to be minimal (perceived barriers), v) they perceive themselves to have the ability of applying and practicing the specific behaviour proposed (perceived self-efficacy) and finally vi) they have the cues for motivating their actions such as internal cues (pain, symptoms and past experience) or external cues (being advice received from family and friends as well as media campaigns etc.) (cues to action).

Figure 2.1: Conceptual Frameworks on Health Seeking Behaviour of Rural-Urban Migrant

Slum Dwellers



Source: Adopted and Modified from (Berry, 2004)

In its application to this study, the model with its intended purpose to influence behavioral change and to encourage health seeking behavior among people is not conceivable when it is applied to rural-urban migrant slum settings. This is because as indicated in the literature, the multiple simultaneous needs of migrants such as the economic reason for migrating to the slum and the settlement needs they have to settle out. These needs make it difficult for them to consider any health seeking behaviour that improve their well-being. As indicated in Figure 2.1, the health belief component is made up of various elements; perceived susceptibility, perceived severity, perceived benefit, perceived barrier and cue to action. The essence of these elements are to influence behavioural change of the migrants at the slum, known as the context environment as directed by a bold arrow. (The term context environment as it is used here, refers to migrant's slum settlements or communities). The arrow upon reaching the context environment, assumes a thin and broken status, an indication of health seeking behaviour not given the necessary attention. As health seeking behaviour is less prioritised, the thin and broken arrow explains the reason for its failure. The reason given is migrant reason for coming to the slum i.e. economic opportunities and multiple simultaneous settlements needs. At this stage, health belief components become weak and unconventional methods of health seeking behaviour are adopted as forms of coping strategies. Hence, self-treatment, the use of unqualified allopath and sleeping under untreated mosquito nets are among the coping strategies employed by migrants to overcome their health challenges.

In order to achieve health seeking behaviours that are not only effective but also sustainable and reduces risk factors for lifestyle diseases (which often fail as a result of mismatch between context environments and health programme interventions) institutional factors such as government policies, other stakeholders need to carry out contextual exploration of the context

environment to be able to establish exactly the health seeking behaviour patterns of the specific slum environment in order to come out with need based policies that bring about expected lifestyle behaviours. It is important to note that health seeking behaviour requires understanding of motivation for such behaviours, this can only be achieved through understanding of the intricate factors shaping behavioural practices. It is only on this grounds that health promotion programmes or interventions can achieve their purpose of among the lives of rural- urban migrant slum dwellers.

2.6 HEALTH SEEKING BEHAVIOUR AMONG RURAL- URBAN MIGRANT SLUM DWELLERS

A major challenge faced by many urban poor in developing countries is poor health (Malanyaon, 1995). The vulnerability of the poor in terms of health needs, apparently affects their health seeking behaviour. The challenge for the urban poor is the city's highly monetised health system which delays or prevents them from accessing modern health services (Montgomery, 2009). Besides, there are also the misguided health practices and the lack of knowledge and information on health promotion and disease prevention which contributes to the worsening health condition of this sub population (Malanyaon, 1995). For example, as a result of the high medical cost in urban centres, most African urban poor communities seek medical care from traditional health providers, lay health care providers, or do not receive any health treatment at all. Poverty, therefore, affects the health seeking behaviour of the poor. This delay their health care utilisation, promotes ineffective and unapproved health care alternatives thereby affecting their health status (Corno, 2008).

Several studies have been conducted on the health seeking behaviour of urban slum residents in Ethiopia. For example, a qualitative study conducted on women of Ethiopia concerning health

seeking behaviour for cervical cancer and found that the perceived benefit of modern treatment among them was rather low. Findings from this study suggested that women with this condition were excluded from society and were not also given emotional support and this caused delays in seeking health care at any point in time. Traditional remedies dominated most preferred treatment options at the early stage of the disease (Zewdie Birhanu et al., 2012).

In another study by Assesfa, Amenu, Nash, Tefera, Tamiru & Byass (2000), it was observed that indicated that health seeking behaviour patterns among leprosy patients in the former Shao Province indicated that 77 percent of the participants delayed for up to one year before visiting a health care facility and during the initial symptoms, 68 percent visited traditional healers. According to Ali (2011), an assessment of health seeking behaviour at community level of Dubti District suggested various determinants factors of health seeking behaviour. In order to encourage health promotion strategy, Kroeger (1983), notes that the need for strategic policy formulation in all health care systems should take into consideration information relating to health promotion, seeking and utilisation behaviour and the factors determining these behaviours. He further notes that such behaviours happen within some institutional structures such as family, community and the health care services, and that there are various contexts in which factors determining health behaviour could be seen and these include socio-economic, physical, political and cultural context. Thus, the utilisation of health care system, be it formal or informal, public or private, to a large extent depends on factors such as socio-demographic factors, level of education, social structures in place, gender discrimination, cultural beliefs and practices, status of women, environmental conditions, disease pattern and the health care system itself (Katung 2001; Navaneetham et al., 2002; Fatimi et al., 2002; Uchudi, 2001; Stephenson et al., 2004).

In relation to this study, a gap in literature is the role of individuals in terms of attitudinal change in the slums. The lack of attitudinal change among the slum residents only makes it difficult for achieving health seeking behaviour and could deter others from health seeking behaviour.

2.7 BARRIERS TO HEALTH SEEKING BEHAVIOUR AMONG MIGRANT SLUM

DWELLERS

Although there is a growing amount of literature on health seeking behaviour and the determinants of health services utilisation in developing countries (Shaikh et al.,2005), available literature on health seeking behaviour often describe patterns of behaviour without providing clarification on the causes behind such behaviors, thereby failing to provide valuable recommendations (Grundy et al., 2010). Financial difficulties, the lack of health insurance coverage and the high cost of out-of- pocket payment for health services are the common challenges among poor urban residence in accessing medical services. According to IOM, WHO and UNHCHR (2013), because of the inability of slum dwellers to afford the cost of health care, they are not allowed to benefit from state-subsidised health insurance plans. For instance, a study among slum dwellers of Nairobi suggests that 89 percent of residents are not covered by health insurance (Kimani et al., 2012). The findings from this study demonstrate that there is the need for social health insurance programmes for the underprivileged (Mberu et al., 2013). In a study in Shanghai, China, on migrant patients, it was observed that financial barriers posed a major challenge to TB services (Wei et al., 2009).

Apart from the direct cost of financing health care services which pose a barrier to health seeking behaviour, there is also the issue of indirect cost. The cost of transportation to a health care facility as well as the time lost for generating income are some of the examples of indirect cost.

In a household survey among slum dwellers in Mumbai, India, the inability to access health care at state hospitals was attributed to the fact that participants thought that going to the hospital was a loss of a day's wage (Mili, 2011). In a similar study, migrant HIV/AIDS patients in Johannesburg, South Africa, reported that the lack of money for transportation was a challenge for accessing treatment and the time to be taken away from their livelihood for collecting treatment posed a problem especially if they were employed under someone (Vearey, 2008).

Another area of challenge is geographic accessibility, and this has often been attributed to the lack of quality health services in reach of slum communities. Although this is often considered as a problem for rural residents, it has been repeatedly reported as a major problem in cities where health care facilities are not in close proximity to poor urban dwellers and travel cost becomes a challenge. A study conducted by Goli, Arokiasamy and Chattopadhyay, (2011), in eight Indian cities found that the non-utilisation of health care facilities was due to either unavailability or the distance of health care facilities. The lack of proximity to hospitals among slum dwellers of Mumbai in India, made residents to resort to lay men practitioners who did not have the medical license but are closer to them (Mili, 2011). In the slums of Nairobi, though there are health care facilities, the few public health facilities available are located far from the slums and residents are unable to access care especially at night due to security concerns (Ziraba et al., 2009).

Knowledge barriers, language barriers and discrimination have also been identified as another areas of challenge to rural-urban migrant slum residence. The lack of knowledge about the location of the health system at the destination, entitlement to access the health service as well as the lack of health literacy pose a major barrier. Furthermore, communication and language barriers are known to adversely impact diagnosis, medication, hospital visits, medical follow-ups

and admissions and patient's adherence to treatments. Miscommunication between health staff and patients for example, when a patient condition was misunderstood can have serious consequences and could lead to death (IOM, WHO and UNHCHR, 2013).

Experience of discrimination and poor quality of health care often put up by some health professionals or the wider society at the destination further discourage migrants who are often with low socio-economic backgrounds from visiting medical facilities for treatment. Among migrant tuberculosis patient in China, participants reported that their employers either dismissed them or avoided them after they had been treated for tuberculosis (Wei et al., 2009). Therefore, marginalisation often suffered by migrants groups amounts to discrimination against the poor (Matthews et al., 2010). This is the case if the urban poor are treated with disproportionately lower standards than their better-off neighbours when using the same facilities in urban settings. This makes it difficult in achieving health equity for all manner of persons, as poor treatment of underprivileged population does not encourage them to seek health services. This occurs especially when they perceive health care professionals to be neglectful, rude, abusive and indifferent (ibid). In South African cities, for instance, abusive attitude towards migrants by health staff was reported in urban health care facilities (IOM, WHO and UNHCHR, 2013).

The next factor is cultural barriers. These are cultural practices and beliefs which are most prevalent in developing countries and pose a challenge to health seeking behaviour (Shaikh et al., 2005). In Yemen, for instance, such practices include cauterisation, massage and local herbal preparations for treatment of an illness. Among most of these cultures, the use of herbs is highly prioritised, and in most cases, are often abused and are thought to be useful and never harmful, when over use can be harmful to the health of an individual (Bamatraf, 2008).

A gap in literature in terms of the barriers is the non-compliance to health precautions. The unwillingness to comply with precautions means that preventive care becomes a challenge which can have negative implication for health seeking behaviour.

2.8 COPING STRATEGIES ADOPTED TO HELP OVERCOME HEALTH

CHALLENGES

While health is clearly a result of favourable social, economic, political, technological (such as improvements in medical technology and environmental conditions such as water supply and sanitation and air pollution, weather, topography). The household represents the most important unit in terms of time and resources invested to attain health. In the urban slum context, it is important to consider not only the supply of formal health care, but the many nongovernmental actors who also shape the conditions of service provision (Environmental Health Project, 2004). However, due to the inability of slum dwellers to afford health care, accessibility, long standing cultural beliefs and the lack of trust of the formal health care systems, most slum dwellers adopt coping strategies in order to overcome their health challenges. They, therefore, rely mainly on the services of lay health care providers such as unqualified pharmacists and traditional healers. It is important to note that while some of these local organisations are reputable in their service delivery, many of them do not have the necessary training and license and, therefore provide lower standard care to the slum residents. In spite of this, most of the slum dwellers consult these lay health care providers to improve health care conditions or to find a cure to their diseases. Such investment in health is associated with factors such as the knowledge of the population and their perceptions about health and illness including what is available in terms of the different types of care. Although, the role played by local influences may determine its use to a large degree, there is variation in the choice of providers by symptoms felt, thus pharmaceutical

products, both herbal and manufactured play an important role in the cure of a disease (Chabot et al., 1995).

The preference for private-for-profit providers ranging from trained medical practitioners to informal providers by a high proportion of patients in many countries is common despite the high fees charged by these service providers (Brugha and Zwi, 1997). In most developing countries, it is common to see most people seeking health advice from pharmacists, midwives, nurses, drug sellers, doctors and alternative practitioners (Smith et al., 2001). In most cases, people utilise variety of health care service that are available within their neighbourhood (Montgomery, Stren, Cohen and Reed, 2004). Literature indicates that for some health conditions, most treatments occur outside the public sector. McCombie (1996) and Montgomery et al., (2004) cited malaria and sexually transmitted infections (Brugha and Zwi 1997; Montgomery et al., 2004) as some of the examples of these diseases. Instead of seeking health care from a formal care provider, the potential patient adopts various coping strategies such as buying over the counter drugs without prescription from a qualified physician, visiting alternative medical providers, or consulting an untrained shop attendant for self – treatment. This, therefore, calls for policy planners not to ignore the services rendered by these group of individuals in the health care delivery to the urban poor. It is suggested that about 50 percent of health services in poor urban settings are delivered by this group to the urban poor (Environmental Health Project, 2004).

The coping strategies adopted by slum residents in the face of the health challenges they encounter are not only limited to seeking unconventional methods of healthcare when they are unable to afford care from formal service providers. Apart from those indicated in literature, this

study has demonstrated that in addition to engaging the services of alternative care providers, rural-urban migrants slum dwellers employed ‘self-activity related mechanisms’ such as sleeping under fans to avoid mosquitoes bite, sleeping under untreated mosquitoes nets and covering themselves with cover cloth while sleeping as coping strategies to avoid being attacked by diseases

2.9 POLICY RESPONSES AIMED AT IMPROVING HEALTH SEEKING BEHAVIOUR

Though urban poor migrants and urban refugees are bedeviled with issues concerning their health and well-being, this has not received much attention over the years. The conclusions that can be drawn from the evidence on different migrant populations in specific urban settings have been cited above, however, this evidence strongly suggest that there are striking inequities between migrants and non-migrants within cities across the world, both regarding their (subjectively reported or objectively assessed) state of health as well as the accessibility and quality of health services. Although the lack of data makes it difficult to say the extent to which these observed gaps remain when socioeconomic factors are controlled, for all reviewed, evidence suggests that in order to make the aim of sustainable urban development achievable, the health of migrants and urban populations needs to be addressed. This is because as already discussed, the lack of data poses a major challenge.

To come out with well-informed policies, there is a need for comprehensive prevention programmes and health services, the nexus between migrants’ health needs and urbanization to be clearly understood. This, therefore, calls for disaggregated data on the health of migrants and the determining factors such as exposure to pollution and poverty and access to basic infrastructure. Generally, data on the health of migrants is scarce and even if it exists, definitions and indicators are seldom harmonised for cross- country comparisons. When studies are being

carried out into rural-urban migration in developing countries, there is always the challenge of monitoring the health of the migrants and other mobile workers because they often return home to die as has been the case in South Africa, (Bocquier et al., 2011).

Second, government policies often tend to neglect the health situations of migrants in cities. In many countries, slum dwellers are not included in the health system, and even if formal policies of inclusion are in place, there are failures by health authorities to implement them. It is worth noting however, that some NGO's and private sector actors have been instrumental in improving the health of urban migrant poor populations. While this calls for some recommendations, it not certain whether their efforts are enough to release local governments from their responsibility (City of New York, 2014).

Third, although some advances in poverty reduction and its consequences over the last two years have been made, most of the responses to the plight of the health of the urban poor migrants taken by local governments indicate certain helplessness because of the absence of the absence of good management and the lack of political will. For example, there are reported cases of ineffective health services as well as weak referral systems in many places (Shetty, 2011). Due to high cost, long distances to facilities and the poor attitude of some health personnel, migrants are unable to access such facilities (Mberu et al., 2013). As a social determinants of health, providing acceptable health service facilities which are of high quality and accessible to migrants is not an easy task as it aims at addressing the root causes of ill-health. This can only be achieved when there is political will and the collaboration of multiple sectors and other stakeholders, especially the health care practitioners and civil organisations etc.

However, it appears that when it comes to issues relating to the health of urban migrants, there is the lack of will power on government agenda (Shetty, 2011). Again, host communities and many government representatives continue to see migrants as nothing but people putting strain on their already scarce resources. This means that there must be a first step that demands that all stakeholders acknowledge the fact that urbanisation is unavoidable (ibid). According to UNDESA (2014), policies that are aimed at restricting rural-urban migration over the years are ineffective in forestalling the growth of the cities and rather leading to social, economic and environmental problems.

In addition to the above, it is obvious that cities cannot be left alone with their associated health related challenges posed by migration and urbanisation. To improve the health of urban poor migrants, governments at sub- national and city-level need support from both national governments and international community which ultimately can bring about sustainable urban development. Since, the majority of the migrants and their left behind families are of low socio-economic status, they have no say in politics and remain in poor communities of the world. This implies that there is a need for intensified and sustained joint action by various governmental, local, national, international and private actors in bringing about the ultimate health of the rural-urban poor migrants (Mili, 2011).

A gap in literature which this study sought to fill is also the need to formulate policies that are based on specific slum context before programmes are implemented else they are bound to fail. There is the need to identify whether the slums are indigenous slums or rural-urban migrant slums. The ability to determine the type of slum that exists should form part of policies that will help with the successful implementation of health programmes.

2.10 SUMMARY OF LITERATURE AND GAPS IDENTIFIED

Review of literature has suggested significant gaps in scholarly work and what this study sought to fill. First, the wide held belief that urbanisation is mainly as a result of rural- urban migration, which in turn pose threat to migrants slum health leaves gap in literature. So far as unequal variations in terms of economic development between the rural and urban areas of Ghana continue to exist, rural –urban migration will continue to manifest. In addition to the failure by governments to effectively implement health education programmes at both migrants’ places of origin and the urban slums they find themselves in.

Second, reviewing literature on the health conditions of rural residents and urban slum dwellers has left some gap. The role or presence of the family member and close friends in support of an individual in overcoming a health challenge and discouraging risky lifestyle behaviours among rural residents has been ignored. When this is factored into the debate, the health condition of rural residents is better than that of urban slum dwellers.

The health belief model, which was adopted and modified for the study is aimed at identifying and understanding the health seeking behaviour of different types of diseases and how best specific slum context health conditions can be understood in order to achieve health intervention programmes. In its application to the study, the conceptual framework proposed that this model is not likely to yield any meaningful result when it is applied to rural-urban migrants’ slum settings. This is because among migrants settlements like those in the slums of Madina, the purpose for coming to the slum which are mainly for economic gains, in addition to multiple simultaneous settlements needs are most importantly prioritised than adherence or the practice of health seeking behaviour. Instead, coping strategies are adopted to overcome health challenges.

For health planners to achieve their aims there is the need to carry out contextual exploration of the slum environment in order to come out with best intervention programmes.

The belief that slum dwellers are poor because they are people with low socioeconomic status and for that matter are not able to afford health care leaves a gap in literature. This study believes that the unregulating nature of the informal sector which they find themselves worsens their socioeconomic conditions. Effective regulation of the informal sector in which they work would have meant good wage commensurate with the various work they perform and consequently to access good health care.

Poor sanitation and the lack of access to basic amenities accounted for the high rate of diseases among slum population. A gap identified in literature is that prior to migration to the slum, some migrant already had some chronic medical conditions. What this means is that not all diseases are acquired in the slums but some may be acquired at the places of origin and are only imported to the slum. In addition, the hazardous nature of work in the informal sector that these slum dwellers mostly find themselves in sometimes has serious consequences on their health. Health seeking behaviour takes into consideration actions taken by an individual to avoid being attacked by disease.

Literature shows that the high cost of health care contributes to the reluctance on the part of many slum dwellers in adhering to health seeking behaviour. This belief presents a gap in literature which has to do with the attitude of slum dwellers. Adhering to attitudinal change from risky lifestyle behaviours is one of the important ways of adhering to health seeking behaviour.

Again, literature indicated that in order to overcome their health challenges, slum dwellers sought care from informal care providers which has created a gap. This study point to the fact that slum dwellers do not only resort to the services of IP's but employ 'self-developed mechanisms as coping strategies to overcome health challenges.

In terms of policy gap, there is the need to formulate policies that demand that policy planners implement programme interventions that are based on specific slum context situations without which such programmes are bound to fail.

CHAPTER THREE

METHODOLOGY

3.0 INTRODUCTION

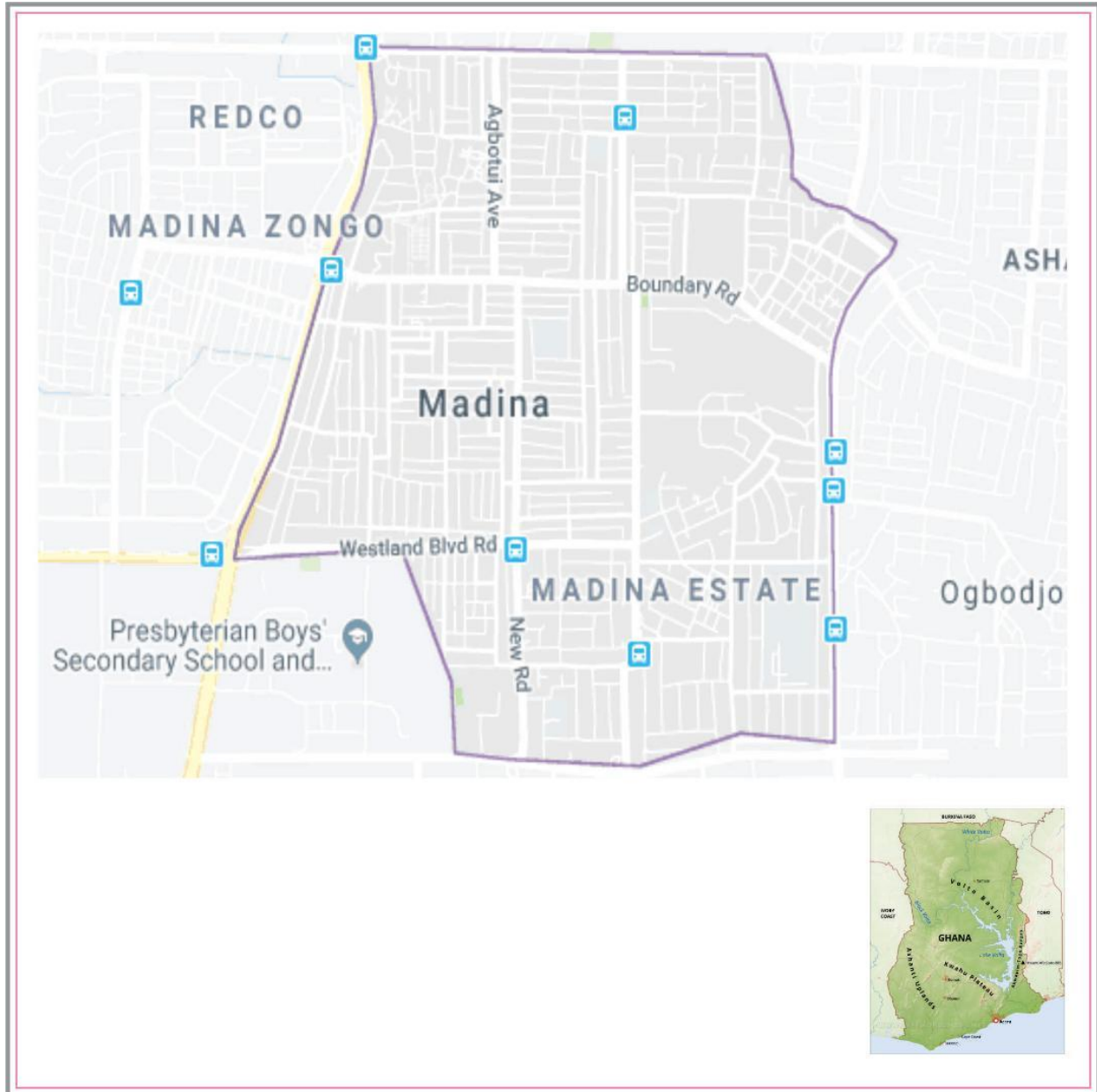
In order to address the objectives of the study, this chapter discusses the research methodology. It covers the study area, research design, philosophical position and orientation, sources of data, target population, sampling technique, sample size, quantitative data collection method, qualitative data collection method, ethical consideration, pretesting, reliability and validity, response rate, field work, limitations and data analysis.

3.1 THE STUDY AREA

The study focuses on Madina, a suburb of Accra in the La -Nkwantanang Madina Municipality of the Greater Accra Region. (see Figure 2), which is one of the sixteen (16) Metropolitan/Municipal/District Assemblies that have experienced an increasing number of rural-urban migration in the region GSS (2010). Madina covers a land area of 166 sq.km and boarded on the west by the Ga East Municipal Assembly (GEMA), on the east by the Adentan Municipal Assembly (AdMA), the South by the Accra Metropolitan Assembly (AMA) and the north by the Akwapim South District Assembly. The La- Nkwantanang Madina Municipality is one of the urban municipalities in the Greater Accra Region with rural settlements which are also developing into peri-urban settlements. Madina, being the capital of the Municipality, has over the years developed into the Central Business District of the Municipality, which has become a hub for major commercial activities. Due to this, Madina has also become a home for a growing number of rural-urban migrant (GSS, 2010). Madina used to be a fully functional Zonal Council of the Ga East Municipal Assembly until it was given a Municipal status in 2012. All the

previous metamorphoses of the area is largely as a result of urban creep in the fast growing peri-urban areas, and the influx of migrants from many parts of the country and beyond led to the creation of La Nkwantanang Madina Municipal Assembly (Composite budget of the municipality, 2016). The total population of the municipality stands at 111,926 of which 73,545 (representing 65.7 percent) are migrants. The high proportion of migrants could be attributed to the fact that the La-Nkwantanang Madina Municipality was a cosmopolitan municipality with various economic activities attracted migrants from all over the country in search of better economic prospects. Most of the houses in the municipality are owned by private individuals. The is lack of sufficient housing units in the municipality, coupled with the high cost of rent, has contributed to the development of temporary structures and overcrowding in rooms. There is pressure on social amenities, streetism and conversion of commercial facilities for residential use. These developments have led to the growth of slums in some suburbs of the municipality. Females constitute a larger proportion of the population and are mostly self-employed. A higher proportion of males have access to formal education than their female counterparts in the municipality. Although the municipality has seen improvement in sanitation, some areas of Madina still lack adequate sanitation, and this has led to the outbreak of some diseases in the area (GSS, 2010).

Figure 3.1: Map of Madina in the La Nkwantanang–Madina Municipality



Source: (Google, 2018)

3.2 PHILOSOPHICAL POSITION AND ORIENTATION

According to Dainty (2007), it is necessary to construct a philosophical position and orientation towards the inquiry in any research work. As far as this study is concerned a pragmatic research paradigm was considered. It is believed that there are many different ways of interpreting the world and carrying out research. This implies that no single point of view can present the full picture of situations as there may be multiple realities (Saunders et al., 2012). Therefore, a combination of mixed methods were put together to find answers to the research objectives for the study.

3.3 RESEARCH DESIGN

A mixed method research design was adopted to draw on relevant information for the research. These include both quantitative and qualitative research approaches. According to Castro et al. (2010) and Creswell et al., (2003), the use of mixed methods approach is suitable because of the strengths and weaknesses of individual methods. Thus, by employing both types of research the strength of each approach can make up for the weaknesses of the other. Also, the use of multiple methods ensured triangulation of data by allowing for the cross-checking of information with the basic aim of validating answers and conclusions reached in the study (Field and Morse, 1985, as cited in Morse, 1991). An explanatory sequential design was employed in order to provide a comprehensive analysis of the research problem (Creswell, 2003). This was to allow the initial quantitative data results to be explained further with the qualitative data. Thus, the study derived data from multiple sources including primary and secondary data sources. The primary data sources included the use of questionnaires and in-depth interviews. While, the secondary sources of data collection included documentary such as books, journals, articles and other scholarly sites of the internet example [jstor.org, database, google advance search], this source also

included the use of photographs and recordings. Therefore, relevant literature documenting conceptual framework on the health seeking behaviour among rural-urban migrant slum dwellers was employed for broader analyses.

3.4 TARGET POPULATION

According to Burns & Grove (1997), a target population in research refers to the total aggregation of respondents that meet the designated set of criteria in a study. The target population for this study was rural-urban slum dwellers residing in poor emerging urban communities in Madina from November 2017 to March 2018. GSS (2010), put the total population of migrants in the Municipality at 73,545. However, for the purpose of this study, only those born outside the Greater Accra Region of Ghana and have settled in migrants slum communities were used for the study. The focus on Madina is important because like other urban areas of Accra, these communities have witnessed an increase in population due to the influx of migrants from the rural areas of the country resulting in the development of slums in some suburb of the area (GSS, 2010). Also, these poor slum communities were chosen because, unlike other slum settlements in Accra and other parts of the country they had not received enough research attention over the years.

3.5 QUANTITATIVE DATA COLLECTION METHOD

The study partially relied on survey questionnaires for the purpose of data collection. According to Couper, (2000), the survey method provides the most effective and convenient way of reaching the targeted population. The questionnaire was structured based on the objectives of the research. Data was collected on morbidity profile of the participants before and after migration, health seeking behaviour among the migrant slum dwellers before and after migration as well as challenges associated with health seeking behaviour before and after migration and coping

strategies adopted by migrant to overcome their health challenges. The quantitative approach afforded the researcher the opportunity to gather broad and quantifiable data. In this case, data was captured using self-administered questionnaire which were distributed to the household heads or their representatives through a translator, where language barrier posed a challenge.

The instruments were pretested among rural- urban migrant slums at Dome in the Ga East Municipal Assembly with 10 questionnaire and 2 interviews. The aim was to help the researcher reassess and restructure the questionnaires. It was also to help in revealing the length of time appropriate for questioning the respondent (Cohen et al., 2002).

3.6 SAMPLING TECHNIQUE

The use of a sampling technique is important for both quantitative and qualitative research. Sampling techniques are necessary when the whole of population would not be included in a study (Williamson, 2002). As far as this study is concerned, based on initial screening, some rural- urban migrant slum household's heads or their representatives were identified to represent a total population of 253 households. The indicator for selection was based on urban population lacking at least one of the following five housing conditions: access to improved water; access to improved sanitation facilities; sufficient-living area, not overcrowded; structural quality/durability of dwellings and security of tenure (UN Human Settlements Programme, 2010).

However, in the absence of an existing reliable sampling frame, the various households were selected by the use of simple random sampling technique. This was done by labeling code numbers to the households after which the labels were put into a box and shuffled. The labels were then picked randomly from the box to form the sample in a series of draws. The aim was to

ensure that each house hold head had equal chance of being selected (Brink, 1996). In order to avoid any bias, the study participants were selected based on the set criteria below:

- Participant should have been an internal migrant residing in the slum communities.
- Participants should have resided in any of the slum communities for not less than 6 months
- Participants should have demonstrated that he or she was willing to participate in the study
- Participants should have been 18 years and above

This means that, the respondents who did not meet the above criteria were not allowed to participate in the study.

3.7 SAMPLE SIZE

Based on population of 253 rural-urban migrants slum households. Yamane's formula (2006) was used to determine the sample size in this study. The formula is stated below:

$$n = [N / 1 + N (e)^2]$$

Determination of sample size is based on the estimated population size (n=253).

n – The sample size

N- The population size

e- The desired level of precision or level of acceptable error = 0.05)

$$\begin{aligned} \text{Total sample size (n)} &= [253 / (1 + 253 (0.05)^2)] = [253 / (1 + 253 \times .0025)] \\ &= [253 / 1 + 0.05] \\ &= [253 / 1.05] \\ &= \underline{241} \end{aligned}$$

Thus a sample size of 241 migrant households was used for the study. This is appropriate looking at the size of the communities under study and time constraint. Hence, the views and opinions of the sampled respondents could be used to generalise about the study.

The sample size for the various communities was then calculated by this formulae:

$$\text{Sample fraction (f)} = \frac{\text{Population for location} \times \text{Sample size}}{\text{Total population}}$$

Table 3.1 Sample Size of the Various Rural-Urban Slum Settlements in Madina

Settlements	Total number	No. of respondents
1. Madina Market Area	75	71
2. Social welfare down area	46	44
3. Nkwantanang/Ritz Area	51	49
4. Redco Area	38	36
5. Zongo Area	43	41
Total	253	241

Source: Field survey, 2018

3.8 QUALITATIVE DATA COLLECTION METHOD

O’Leary (2008) argues that key informant interview is a standard anthropological method that is employed in health related research and other areas in social development enquiries. It is relevant in rapid assessment for getting information from those who have been affected in a community.

A population of ten 10 key informants including opinion leaders and health officials and as well

as ten 10 migrants from the slum communities were selected for the in-depth interview, however, due to saturation or redundancy a sample size of eight 8 migrant key informants including opinion leaders and health officials and eighth 8 migrants from the slum communities. The English language served as the main mode of communication, however, the services of a translator were also engaged to help with translation. The sample size of the participants is appropriate due to the time allotted for each participant. The various questions were based on morbidity profile among the participants before and after migration, health seeking behaviour among the migrant slum dwellers before and after migration, challenges associated with health seeking behaviour before and after migration, coping strategies adopted by migrant to overcome their health challenges and policies in place for health seeking behaviour for the slum dwellers in the district. The aim was to offer the opportunity to capture rich, descriptive data and also to understand the thoughts, feelings and experiences of the migrants with regard to health seeking behaviour of the migrants before and after they migrated into their present environment.

3.9 ETHICAL CONSIDERATION

According to Pera and Van Tonder (1996), ethics refers to a code of behaviour considered correct. With regard to ethical issues, the researcher obtained ethical approval from the Ethics Committee for Humanities, University of Ghana, Legon and this is in line with national ethical clearance. After consent was granted, information about the research was read to the participants who were willing to take part in the study. The participants were assured of anonymity and confidentiality. Each participant was made to either sign or thumb print a consent form. For the purpose of ethical reasons, all names used in this study are pseudonyms.

3.10 RELIABILITY AND VALIDITY

Reliability means consistency in the event of someone else doing the same survey with the same people at the same time (Cooper & Schindler, 2008). The questionnaire was made simple and unambiguous to promote reliability. For reliability to be high there must also be a description of how the measures were conducted and that they were precise and accurate. Another requirement is that the investigator documented everything done. This is because in retrospect other investigators will be able to use the data gathered for comparison purposes. All these were done to ensure that the findings were reliable.

Validity, on the other hand, is the core of any assessment that presents an accurate and trustworthy outcome (Bond, 2003). In order to ensure validity in this study, the investigator conferred with the supervisor over the content of the research instrument. A brief initial study was also undertaken as a trial among rural- urban migrant slum dwellers in an emerging slum at Dome in the Ga East Municipal Assembly in November 2018. Questionnaire and interview guides were used to collect data from the slum migrants as well as the Ga- East Health Directorate. Based on the findings of the pilot study, some concepts and statements were rephrased in the questionnaire before finalisation. The pretesting helped the researcher to clarify the tool, and to ensure research adequacy and freedom from bias, ambiguity and logical flow of the items on the sheet. The aim was to enable participants in the study to understand the questions better.

3.11 RESPONSE RATE

A total of 241 questionnaires were distributed to the various household heads in the various slum communities. In all 241 questionnaires were retrieved to form a response rate of 100% of the

households contacted. This, therefore, means that there was no short fall in the sample size meant for the study.

3.12 FIELD WORK

The investigator and a research assistant first visited the study area in December 2017 to familiarise themselves with the area and to make the necessary contacts. The second visit in January 2018 witnessed the administration of the instruments and conduct of interviews. The instruments were read out to the respondents to respond to them. In situations where they were illiterates, the questions were explained in the local dialects for them to be able to respond appropriately.

3.13 LIMITATIONS OF THE STUDY

The study is mainly confined to rural-urban migrant slum dwellers in Madina in the Greater Accra Region of Ghana. However, for the purpose of knowing government policies and programmes for ensuring better health outcomes of these subgroups, an institutional interview was conducted with health directorate of the district. Other than that only household heads or their representative of the rural- urban migrant slum communities were administered with questionnaires and interviewed. Even though this study was carefully prepared, there are still some limitations and short comings that I must admit.

First, having access to data proved quite difficult as a result of the unwillingness of some of the respondents to cooperate with the researcher. This is because most of the respondents had been involved in various studies without yielding any benefit. They had, therefore, become fed up with the entire process. This challenge, however, was overcome by the use of identification card to identify the researcher as a student and so did not affect the quality of data in any way. There

was also a challenge with language barrier since most of the participants were from the three Northern regions of Ghana and spoke languages the investigator did not understand. However, the use of a research assistant who understood the language helped overcome this challenge. Finally, the lack of formal education among most of the participants also raised some challenges. Some, for instance, found it difficult to tell their actual ages at the time of the study. Events such as elections and natural disasters of national concern were used to overcome the challenges.

3.14 DATA ANALYSIS

Data analysis basically entails categorising, ordering, manipulating and summarising the data and describing them in a more meaningful ways (Brink, 1996). The statistical package for social science research (SPSS) software version 20 was used to analyse quantitative data. The data was coded before the analysis was made. Univariate and bivariate were used in the data analysis. In univariate analysis descriptive and frequency statistics were used to determine the general characteristics of the study population. As with bivariate analysis, cross tabulation was used to determine if there was a relationship between various variables. Also, cross tabulation was used to examine whether a significant difference between place of origin and specific type of diseases one is likely to suffer at the destination at 0.05 level of which a conclusion was made. Similarly, a cross tabulation was carried out to examine whether a significant difference between diseases suffered before migration and after migration to the slum at 0.05 level of which a conclusion was drawn. In terms of qualitative, data was transcribed and translated for uploading on to NVIVO software. The data was done by identifying themes and sub themes.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS, MIGRATION HISTORY AND MORBIDITY PROFILE OF THE RURAL-URBAN MIGRANT SLUM DWELLERS

4.0 INTRODUCTION

This chapter discusses the socio- demographic and economic characteristics, migration trajectory and morbidity profile of the rural- urban migrant slum dwellers in Madina. This section is important because it discusses the social indicators of the study population as well as the morbidity profile among the rural- urban migrant slum residents.

4.1.1 SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

The social indicators of any people in a society are very important because they represent the actual status of such people in terms of their quality of life (Singh, 2016). Thus, the socio-economic status of a population depends upon the living standard of individuals within a community, while, the living standard also depends upon the income of the family. This is helpful for improvement of good life. As far as this study is concerned the socio- demographic and economic variables that were considered included gender, age, educational background, marital status, current occupation, current monthly household income, lengths of stay in slum, type of housing in slum and the number of persons sharing rooms.

The population was female dominated, accounting for 74.3 percent, while their male counterparts accounted for 25.7 percent, (see Table 4.1).The high proportion of female shows that the number of females who are migrating are on the rise. In a related finding, Awumbila et al., (2015) noted that the migration of young females has become a common phenomenon

recently as a result of the benefit of remittances from female members who work as head porters and domestic workers in the city.

The population was very young at the early age of reproductive life span with a mean age of 1.73, (see Table 4.1). The highest age group sampled was the 18-25 age category, accounting for 53.1 percent. The least age group sampled was 58 years and above, accounting for 0.8 percent. The young nature of the population supports findings in existing scholarly works that suggest that young men and women have often accounted for the bulk migratory movements both within and outside Ghana (Gingsburg et al., 2014; Awumbila et al., 2015; Msigwa, 2013). Similar findings from UNICEF (2014) also notes that the age of most of these migrants workers often range from 15-24 years accounting for one-eighth of the age groups that are often seen moving in search of better economic opportunities. As far as this present study is concerned, one may say that migration in its widest sense is beneficial, however, certain age groups and categories of the population such as women and children are more vulnerable. Therefore, distress migration can expose them to health.

Generally, there was low educational standard reported among most of the respondents (see Table 4.1). A little over half (59.8 percent) had no education at the time of the survey. About 22.0 percent of the respondents had middle/junior secondary school certificate. The least education sampled, primary and vocational/technical/senior secondary school and the ordinary level certificates accounted for 9.1 percent respectively. The low education reported among the respondents is consistent with Singh (2016), who found that in most cases the social status of the slum dwellers is generally bad. They lack education and as a result, they are unable to secure well paid jobs but rather end up with informal sector jobs which some are sometimes dangerous

and poses health risks. As education remains an important factor of the socioeconomic characteristics of households, it is not surprising that respondents end up with low paid jobs.

The majority of the respondents sampled had had some kind of marital relationship in their lifetime. A little over half (58.9 percent) of the respondents were married and about 35.3 percent had not had any marital relationship before. Both consensual union and separated marriages accounted for 1.7 percent. The least sampled the divorcees accounted for 1.7 percent (see Table 4.1). The high marital relationship reported in this study corroborates the findings of Agesa and Kim (2001), who observed that households with more dependents are more likely to embark on migration as a livelihood strategy in Kenya. Similarly, the African Migration Project conducted a research in some selected West African countries including Burkina Faso, Ghana, Nigeria and Senegal. The study found that the probability of a household member emigrating depends on the largeness of the household (Ratha *et al.*, 2011b). This could have accounted for the need to migrate to look for better economic opportunities to cater for left behind members of the family.

In an interview with a young man, his quest to emigrate was as a result of the need to come look for money and be able to cater for his family. Kofi, the 22 years old electronic waste dealer said that life in my village is difficult for me and my family so I came here to look for money and look after them.

Table 4.1 Summary of Part of Survey Population by Socio-Demographic and Economic

Characteristics

Variables	Number	Percentage
Gender		
Male	62	25.7
Female	179	74.3
Total	241	100
Age		
18-25	128	53.1
26-33	66	27.4
34-41	34	14.1
42-49	11	4.6
50-57	-	-
58+	2	0.8
Total	241	100
Education		
No education	144	59.8
Primary	22	9.1
Middle/JSS	53	22.0
Voc/tech/SSS/O'level	22	9.1
Total	241	100
Marital status		
Never married	85	35.3
Married	142	58.9
Consensual union	4	1.7
Separated	6	2.5
Divorced	4	1.7
Total	241	100
Lengths of stay		
1 or < years	165	68.5
2-6 years	34	14.1
7-11 years	31	12.9
12-16 years	2	0.8
17> years	9	3.7

Total	241	100
Type of house in current settlement		
Compound house	4	1.7
Single family house	16	16.6
Temporary structure	214	88.8
Others	7	2.9
Total	241	100
Number of persons sharing rooms		
1-3	32	13.3
4-6	24	10.0
7-9	8	3.3
10-12	27	11.2
13-15	38	15.8
16-18	18	7.5
19-21	45	18.7
22 and above	49	20.3
Total	241	100

Source: Field Survey, 2018

The occupation of respondents before migration was predominantly farming (60.6 percent). About 21.2 percent were unemployed. Apprentices and students accounted for 12.9 percent respectively (see Table 4.3). The seeming lack of economic opportunities before migration supports the scholarly work of WB (2006a) and Herrera and Sahn, (2013), who argue that rural households are confronted with labour and financial market constraints and migration serves as a means to diversify income sources and cope with risks. Although agriculture remains the dominant occupation, the low productivity and the subsistence nature of farming makes it difficult for the youth to take up agriculture as an employment option in the rural areas (Leavy and Hossain, 2014).

Mumuni is a 20 years old young man and a truck pusher without formal education who was unemployed so he decided to migrate from the Northern Region of Ghana to the city because he has to quit farming due to the low productivity. Though things are difficult here in the city, it is far better here in the city than in his village. Figure 4.1 shows a picture of Mumuni at his job.

Figure 4.1: Truck Pusher Going about his Duty



Source: Fieldwork pictures, 2018

Generally income levels often commensurate with the type of occupation in which one finds himself /herself. Due to the poor economic opportunities in most rural areas of the country, what appears to be the highest monthly earned income sampled was between Ghc10-50, accounting for 88.4 percent. This was followed by those who earned Ghc51-100 every month, accounting for 6.2 percent (see Table 4.4). The low income level reported in the study corroborates the findings by FAO et al., (2010) who argue that generally there are failures in rural labour markets

coupled with the seasonal nature of agricultural calendar and this according to them lead to wage fluctuations and employment opportunities and poor working conditions.

Short stay in slum communities was reported among the majority of respondents (see Table 4.1). The highest duration of stay in slum communities was one year or less accounting for 68.5 percent. The least duration sampled 0.8 percent lasted for 12-16 years. The short duration in which most of the respondents had stayed in the slum communities is consistent with (IOM, 2005; WB, 2011b), who argue that because of the expensive nature of some types of migration for the poor seasonal migration becomes the only alternative for the landless as it offers households with income supplement during the lean season.

One characteristic of slums is the poorly constructed nature of shelters often shared by many individuals and the lack of basic necessities associated with them (see Table 4.1). Literature shows that because they are unable to afford decent housing due to the high cost of accommodation in most cities, most slum dwellers are forced to live in shanty type of structures (Retnaraj, 2001). In this study, large proportion of respondents (88.8 percent) live in shack or temporary structures (kiosks roofed with corrugated iron sheets). The deteriorated housing condition in the slums is in line with Berger (2006), who argues that due to the high rate of poverty among the urban poor, they are not able to secure decent accommodation but rather live in insecure shelter. This is obvious looking at the high cost of rent in Madina and its associated environs. One interviewee had this to say:

I prefer to stay in kiosk than decent accommodation, because I cannot afford the cost of decent accommodation they are too expensive for me and my sister. Besides I came here to look for money and go back'[Afi a 20 year old young woman and trader].

Figure 4.2: Temporary structures serving as homes for the migrants



Source: Fieldwork pictures, 2018

As is common with most slums, congestion in temporary structures dominated the study (see Table 4.1). The highest sampled number of persons sleeping in a room (22 and above) accounted for 15.8 percent. This was followed by 19-21 respondents who were sharing one room, accounting for 10.0 percent. The least number of respondents sharing a room (1-3) accounted for 13.3 percent. The high number of occupants per room in the slum communities is consistent with findings by (Sajjad, 2014), who found that slums of Mumbai in which houses were located were of poor structures and ventilation and were often overcrowded, thereby attracting various forms of diseases and infections to the inhabitants. This is expected looking at the high cost of renting rooms in Madina.

A young female respondent, revealed in an interview:

Here in Madina, rooms are too expensive to rent, so we share rooms together. In my case, we are 40 people in our room, and each person pays Ghc4 every week to our landlord. The rooms are so congested that sometimes we have to struggle for space. At times you feel reluctant to attend to nature's call in the night because by the time you come back, someone would have occupied your space. The landlord does not care about our plight so he keeps bringing more people. Unfortunately, we cannot complain because we have no where to go. [Akos a 30 years old head porter].

4.1.2 MIGRATION HISTORY

In this section, issues such as where migrants originated, reasons for migration, persons they accompanied, who financed their journey, previous occupation before migration and monthly income before migration are discussed.

The three Northern Regions appear to be the three leading sending regions to the slum settlements. (see Table 4.2). Nearly half of the respondents (45.2 percent) originated from Upper West Region of Ghana, with the Upper East being the next, accounting for 17.4 percent. The Northern Region accounted for 14.5 percent with the least region being the Ashanti Region which accounted for 3.7 percent. The three Northern Regions of Ghana pushes several of the youth who originate from these places to the southern cities of Ghana. The concentrations of migrants from this particular zone of the country to this slum are linked to the presence of migrant networks. This finding supports Yaro et al., (2011) who suggests that the clustering of the three Northern tribes of Ghana in a study should be attributed to migrants clustering due to social networks.

Several reasons motivated the respondents to migrate to Accra. Among these are the search for better job opportunities and prospects (95.4 percent), and the need to further education (2.9 percent). The desire to learn a trade accounted for 1.7 percent (see Table 4.2).The need to search for better economic opportunities, which is dominant in the findings of this study, corroborates

with UNICEF (2007), which suggests that in rural Morocco, there were reported incidence of the movement of rural youth to the big cities to overcome economic challenges of their households.

In an interview it was revealed that:

Over there, there are no jobs. Though I worked as a farmer, all the money I got from the farming business went to my husband, and I didn't get a penny except food I get to eat. I therefore, decided to come here to work and save some money so I can buy a sewing machine for myself and go back and learn a trade [Asana, 29 years old Domestic worker].

More than half (63.1 percent) came to the city in the company of a relative. About 35.7 percent came with friends. The remaining 1.2 percent migrated to the city on their own (see Table 4.1).

The company in which most of the respondents came with as reported in the study stands in sharp contrast with other findings that suggest that young people who are often engaged in out migration tend to move alone without accompaniment and the likelihood of independent migration increases with age (WB, 2011b). It is, therefore, no surprise that most of the migrants came in the company of a relative or friend.

Nearly half (46.5 percent) were supported financially by a relative to migrate to the city. Personal savings 46.6 percent accounted for the highest source of funding in the migration process. The least source of financial support came in a form of loan from friends and accounted for 10.0 percent (See Table 4.2). The seemingly high financial support from relatives as reported by most of respondents is in line with New Economics of Labour Migration (NELM) that argue that, in developing countries migration serve as part of household strategy that is intended to maximise utility of members and driven by insurance motives (see Lucas and Stark 1985, Stark 1991). It is further contended that the environment pose a lot of risk that is income insecurity therefore encourage most of the youths to migrate as diversification strategy (Lucas and Stark 1985).

Table 4.2 Summary of Part of Survey Population by Migration History

Variables	Number	Percentage
Region of origin		
Ashanti	2	0.8
Brong Ahafo	14	5.6
Central	6	2.5
Eastern	12	5.0
Northern	35	14.5
Upper East	42	17.4
Upper West	109	45.2
Volta	12	5.0
Western	9	3.7
Total	241	100
Reason for coming to Accra		
Further education	7	2.9
Seek better job	230	95.4
Others	4	1.7
Total	241	100
Person came with		
Alone	3	1.2
Relative	152	63.1
Friend	86	35.7
Total	241	100
Person who finance		
Personal savings	112	46.5
Loan from friend	24	10.0
Relative	105	43.6
Total	241	100

Source: Field Survey, 2018

The occupation of respondents shows some improvement after migration though the occupation most of them found themselves in offered minimal wages (see Table 4.3). Though farming remained the predominant occupation (60.6% percent) before migration, the low wage earned from this occupation presented the migrants with no alternative than to migrate. Even with this, unemployment was quiet high (21.2 percent) before migration as compared to after migration

(1.7 percent). Overall, head portering (Kayayei) (70.5 percent) was reported as a dominant occupation among the migrants after migration. The variety of economic opportunities presented by the city is similar to those found in the scholarly work of Songso (2003a) who found that the cities most of these youth migrate to provide some kind of hope in the informal settlement, where employment opportunities are lost in their rural settlements. This provide some hope of relief as they found their ways to informal settlement. As 20 years old Fausia, an unemployed before migration stated, ‘Before I came here I was not doing anything I depend on my parents however since I came here I do ‘Kaya’ ie. head pottering and I earn some income though meager it is, I am trying to save some so I can go back and do my business.

Figure 4.3: Busy working day of a female head porter and male trader



Source: Fieldwork pictures, 2018

Table 4.3 Occupation Status of Migrants before and after Migration

Occupation	Before N (%)	After N (%)
Farmer	146(60.6)	0(0.0)
Trader	13(5.4)	14(5.8)
Unemployed	51(21.2)	4(1.7)
Domestic worker	31(12.9)	5(2.1)
Head porter	0(0.0)	170(70.5)
Others	0(0.0)	48(19.9)
Total	241(100)	241(100)

Source: Field Survey, 2018

Generally, the income levels of the migrants show some improvement after migration, (see Table) 4.4. The highest monthly income earned after migration is Gh¢ 1000-1500 accounting for 34.4 percent compared to the period before migration, which was never earned accounting for 9.4 percent. However, the least monthly income Gh¢ 10-50 after migration was 11.6 percent but high before migration (35.3 percent). Thus the income differentials reported in this study support Harris and Todaro (1970), who argue that there is the tendency that people will migrate for longer periods to the cities when they are lured by the differences in expected income as compared to those they earned in the rural areas. This is by no means the reason most of respondents were attracted to the city. This assertion was affirmed in an interview.

Though the work I do is not very lucrative, I get something little at the end of the day. I use some of the money to pay for rooms which cost me Gh¢ 4, toilet 60 pesewas, 20 pesewas for a bucket of water and the remaining I save. I can confidently say that life here in Madina is far better than life in the village. [Kojo a 25 years old truck pusher].

Table 4.4 Migrant Monthly Income before and after Migration (Cedis)*

Income	Before N (%)	After N (%)
10-50	85(35.3)	22(11.6)
51-100	50(20.7)	28(11.6)
110-150	28(11.6)	51(21.2)
151-200	55(22.8)	57(23.7)
Others	23(9.5)	83(34.4)
Total	241(100)	241(100)

Source: Field Survey, 2018* The exchange rate at the time of survey was 4.9 Cedis = US\$1

4.1.3 MORBIDITY PROFILE AMONG THE RURAL-URBAN MIGRANT SLUM

DWELLERS

There are episode of diseases that are often associated with urban slums, due to the deplorable conditions in most of these areas. This section, therefore, attempts to identify the common diseases prevalent among slums dwellers at Madina.

Most of the respondents sampled had been attacked by all kinds of diseases ranging from fever, malaria, cholera, cough, diarrhoea and cold/flu. According to WHO (2011), many of these diseases are caused by the poor sanitation and unhygienic environments.

Common diseases prevalent among respondents who lived in temporary structures included malaria (41.6 percent), cold/flu (21.5 percent), body, stomach and chest pains (15.4 percent) respectively, diarrhea (10.3 percent), cholera (5.6 percent), fever (3.7 percent), and skin diseases (1.9 percent). (see Table 4.5). However, diseases like malaria were unanimously reported almost across all types of houses. The deficiency in safe housing conditions with its attendant diseases is consistent with observation made by Nijama et al., (2003), who contend that the lack of proper conditions in slum environments as well as poor housing conditions among slum dwellers are a

major cause of malaria, diarrhoea, typhoid, and other such diseases among such under privileged populations. Also, Singh and Rahman (2002) found that though malaria is among the leading diseases in most developing countries, slum dwellers are most affected due to the poor housing conditions in which most of them live in.

In an interaction with one of the leaders of the head porters who was down with malaria three weeks before the interview, she indicated that:

Memouna a 23 years old young woman with no formal education from Upper East Region, narrated her ordeal of having a serious stomach upset after eating noodles- indomie from a vendor and later had a running stomach for 3-4 times daily for two days. She later went to Kekele- Madina District Hospital and was diagnosed with diarrhoea after which she was treated.

In a related interview, one respondent had this to say:

I felt feverish and unable to do anything. I met a drug peddler and I narrated my situation to him. He told me I was suffering from malaria and so, he gave me some drugs which he claimed could cure me. According to him, I was supposed to take 4 tablets on the first day and then take the others later. I recovered after a couple of days.[Salima, 20 years old head porter].

As indicated in Table 4.5, statistical tests suggest a significant relationship between houses in current settlement and disease one is likely to suffer in the slum. ($\chi^2= 54.821$, $df=18$, $P = 0.000 < 0.05$). This is because the P-value was higher than the confidence level. Thus rural urban slum dwellers are most likely to suffer from diseases because of the type of house in current settlement.

Table 4.5 Assessment of Fallen ill Recently with Houses in Current Settlement and Diseases one is likely to Suffer

Type of Sicknesses	Type of house in Current Settlement				Total N(%)
	Compound House N(%)	Single family house N(%)	Temporary structure N(%)	Others N(%)	
Fever	0(0.0)	0(0.0)	8 (3.7)	0(0.0)	8(3.3)
Malaria	4(100)	12(75.0)	89(41.6)	0(0.0)	105(43.6)
Cholera	0(0.0)	0(0.0)	12(5.6)	0(0.0)	12(5.0)
Skin Diseases	0(0.0)	4(25.0)	4 (1.9)	0(0.0)	8(3.3)
Diarrhoea	0(0.0)	0(0.0)	22(10.3)	0(0.0)	22(9.1)
Cold/flu	0(0.0)	0(0.0)	46(21.5)	4(57.1)	50(20.7)
Others	0(0.0)	0(0.0)	33(15.4)	3(42.9)	36(14.9)
Total	4(100)	16(100)	214(100)	7(100)	241(100)

Source: Field Survey, 2018($\chi^2 = 54.821$, $df = 18$, $P = 0.000 < 0.05$)

Attempts to know if migrants had suffered similar type of diseases even before they came to slum community showed very little or no attack of such kinds of diseases before migration. (see Table 4.6). The diseases they suffered before migration ranged from cough (12.5 percent), fever (8.3 percent), stomach (4.5 percent) respectively, cold/flu (4.0 percent) and malaria (1.0 percent), however, none of the respondents experienced cholera and diarrhoea. The low or no available cases of disease reported in the study before migration supports findings by Szwarcwald et al., (2002), Sclar et al., (2005), Fotso (2006), who note that slums are characterised by worse health outcomes than rural areas. Besides, slum residents delay their sicknesses until it gets worse before they visit health care facility. As most migrants have reasons for which they think they hardly suffer disease attack prior to migration to the slum, in one of the interview a respondent commented thus:

Though I do have some slight headache sometimes, I did not experience similar kinds of diseases before I came to this community, because the environment in my hometown is clean, besides there are no gutters around but here every place is dirty and one also has to work hard too [Abiba, 21 years young woman].

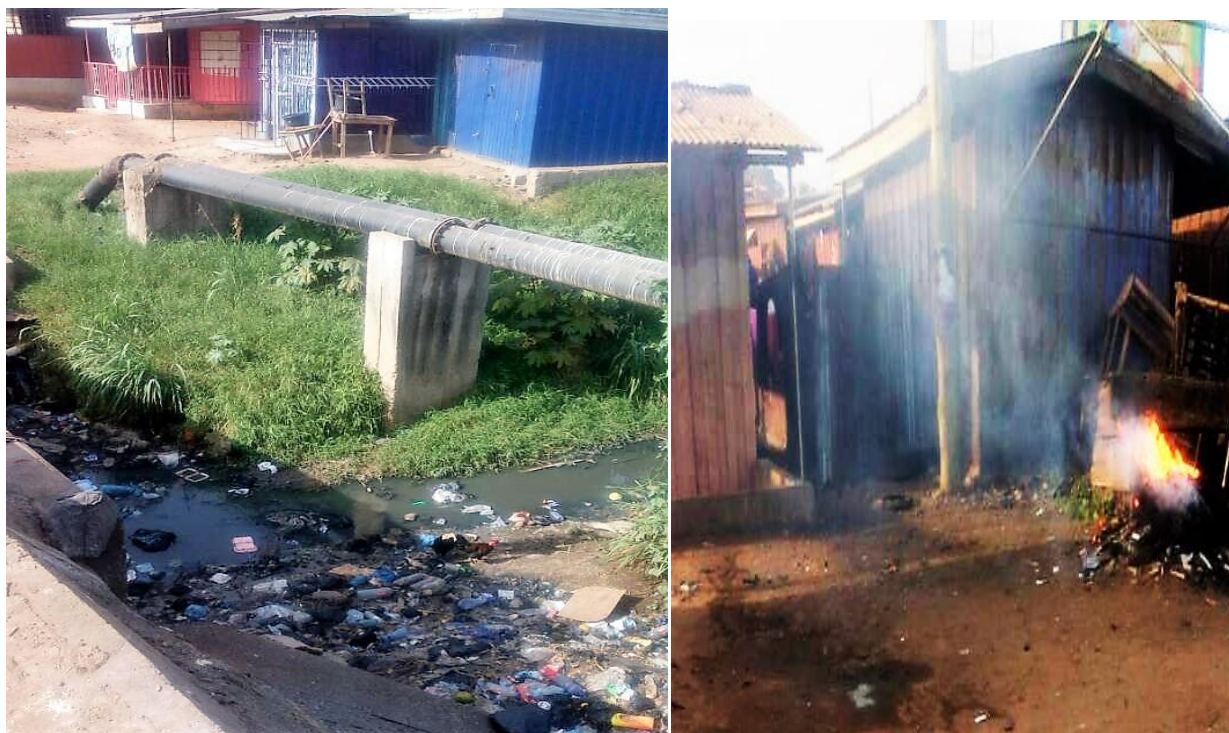
Meanwhile, chi-square test shows no significant relationship between similar type of diseases before and after migration to the slum. ($\chi^2 = 7.989$, $df = 6$, $P = 0.239 > 0.05$). This is because the P-value was more than the confidence level. Thus, there are no similarities between diseases suffered before migration and what was experienced in the slum.

Table 4.6 Proportion of Migrant who have Experienced Similar kind of Sickness before Coming to Slum Community

Response	Diseases Suffered before Migration							Total N (%)
	Fever N (%)	Malaria N (%)	Cholera N (%)	Cough N (%)	Diarrhoea N (%)	Cold/flu N (%)	Others N (%)	
Yes	1(8.3)	1(1.0)	0(0.0)	1(12.5)	0(0.0)	2(4.0)	1(4.5)	6 (2.5)
No	11(91.7)	104(99.0)	8(100)	7(87.5)	36(100)	48(96.0)	21(95.5)	235(97.5)
Total	12(100)	105(100)	8(100)	8(100)	36(100)	50(100)	22(100)	241(100)

Source: Field survey 2018($\chi^2 = 7.989$, $df = 6$, $P = 0.239 > 0.05$)

Figure 4.4: Slum environment conditions



Source: Fieldwork pictures, 2018

An assessment of whether or not other diseases were prevalent among the migrant slum dwellers suggested there were various diseases among the respondents (see Table 4.7). Although various diseases were relatively wide spread across board. Head porters and other workers including truck pushers, truck off loaders, drivers, masons, carpenters, electronic waste dealers, hair dressers and seamstresses suffered all diseases. For example, chest pain accounting for 41.7 percent, was reported among other occupations and 21.8 percent among head porters respectively. Similarly, headache accounted for 22.9 percent among other work and 21.8 percent among head porters.

The various diseases suffered as a result of the nature of the work they performed is in line with Sigerist (1955) who advised that for the purpose of health maintenance work is essential

however, it may be harmful to health and become the cause of disease if it exceeds the capacity of the individual and most especially when it is performed under adverse circumstances.

Salima, a 20 years old young woman, with no formal education and from Upper West was carrying 6-7 months fetus as at the time the researcher was collecting quantitative data, however, on my return to collect qualitative data she had miscarriage which was confirmed to her by health professionals that the miscarriage was triggered by the heavy load.

However, as indicated in (Table 4.7), a chi-square test shows no significant relationship between the nature of work performed and possibility of being attacked by other illnesses. ($\chi^2 = 27.090, df = 24, P = 0.300 > 0.05$). On the basis of that, the P-value was more than the confidence level. Thus, the likelihood of fallen ill to certain illnesses cannot be attributed to the work respondents are engaged.

Table 4.7 Current occupation and other diseases one is likely to suffer

Other Illnesses	Current Occupation					Total N(%)
	Trader N (%)	Domestic Worker N(%)	Unemployed N(%)	Head porter N(%)	Others N(%)	
Waist pains	0(0.0)	0(0.0)	1(25.0)	5(2.9)	2(4.2)	8(3.3)
Eye pains	2(14.3)	0(0.0)	0(0.0)	13(7.6)	1(2.1)	16(6.6)
Body pains	2(14.3)	0(0.0)	0(0.0)	20(11.8)	3(6.2)	25(10.4)
Dizziness	3(21.4)	2(40.0)	1(25.0)	29(17.1)	6(12.5)	41(17.0)
Headache	1(7.1)	1(20.0)	0(0.0)	37(21.8)	11(22.9)	50(20.7)
Chest pains	5(35.7)	2(40.0)	2(50.0)	37(21.8)	20(41.7)	66(27.4)
No sickness	1(7.1)	0(0.0)	0(0.0)	29(17.1)	5(10.4)	35(14.5)
Total	14(100)	5(100)	4(100)	170(100)	48(100)	241(100)

Source: Field Survey, 2018 ($\chi^2 = 27.090, df = 24, P = 0.300 > 0.05$).

Figure 4.5: Nature of work



Source: Fieldwork pictures, 2018

A further investigation was also carried out to ascertain whether previous occupation migrants were engaged in made them suffer some disease conditions before they migrated to the slum as indicated in (Table 4.8). Result shows that nearly all diseases reported were suffered across all occupations before migration. Although these diseases were suffered, they tended to be less reported among the respondents. For example, headache was suffered among traders accounting for 37.3 percent. The various diseases reported among the migrants before migration corroborates similar ones by McKay et al., (2003), who note that when it comes to the epidemiological analysis of illnesses and diseases, it is important to consider the health status of migrants at the time of migration and to study the evolution of health characteristics over time. The finding suggests that migrants suffered from certain disease conditions way back before migrating to the slum. This could be attributed to the socio-economic factors, genetic, behavioural lifestyle and chronic illnesses etc.

Table 4.8: Previous Occupation and the Disease suffered before Migration

Previous Diseases	Previous Occupation				Total N(%)
	Farmer N(%)	Trader N(%)	Unemployed N(%)	Others N(%)	
Headache	35(24.0)	4(30.8)	19(37.3)	8(25.8)	66(27.4)
Cold/flu	35(24.0)	1(7.7)	10(19.6)	4(12.9)	50(20.7)
Dizziness	22(15.1)	3(23.1)	8(15.7)	8(25.8)	41(17.0)
Cough	20(13.7)	1(7.7)	6(11.8)	8(25.8)	35(14.5)
Chest pains	16(11.0)	2(15.4)	5(9.8)	2(6.5)	25(10.4)
Eye pains	12(8.2)	2(15.4)	2(3.9)	0(0.0)	16(5.6)
Waist pains	6(4.1)	0(0.0)	1(2.0)	1(3.2)	8(3.3)
Total	146(100)	51(100)	13(100)	31(100)	214(100)

Source:

Field Survey, 2018

CHAPTER FIVE

HEALTH SEEKING BEHAVIOUR, CHALLENGES, COPING STRATEGIES AND EXISTING POLICIES AIMED AT HEALTH SEEKING BEHAVIOUR

5.0 INTRODUCTION

This chapter takes into account health seeking behaviour, challenges with health seeking behaviour, coping strategies adopted by rural-urban slum migrants to overcome health challenges and existing policies aimed at health seeking behaviour for rural-urban migrant slum residents.

5.1 HEALTH SEEKING BEHAVIOUR AMONG RURAL-URBAN MIGRANT SLUM DWELLERS

The remedial actions an individual undertakes in order to remedy perceived illness have often been linked to health seeking behaviour. This section examines the health seeking behaviour the migrants employed in order to avoid diseases they often suffered in their communities before and after migration.

Generally, health seeking behaviour practices were adhered at places of origin as compared to the slum (see Table 4.9). More than half of the respondents (58.0 percent) maintained clean environment which was not reported in slum communities. However, long working hours (55.6 percent) which impede health seeking behaviour prevail in the slum than places of origin. Baba, a 25 years old load off loader, said we came here to look for nothing else than money so you cannot sit down and rest you have to work extra hard to get the money.

In a similar interview, one respondent stated that:

Unlike the situation in my hometown, people here do things anyhow. Besides, here in Madina, a person needs money to do virtually everything including disposing of refuse. People, therefore, dump their refuse indiscriminately to avoid paying
[Adjoa 23 years].

The unwillingness to adhere to health seeking behaviour after migration supports the scholarly work of Maneze (2014), who maintains that it is difficult for migrants who have migrated to new locations for better economic opportunities to engage in the practice of health seeking behaviour. This is because, due to the many settlements needs they have to face in the current environment health seeking behaviour are not given the needed attention. Given the various needs they have to meet it is not surprising that they could not adhere to health seeking behaviour practices.

Table 4.9: Health Seeking Practices Before and After Migration

Activities	Before N (%)	After N (%)
Do not engage in risky lifestyle behaviours e.g. smoking, alcohol use etc.	53(22.0)	0(0.0)
Cleanliness of environment	140(58.0)	0(0.0)
Conscious effort to eat healthy diet	8(3.3)	0(0.0)
Getting adequate rest and sleep	13(5.3)	2(0.8)
Medicare benefits for timely accessibility of health care services	15(6.2)	3(1.2)
Engagement in regular physical activity	10(4.1)	102(42.3)
Participate in health promotion programme	2(0.8)	0(0.0)
Over working with less rest	0.0	134(55.6)
Total	241(100)	241(100)

Source: Field Survey, 2018

According to literature, it is important for early diagnosis of any disease condition because it is considered a tenet in oncology that paves way to early treatment with the expectation of better health outcomes. In this study, the stage of disease before migrants approach a provider for cure presents some variations before and after migration, (see Table 4. 10). For example, 78.0 percent

consulted at a tender stage of the disease at places of origin as compared to after migration (68.0 percent), though the difference was not significant. The delayed until serious stage of disease 8.7 percent was reported in the slum. The relative variation in terms of the willingness to see a health provider at a tender stage of a sickness before migration is in line with Arndt, Sturmer and Brenner (2002), who note that the support from relatives in seeking treatment in addition to the fact that in some countries like India, for instance, government policies tend to be rural-centric and that rural areas tend to benefit from health policies than slums because slums are illegal in nature making the rural health better than that of slums in most cases.

Mustapha, a 25 years old junior high school leaver and driver believed that it was always easy seeking early treatment before he came to the slum community because back home, the national health insurance and support from family helped him access medical treatment any time he fell sick. When compared to his stay in the slum, he intimated that, though it is difficult you cannot also delay that much because it will eventually break you down and you cannot go and work, the reason why I came here.

In an interview, a respondent explained that:

Because I don't know if the sickness could get serious and, render me immobile. to I always prefer seeking early treatment before my condition worsens. I used to do the same thing before I came here. [Celina, 20 years old young woman and domestic worker] .

Table 4.10 Stage of Disease and Seeing Provider Before and After Migration

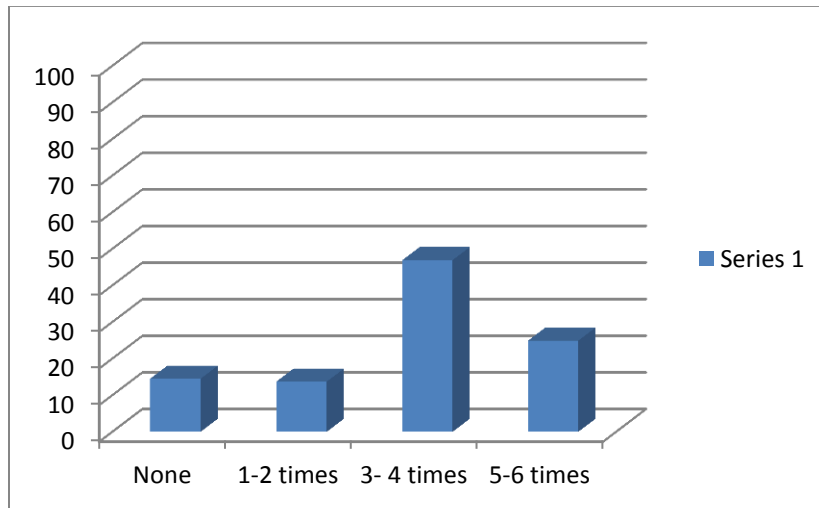
Stages	Before	After
	N (%)	N (%)
Early stages and onset of symptoms mild	189(78.4)	165(68.0)
Time of disease and its symptoms	52(21.6)	55(22.8)
At serious stage of disease	-	21(8.7)
Hospital/clinic emergency room	-	-
Total	241 (100)	241 (100)

Source: Field Survey, 2018

As most of the migrants had to battle with various diseases in their slum communities, the frequency of disease treatment appeared to be quite high since they migrated to the communities, (Figure 4.2), shows that nearly half of the respondents (46.9 percent) had treated diseases between 3-4 times, the least treatment times being 1-2 and accounting for 13.7 percent. The high frequency of treatment reported in the study can be attributed to the poor sanitation, unhygienic conditions as well as risky behavioural lifestyle which prevail in the slum. This finding is consistent with WHO (2000), who argue that slums serve as breeding grounds for different types of infectious diseases as a result of poor hygienic conditions which easily spread in highly concentrated populations. They further identified other infectious conditions such as HIV/AIDS and substance abuse as the cause of disease prevalence in slums that need to be treated. It, therefore, came as no surprise when this came to light in an interaction with a respondent. According to her:

While I was in my home town I hardly fell sick, I remember that once I had experienced stomach ache and that was all. Unfortunately, because of the poor sanitation here, there are too many mosquitoes so I fall sick almost every week. Again, the bed bugs in our room bite us in the night so I always have my my skin itching me every now and then' [Salamatu, a 25 years old woman].

Figure 4.6: Frequency of Disease Treatment in Slum Community



Source: Field survey 2018

Figure 4.7: Unhygienic Condition of Slum Settlements



Source: Fieldwork pictures, 2018

Regular health exams and tests can help one detect potential health issues before they start, (see Table 4.11). Findings from survey shows that, though seeking treatment only in times of sickness was reported across all groups, the tendency was quiet higher among the married (92.0 percent) than in any other groups. The low regular exams and test reported among married households corroborate Yip et al., (2008), who contends that the lack of financial protection among the poor vis-à-vis the cost of medical treatment has eventually forced many households further into poverty. It is, therefore, important to note that the cost of medication in times of ill health contributes to poverty among more than half of households (Krishna, 2004). Given the additional responsibility of catering for each member of the family which is not commensurate with the meager income they earned it is possible the married ones would not be able to afford regular checks. This was confirmed in an interview;

Over here, I take care of two other children. My husband is not here and sometimes we find it difficult to buy food let alone medicine. However, by the grace of God we always survive it [Adwoa, a 22 years old nursing mother].

Table 4.11 Seeking Treatment in times of Sickness by Marital Status

Response	Marital status					Total N(%)
	Never Married N(%)	Married N(%)	Consensual union N(%)	Separated N(%)	Divorced N(%)	
Yes	76(89.4)	127(92.0)	7(87.5)	5(83.3)	3(75.0)	218(90.5)
No	9(10.6)	11(8.0)	1(12.5)	1(16.7)	1(25.0)	23(9.5)
Total	85(100)	138(100)	8(100)	6(100)	4(100)	241(100)

Source: Field Survey, 2018

Relatives or friends whom migrants came to the cities with are likely to have an influence on individuals in seeking regular check-ups (see Table 4.12). According to literature, the response to symptoms posed by illnesses is mediated by various factors and one of such factors is the responses of friends, relatives and colleagues to an individual's illness leading to the use of health care service. The influence that relatives and friends have on their colleague's health in the study is supported by the scholarly work of Harding et al., (1990), when they state that the ability to use health care services among underprivileged populations is sometimes influenced by the composition and values of one's immediate network of friends and relatives and the attitude they have towards professional health care.

Salima, a 20 year old young woman, with no formal education and from Upper West Region who had miscarriage in her seventh month of pregnancy, narrated how her friends and some family members encouraged her to go for regular antenatal care which she did not heed to until that unfortunate incident occurred.

However, as indicated in Table 4.12, chi-square test reveal statistically no significant relationship between relatives, friends and influence on seeking regular checks by an individual ($\chi^2 = 2.224, df = 2, P = 0.329 > 0.05$). Because the P-value was more than the significant level, therefore, relatives and friends did not have influence on the tendency of an individual to seek regular check-up.

Table 4.12: Relatives/Friends came with and their influence on Regular Checks

Response	Relative/Friends			Total N (%)
	Alone N (100)	Relative N (%)	Friend N (%)	
Yes	2(66.7)	139(91.4)	77(89.5)	218(90.5)
No	1(33.3)	13(8.6)	9(10.5)	23(9.5)
Total	3(100)	152(100)	86(100)	241(100)

Source: Field Survey, 2018 ($\chi^2 = 2.224$, $df = 2$, $P = 0.329 > 0.05$)

Although preventive care echoed throughout the study, it is likely that the low educational background reported among the respondents might have played some role in adhering to precautions in their slum communities, (see Table 4.13). The highest precaution sampled (77.3 percent) was reported among those with vocational, technical and O'level certificates. Middle/JSS certificates holders 68.2 were also found to adhere to precautionary practices. Consistent with findings by Berkman et al., (2004 and Dewalt et al., (2004), the study shows that limited functional health literacy is associated with adverse health outcomes which lead to less preventive health behaviours and high health care cost. However, Chi-square test reveal statistically no significant relationship between education and precautionary measures against diseases among migrants slum dwellers ($\chi^2 = 3.126$, $df = 3$, $P = 0.373 > 0.05$). This is based on the fact that P-value calculated was more than the significant level. That is, the educational level of respondents did not influence the attitude towards certain lifestyle choices in disease prevention.

Table 4.13: Education and Assessment of Precaution among Migrant

Responses	Education				Total N (%)
	No education N (%)	Primary N (%)	Middle/JSS N (%)	Voc/tech/ O'level N (%)	
Yes	85(59.0)	32(60.4)	15(68.2)	17(77.3)	149(61.8)
No	59(41.0)	21(39.6)	7(31.8)	5(22.7)	92(38.2)
Total	144(100)	53(100)	22(100)	22(100)	241(100)

Source: Field survey, 2018($\chi^2= 3.126$, $df=3$, $P = 0.373 > 0.05$)

An assessment to ascertain what informed migrant slum dwellers' decision to seek health- care treatment in the slum on likert scale items is indicated in (Table 4.14). Result shows that, little over half (56.8 percent) would seek care only if they could afford. The mean 2.48 and standard deviation of 1.12 imply that though the majority of respondents agreed on the issue, there were some divergent opinions in the responses. Those who would fall sick and did not even have the money but would still seek care accounted for 19.5 percent, with a mean of 3.27 and a standard deviation of 1.39. This shows that, respondents had mixed feelings over the issue. Little over half of the respondents (51.5 percent) would seek care only when they realised their sickness was getting worse with a mean of 2.23 and standard deviation of 1.17, which implies that though the majority agreed on the issue there, there were divergent opinions. More than half (59.0 percent) would seek health care when self- medication failed. With a mean of 2.48, a standard deviation of 1.11 was recorded. This implies that, though there were different opinions expressed over the issue, the majority of the respondents agreed. Less than half (40.7 percent) would seek care when they are encouraged by relatives or friends. With a mean score of 2.92, a standard deviation of 1.31, which indicates that respondents shared different views over the issue. Those who would get financial support from friends/relatives and would seek care in times of sickness

accounted for (46.1 percent) with a mean value 3.15 percent, a standard deviation of 1.31 was recorded, indicating relative differences in opinion held by respondents. Income remained a key factor in accessing health care. It is clear that healthcare needs depend on economic positions of an individual. Given the low income earnings of the respondents, policy makers and other stakeholders should make access to basic healthcare services affordable to the urban poor. One way by which this can be achieved is through the principle of universal access to health care. The various factors that informed the decision to seek care treatment corroborate Jen et al., (2009), who note that the difficulties faced by the urban poor in procuring even the basic necessities of life pose a great challenge.

Table: 4.14 Assessment of migrant on the basis of what informed decision to seek care treatment. (Likert scale based on 1-5 scale: 1 representing “Strongly Agree”, 2 “Agree”, 3 “Neutral”, 4 “Disagree”, 5 “Strongly Disagree”)

Statement	N	Percentage In Agreement	Mean Score Error	Standard Mean	Standard Deviation
Any time I fall sick	241	50.2	2.21	0.08	1.26
When I fall sick and I have the money	241	56.8	2.48	0.72	1.12
When I fall sick and I do not have the money	241	19.5	3.27	0.08	1.39
When I feel sickness is getting worse	241	51.5	2.23	0.75	1.17
When self-medication does not work	241	59.0	2.48	0.70	1.11
When I am encouraged by a relative/friend	241	40.7	2.92	0.07	1.23
When I get support from a relative/friend	241	46.1	3.15	0.08	1.31

Source: Field Survey 2018

5.2 CHALLENGES WITH HEALTH SEEKING BEHAVIOUR AMONG RURAL- URBAN MIGRANT SLUM DWELLERS

For many rural-urban migrant slum dwellers, the quest for a better life has often been a major priority in their daily life activities. This section attempts to ascertain the challenges faced by the slum dwellers at Madina.

There were some challenges associated with health seeking behaviour sampled before and after migration. Other studies have also identified challenges that confront individuals in their health seeking behaviour. Though challenges were reported across (see Table 4.15), the cases tended to be higher after migration (62.3 percent) as compared to the period before migration (34.9 percent). The high challenges that were reported in the slum attest to similar findings by WHO (2000), which states that, the poor access to health care and unfavourable policies by government lead to exclusion and poor health outcomes.

Table 4.15 Challenges in Health Seeking Behaviour before and after Migration

Responses	Before N (%)	After N (%)
Yes	84(34.9)	155(62.3)
No	157(65.1)	85(35.3)
Non response	-	1(0.4)
Total	241(100)	(241)100

Source: Field Survey, 2018

Among the challenges (see Table 4.16), the cost of accessing health care was higher (60.2 percent) in the slum as compared to their places of origin (49.8 percent). The poor dirty

environment in which respondents lived in their slum communities accounted for 18.3 percent. Though some challenges were reported across, they were more encountered by the respondents in the slums than before they came to the slums. The variation in terms of challenges before and after migration is similar to the scholarly work of Derose et al., (2007), who contend that migrants encounter numerous challenges in maintaining health seeking behaviour in the destination in which they find themselves. This has contributed to the low levels of health keeping behaviour resulting in poor health outcomes. One of the respondents had this to say:

It is difficult here but in my hometown, I did not experience these kinds of difficulties because my parents were always ready to support me both in kind and in cash, but here nobody is willing to help. Everybody does what pleases him or her. [Fuseini a 26 year old man].

Table 4.16: Challenges Faced Before and After Migration

Challenges	Before N (%)	After N (%)
Monetary/high cost of medication	120(49.8)	145(60.2)
Physical impediment (laziness, disability)	5(2.1)	-
Cultural barriers	5(2.1)	17(7.1)
Lack of program education on healthy leaving	10(4.1)	22(9.1)
Poor/dirty environment	-	44(18.3)
In adequate rest and sleep	20(8.3)	
Long distance from facility	40(16.6)	-
Family support in care and in making healthy life style Decisions	41(17.0)	13(5.4)
Total	241(100)	(241)100

Source: Field Survey, 2018

As part of challenges migrants slum dwellers face in seeking care behaviour, a further assessment was carried out to ascertain how migrant slum dwellers face these challenges on likert scale items (see Table 4.17). Results show that poor quality of care (44.8 percent) poses challenge to the migrants who visited formal health-care facilities in treating their ailments, a mean of 2.22 and a standard deviation of 1.51, which implies that respondents expressed differences in terms of opinion over the issue. Language barrier accounted for (31.2 percent) of the respondents who visited care facilities. A mean score of 2.22 and standard deviation of 1.51 indicating that respondents shared mixed feelings over the issue. The challenge with waiting for long periods before being attended to at the facility accounted for (24.9 percent). It came with a mean score of 3.41 and a standard deviation of 1.42, which suggests mixed reactions expressed by respondents on the issue. The least challenge sampled (5.8 percent) accounted for poor health worker attitude. With a mean score of 4.49, a standard deviation of 1.39 was recorded implying that respondents expressed various sentiments in terms of their responses over the issue.

The difficulties reported to access health care at a facility is consistent with Shaikh et al., (2005), who note that an important determinant for health seeking behaviour depends to a large extent on how the health system is organized. In a related finding Hunte et al., (1992), found that in most developing countries like Uganda, the quality of care and other determinants have adverse effect on the health seeking practices of poor urban communities.

Table 4.17: Other Challenges in Health Seeking Behaviour

(Likert scale based on 1-5 scale: 1 representing “Strongly Agree”, 2 “Agree”, 3 “Neutral”, 4 “Disagree”, 5 “Strongly Disagree”)

Statement	N	Percentage In Agreement	Mean Score	Standard Mean Error	Standard deviation
1. Language barrier	241	31.2	2.22	0.97	1.51
2. Long waiting time	241	24.9	3.41	0.09	1.42
3. Poor attitude of health care worker	241	5.8	4.49	0.52	1.39
4. Poor quality of care	241	44.8	3.26	0.90	1.39

Source: Field Survey 2018

The purpose for coming to the city served as a clear predictor of knowing whether health seeking behaviour could be achieved in the slum or not (see Table 4.18). Results, however, suggest that 37.4 percent with education intentions for coming to the city were optimistic. The desolation reported among the economic migrant supports their motivation behind migration to the city.

Table 4.18: Purpose of Coming to the City and Health Seeking behaviour

Response	Reasons for coming to Accra			
	Further Education N (%)	Seek better job N (%)	Others N (%)	Total N (%)
Yes	86(37.4)	0(0.0)	1(25.0)	87(36.1)
No	144(62.6)	7(100)	3(75.0)	154(63.9)
Total	230(100)	7(100)	4(100)	241(100)

Source: Field Survey, 2018

Achieving the best health outcome of the rural urban migrant residents in terms of health seeking behaviour could not have been achieved without involving residents. According to Rollnick et al. (1993), there are always difficulties among health practitioners in designing strategies to encourage appropriate health seeking behaviour that are effective and sustainable in curbing risk factors associated with lifestyle diseases, this is often due to the mismatch between programs priorities and individual preferences. (see Tables 4.19), in quest for the solution, although various suggestions were made almost across all lengths of stay in the slum, the highest sampled 62.5 percent and were those who have stayed for 12-16 years in the slum. This was followed by those who have stayed for 17 years and above accounting for 55.6 percent who also made the call for affordable access to health care. This suggestion is consistent with WHO (2011), argue for the need of community health workers and volunteers to play a key role in empowering the urban poor in adopting self-care practices and actively steward their environment in which they live. In this case preventive and promotive health care should form the basics of urban health programs.

In an interaction I had with Kuma a 20 years old young man, he said:

Government should not relent on certain things as far as our communities here are concerned. In fact, we need health education in these communities from time to time, For example, people need to be educated on the consequences of indiscriminate littering of our environment. Besides, it would be beneficial for us to have a clinic here in the Zongo as well as ‘zoom nurse’ (community health nurses) so that they can be coming round as it used to be in the past.

In the case of Ajara 24 years old who was concerned about the high rate of diarrhea cases in the community suggested that Government should bring in sanitation officers to do regular inspection in Nkwantanang here especially with food vendors to ensure they prepare food in

clean environment and under hygienic conditions either than that they should not allow them to sell food in this area’.

Table 4.19: Assessments of Lengths of Stay and Achieving Health Seeking Behaviour in Slum Community

Suggestions	Lengths of Stay					Total N (%)
	1 or less N (%)	2-6 years N (%)	7-11 years N (%)	12-16 years N (%)	17+ N (%)	
Educate slum communities on health related issues	56(34.6)	16(50.0)	6(20.0)	1(12.5)	3(33.3)	82(34.0)
Government formulate Policies that benefit slums	14(8.6)	6(18.8)	4(13.3)	1(12.5)	1(11.1)	26(10.8)
Government should intensify on health seeking campaign	11(6.8)	3(9.4)	4(13.3)	0(0.0)	0(0.0)	18(7.5)
Affordable access to health care services	80(49.4)	7(21.9)	8(26.7)	5(62.5)	5(55.6)	105(43.6)
Others	1(0.6)	0(0.0)	8(26.7)	1(12.5)	0(0.0)	10(4.1)
Total	162(100)	32(100)	30(100)	8(100)	9(100)	241(100)

Source: Field Survey 2018

5.3 COPING STRATEGIES ADOPTED TO OVERCOME HEALTH CHALLENGES AMONG THE RURAL-URBAN MIGRANT SLUM DWELLERS

Due to the various challenges many of the migrants face in adhering to health seeking behaviour especially regarding the low income earned by most of them, they tend to adopt some coping strategies to enable them overcome their health challenges. This section investigates the coping strategies adopted by the migrants (see Table 4.20). For example, though self-medication was widely practised across gender, the practice was higher among male (88.7 percent) than female

(81.6 percent). The gender variations of coping mechanisms adopted in disease prevention as sampled in this study contradict the findings of Cosminsky (1987), Raikes (1989) and Reuben (1992), that women in developing countries would prefer a variety of health care including self-treatment to visiting formal care centres, because of domestic work, cost and the long distances they have to travel before accessing health care. In this study, low income, coupled with the unregulated manner by which drugs are dispensed, will force respondents to use self-medication as coping strategy in seeking treatment.

Other coping strategies adopted by the respondents include taking in regular herbal medication whether one fell sick or not accounted for 11.2 percent among female as compared to 8.0 percent for males. Observing particular cultural beliefs to avoid disease attack accounted for 4.8 percent among male as compared to 0.6 percent among female. Also, regular taking of purgatives to avoid being attacked by disease dominated the study with female representing 3.9 percent as compared to 3.2 percent for males.

In an individual interview respondent explained that;

I often buy medicine from those who move around selling in polythene bags. This is because I do not have money so I deal with them. Besides, their drugs are sometimes cheaper than those sold at the pharmacy shops, I hear that sometimes some of their drugs are expired but because I cannot read, I take whatever they give me. [Oforiwaa, a 24 year old woman].

Table 4.20: Coping Strategy Adopted in Seeking Treatment by Gender

Options	Gender		
	Male N (%)	Female N (%)	Total N (%)
Self-medication	55(88.7)	146(81.6)	201(83.4)
Consult unqualified allopath	1(1.6)	0(0.0)	1 (0.4)
Take regular purgatives	2(3.2)	7(3.9)	9(3.7)
Say regular prayers	0(0.0)	5(2.8)	5(2.1)
Observe cultural beliefs	3(4.8)	1(0.6)	4(1.7)
Regular herbal med.	1(1.6)	20(11.2)	21(8.7)
Total	62(100)	179(100)	241(100)

Source: Field Survey, 2018

People in close network can influence each other's lifestyle both positively and negatively. This influence might have taken place at the point of migration or after migration in the slum. This influence comes in the form of coping strategies adopted by respondents in the face of health challenges (see Table 4.21). Generally, survey result from the study shows influence of relatives and friends on coping strategies adopted by a respondent. For instance, resorting to the use of fans to prevent mosquito bite as a coping strategy accounted for 20.4 percent and was influenced by relatives. Similarly, buying food from the same vendor no matter the hygienic condition under which it was prepared was influenced by a relative, which also accounted for 20.4 percent. The various influences by relatives and friends as reported in the study are in line with Li et al., (2014), who found that high network or social capital lowered the likelihood of

smoking among male the population in china. In this study, coping strategy largely helped the slum residents to overcome health challenges in a way.

However, chi-square test as indicated in (Table 21) suggests statistically no significant relationship between relatives, families and influences on coping strategies adopted to overcome health challenges ($\chi^2 = 7.209$, df 12, $P = 0.843 > 0.05$). This is based on the fact that P-value calculated was more than the significant level. That is relatives and friends had no influence on coping strategies adopted by migrants to overcome their health challenges in the slum.

Table 4.21: Relatives/friends influences on other coping strategies

Coping strategies	Relative/Friends			Total N (%)
	Alone N (%)	Relative N (%)	Friend N (%)	
Sleep under fan	0(0.0)	31(20.4)	17(19.8)	48(19.9)
Buy food from same vendor no matter what the sanitation condition under which food was prepared	1(33.3)	31(20.4)	16(18.6)	48(19.9)
Use untreated mosquitoes net	1(33.3)	21(13.8)	11(12.8)	33(13.7)
Spread the use of mosquitoes coil for a week	0(0.0)	18(11.8)	13(15.1)	31(12.9)
Blow room with piece of cloth to drive away mosquitoes	1(33.3)	19(12.5)	6(7.0)	26(10.8)
Always sleep with cover cloth	0(0.0)	16(10.5)	11(12.8)	27(11.2)
Do not do anything just wait to recover	0(0.0)	16(10.5)	12(14.0)	28(11.6)
Total	3(100)	152(100)	86(100)	241(100)

Source: Field Survey, 2018 ($\chi^2 = 7.209, df = 12, P = 0.843 > 0.05$)

Various facilities/places were visited by migrant slum dwellers in an attempt to seek care, (see Table 4.22). Income was the main determinant of particular places where health care was sought. However, because most of the respondents could not afford care from formal health care providers the services of informal providers (IPs) were patronised as a form of coping strategy.

Results from the survey suggests that the majority of the respondents who earned less income ranging from GH¢10-50 patronised the services of itinerant drug vendors. Also, those who earned between GH¢ 110-150 monthly utilised similar services. Only a few (14.3 percent) who earned less income ranging from GH¢10-50 were able to access healthcare from government facilities. The use of IPs among the majority of respondents reported in this study is consistent with Bloom, Standing, Lucas, Bhulya and Oladepo,(2011), who emphasised that in many developing countries, the IP's provide a significant proportion of health care for the urban poor who are unable to afford health care from approved facilities.

Chi-square test as indicated in (Table 4.22) shows statistically significant relationship between income and type of health facility or place for seeking treatment among migrants. ($\chi^2=61.582, df=24, P = 0.000 < 0.05$). The outcome of P-value 0.000 was less than the significance level 0.005. Thus income is a key determinant of the type of health facility or place visited by respondents for treatment.

Table 4.22: Income and Place of Seeking Care

Health facility/ place used	Current Income					Total
	10-50	51-100	110-150	151-200	Others	
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
Gov't facility	4(14.3)	6(10.3)	0(0.0)	0(0.0)	3(5.9)	13(5.4)
Private facility	0(0.0)	4(7.0)	0(0.0)	5(6.0)	3(5.9)	12(5.0)
Pharmacy	3(10.7)	9(15.8)	4(18.2)	19(22.9)	5(9.8)	40(16.6)
Quack	4(14.3)	11(19.3)	3(13.6)	30(36.1)	6(11.8)	54(22.4)
Prayer camps	0(0.0)	2(3.5)	0(0.0)	0(0.0)	0(0.0)	2(0.8)
Herbalist	0(0.0)	0(0.0)	0(0.0)	4(4.8)	13(25.5)	17(7.1)
Others	17(60.7)	25(43.9)	15(68.2)	25(30.1)	21(41.2)	103(42.7)
Total	28(100)	57(100)	22(100)	83(100)	51(100)	241(100)

Source: Field Survey, 2018 ($\chi^2 = 61.582$, $df = 24$, $P = 0.000 < 0.05$).

Generally, when it came to seeking treatment, respondents tended to use formal health care facilities at the period before they migrated to the slum. This also implies that the majority of respondents did not adopt coping strategies in seeking treatment before they migrated to the slum (see Table 4.23). More than half of the respondents (63.7 percent) sought health care from government facilities before migration, though the use of pharmacy was also reported, this accounted for 18.5 percent. The high patronage of formal health care facilities can be attributed to the use of the national health insurance at their places of origin as most of them had subscribed to the policy.

In an interaction, Berikisu, a 22 year old head porter, notes that, over here I do not have money to go to the hospital so I always buy from the ‘mobile drug dealers’. However, before I came here in my hometown, I always go to the hospital because I have health insurance to cater for my medical bills.

In a similar interview, a participant noted that:

I always buy ‘topaya’ (Andrew’s lever salt) from chemical seller in this community as well as in my home town any time I have stomach upset. However, in case I do not recover I am unable to visit the clinic as with the case in my home town because I have national health insurance [Rashida, 26 years old opinion leader].

Table 4.23 Different places treatment was sought before migration

Places	Responses		
	Yes N (%)	No N (%)	Total N (%)
Government Hospital	79(63.7)	78(66.7)	157(65.1)
Private hospital	4(3.2)	8(6.8)	12(5.0)
Pharmacy	23(18.5)	17(14.5)	40(16.6)
Self-medication	3(2.4)	10(8.5)	13(5.4)
Quack	2(1.6)	0(0.0)	2(0.8)
Herbalist	13(10.5)	4(3.4)	17(7.1)
Others	0(0.0)	0(0.0)	0(0.0)
Total	124(100)	117(100)	241(100)

Source: Field survey 2018

Though the misuse of drugs in treating a disease did not appear as a common coping strategy among the respondents after migration (see Table 4.24), results show that a significant proportion (91.3 percent) were involved in multiple drug use to cure an ailment.

This was supported in an interview with Fatoumata, 22 years head porter; Paying for hospital bills has been very difficult for me ever since I came to Nkwantanang, so I take different drugs at the same time any time I fall sick so as to recover early and go back to work.

Table 4.24: Drug Misuse after Migration

Multiple treatment	Number	Percentage
Yes	220	91.3
No	21	8.7
Total	241	100

Source: Field Survey, 2018

Other additional suggestions made by the respondents as indicated in Table 4.25, suggests that nearly half of the respondents (42.7 percent) of the respondents were concerned with the need for more health related facilities to be established in their areas. The deployment of environmental supervisors needed to ensure cleanliness of the slum communities accounted for 22.8 percent. The additional suggestions are consistent with Satterthwaite (2007a), saw the need to inculcate healthy urban governance in addressing the health issues among urban poor. It is important that interventions that provide these infrastructures are a major steps in addressing health inequalities. Many of these have been cited in the Millenium project report on how to improve the lives of slum dwellers (Garau et al 2005).

Table 4.25 Additional Suggestion on Health Issues of the Slum

Suggestions	Number	%
Well planned drainage systems	23	9.5
Eradication of expired medicines the market	1	0.4
Environmental supervisors needed to ensure cleanliness	55	22.8
Creation of jobs to enable afford health care	23	9.5
More affordable health insurance package	35	14.5
More health- related facilities should be established near or in community	103	42.7
Non response	1	0.4
Total	241	100

Source: Field Survey, 2018

Various coping strategies were adopted by both male and female respondents to overcome their health challenges in the slum (see Table 4.26). Results show that nearly half 40.3 percent of male used untreated mosquitoes net as compared to female (17.3 percent). Again, 24.6 percent of respondents would buy food from the same food vendor without taking into consideration the hygienic condition of the environment. The result of Chi-square test as indicated in (Table 4.27) suggest no significant difference between male and female coping strategies adopted to overcome their health challenges in the slum. ($\chi^2 = 16.508, df=6, P = 0.11 > 0.05$). Thus there are differences in terms of coping strategies adopted to overcome their health challenges in the slum.

Table 4.26: Chi-Square Test of Relationship between Gender and Coping Strategies adopted to overcome health challenges in the slum

Coping strategies	Gender		
	Male N (%)	Female N (%)	Total N (%)
Sleep under fan	6(9.7)	14(7.8)	20(8.3)
Buy food from same vendor no matter the sanitation condition under which food was prepared	9(14.5)	44(24.6)	53(22.0)
Use untreated mosquitoes net	25(40.3)	31(17.3)	56(23.2)
Spread the use of mosquitoes coil for a week	8(12.9)	39(21.8)	47(19.5)
Blow room with piece of cloth to drive away mosquitoes	3(4.8)	17(9.5)	20(8.3)
Always sleep with cover cloth	6 (9.7)	23(12.8)	29(12.0)
Do not do anything just wait to recover	5(8.1)	11(6.1)	16(6.6)
Total	62(100)	179(100)	241(100)

Source: Field Survey, 2018 ($\chi^2 = 16.508, df = 6, P = 0.11 > 0.05$)

5.4 POLICIES IN PLACE FOR HEALTH SEEKING BEHAVIOUR FOR THE RURAL-SLUM MIGRANTS DWELLERS

In order to ensure that populations achieve the best health outcomes, health service providers have an important role to play in helping to realise this dream. This section seeks to investigate the various efforts made by Madina Health Directorate to promote health seeking practices among the slum residents.

Findings from the study point to the fact currently there are no specific policies or programmes in place to promote health seeking behaviour among the slum communities at Madina. However, as the health authorities are aware of the existence of the slum communities in the municipality and the diseases outbreaks that often confront them, poor health seeking practices have been identified as a major problem in quest for better health outcomes among the slum settlements and a major contributing factor to many reported cases of diseases in the area. The absence of any policy on health seeking behaviour means that essential information base for health promotion may become difficult for such populations. Coming out with appropriate health messages has a high chance to facilitate uptake of planned interventions for poor urban settlements. In many instances, there have been calls for government to play a critical role in health care delivery especially for the urban poor. However Non-governmental organisations continue to fill in the wide gap where government has partially or completely failed in its responsibilities of providing health care for the urban poor which has contributed to health inequity (Liu et al., 2008). The most important issue that needs not be ignored in this study is that since health seeking behaviour enables people to make healthy choices in lifestyle behaviours and the kind of medical treatment and care they have to embrace. Health seeking behaviour remains an important ingredient in health management, it is therefore important that policy makers understand the health seeking

behaviour of the urban poor in order to come out with the desired policy in the delivery of health care. One way by which health seeking behaviour patterns can be understood by policy makers is through constant operational research as this will inform effective and efficient situation – specific solutions to address health related issues among the urban poor.

Among the urban poor, the lack of job security and poor working conditions means a particular health threat for them. It is not surprising, therefore, that risky lifestyle behaviours were cited in the study, coupled with financial challenges among these populations, this often put most of them in deplorable conditions. For instance, the trade in sex for money among many of the young women in the area has become a cause of concern due to the health related implications, it comes with the spread of Sexually Transmitted Diseases (STD's as well as HIV/AIDS). For most young men, the smoking of indian hemp or what is popularly referred to as weed in broad day light is very common among them. As teenage pregnancy continues to be on the rise among young girls, malnutrition continues to be common among children. For most adults and the population in general, there have been many reported cases of malaria, skin rushes and diarrhea etc. This finding is corroborated by a study conducted in one of Indian's most congested state, Uttar Pradesh, which shows a prevalence of casualisation of the work force with a proportion of casual labourers having doubled from 11% in 1972/3 to almost 24 % in 1992 – 2000 and about two thirds of households that earn income from casual source are poor. This unhealthy and unpleasant situations lead to ghetto lifestyle choices that have implication on their health (World Bank, 2002).

Prioritising the health needs of the urban poor through national health policies and programmes are important to ensure universal access to health care for all. In Ghana, the year 2003, the

Government of Ghana, through an Act of Parliament (ACT 650), introduced the National Health Insurance Scheme (NHIS) to remove the financial challenges associated with receiving health care among the urban poor, however, studies have shown that most of the poor are unlikely to enroll into the programme. For example, Kimani et al., (2012) have found that the high proportion of slum dwellers in Nairobi (89 percent) were unable to enroll in the programme. It is, however, not surprising that not much has been done in addressing the health needs of the urban slum dwellers in Madina with regards to health seeking practices. Whereas for the purpose of seeking treatment a little has been done in terms of the provision of national health insurance scheme which they are eligible to subscribe, however, the low income they earn poses a challenge for them to subscribe to the scheme or renew when it has expired. This makes it difficult for the majority of these populations to utilise health care services from the various facilities that are situated around the slum. It is sad to know that health insurance coverage among these populations so poor to that extent that insurance coverage among this population currently stands at less than 50%. The low subscription to the health insurance scheme is similar to trends observed in Chowdhury (2011) that has identified significant proportion of people involved in urban poor work in the informal sector with no health insurance attached. When this becomes the norm, the high cost of health care can pose a major challenge to the urban poor and therefore push them into poverty. In a related study, it was found that 40% of households in the slums of Delhi spent up to 15% of their income and this accounted to the half of their income on health care. Thus those who end up seeking health care from informal providers end up with catastrophic expenses.

In this study, although, the unavailability of free medical services for respondents to avail themselves at all the five (5) public institutions/hospitals in the municipality did not exist, it was

indicated that once in a while, some NGO's came around to organise a free medical screening exercise for these individuals and this provides opportunities for minor ailments to be treated. The role of NGO's in primary health care delivery as indicated in the study corroborates finding by Gellert (1996), who contends that the role of NGO's in the delivery of basic health services among specific populations in many low income countries cannot be underestimated. They have been very effective in the sustainability of primary health care systems that have been linked with the poor.

The need for collaboration requires decentralisation since this will impact legal and regulatory framework thereby spelling out shared responsibilities in the health care delivery and also provide institutional and managerial capacity. It is important to note that working with private institutions like the NGO's is a sensible strategy because they are known as key service providers for the poor. Their calls can often be fully accomplished by interacting with the environment to know the health situations and come out with program interventions that are critical to problems facing the urban poor like those of Madina.

CHAPTER SIX

CONCLUSION, POLICY IMPLICATION AND RECOMMENDATION

6.0 INTRODUCTION

This thesis is aimed at investigating the health seeking behaviour among the rural- urban migrant slum dwellers at Madina before and after migration. As the increase pace of urbanization which is mainly as a result of rural-urban migration has led to the growth of many informal settlements and its associated health challenges in many part of the cities (Vlahov et al., 2006). Knowledge about health seeking behaviour among these populations is, therefore, essential in providing need based health outcome. However, this is often ignored and even where this knowledge exists, there is often a mismatch between specific community needs and programme priority due to context environment variations such as the need to fulfill the purpose of coming to the city and the need to address many settlement issues (Maneze 2014), which eventually render programmes unproductive. These issues make health seeking behaviour practices very complex and needs contextual exploration (Singh et al., 2014). Although, a considerable amount of research on health seeking behavior of slum dwellers exists. Studies on contextual exploration of rural- urban migrant slum settlements are relatively few.

The thesis has provided both empirical depth and theoretical clarification on morbidity profile among the rural – urban migrant slum dwellers at places of origin and at the slum, health seeking behaviour among the rural-urban migrant slum dwellers before and after migration, the challenges associated with health seeking behaviour before and after migration, coping strategies adopted by these migrants to overcome their health challenges and also existing policies aimed at health seeking behavior among the slum dwellers. The thesis adopted the mixed method

approach for the methodology. Questionnaires and interview guides were used to collect data from rural-urban migrant slum household heads through the simple random technique and purposive sampling respectively. An institutional interview was also held with officials of the Madina District Directorate. A total of 241 questionnaires were retrieved from the respondents representing a response rate of 100%. Eight (8) key informants and health officials were interviewed. The chapter highlighted on key findings of the study and the key conclusions made and some recommendation for policy and research.

6.1 MAIN FINDINGS

The following were the key findings of the study. First, the study indicates that most of the migrant slum dwellers had suffered various types of diseases such as malaria, cold/flu, stomach, diarrhoea, cholera, fever and skin diseases and this was as a result of deficiency in safe housing conditions in the slum. Statistical tests suggest a significant relationship between houses in urban slum settlement and diseases one is likely to suffer. ($\chi^2 = 54.821$, $df = 18$, $P = 0.000 < 0.05$). On the other hand, the study also suggests few cases or no cases of similar diseases encountered in the slum before migration. Headache, cold/flu, dizziness, cough, chest pains, eye pains and waist pains were among a few of the reported cases. Meanwhile, cholera and diarrhea were never encountered at various places of origin. However, chi-square test suggests no significant relationship between similar type of diseases before and after migration to the slum. ($\chi^2 = 7.989$, $df = 6$, $P = 0.239 > 0.05$). Other diseases prevalent in the slum were often linked to various occupation migrants were engaged in. There was relatively wide spread of various diseases across all occupation in the slum but widely spread across all occupation before migration but whose prevalence was quiet low as compared to the slum. Such diseases include headache, cold/flu, cough, chest pains and eye pains. Chi-square test shows no significant relationship

between the nature of work performed and possibility of being attacked by other illnesses. ($\chi^2 = 27.090$, $df=24$, $P = 0.300 > 0.05$).

The study further indicates that respondents observed activities in relation to health seeking behaviour at various places of origin as compared to the slums; for example, cleanliness of surroundings was considered an important aspect of life. Long working hours in the city just to make ends meet which had a toll on their health was not allowed. The intention to see a health provider at early stage of disease was also adhered to. Though this was also reported in the slum, the idea behind it was to always remain fit in order to cope with the tedious daily work which serves as the main reason for coming to the slum. Chi-square test reveals statistically no significant relationship between influence of relatives, friends and seeking regular medical checks by an individual ($\chi^2 = 2.224$, $df = 2$, $P = 0.329 > 0.05$). Similarly, chi-square test reveals statistically no significant relationship between education and precautionary measures against diseases ($\chi^2 = 3.126$, $df=3$, $P = 0.373 > 0.05$).

The study further indicates that though some challenges were faced by respondents in their quest to health seeking behaviour before and after migration, these challenges were most encountered in the slum than in various places of origin. For example, the high cost of healthcare was mostly reported in the slum than in places of origin. The poor living conditions in the slum also posed a major challenge as compared to places of origin.

The study also suggests that the inability of slum dwellers to afford health care forced migrants to adopt various coping strategies which were mostly unconventional to overcome the challenges of health care needs. Self-medication was predominant among the coping strategies adopted. Others included regular consumption of herbal medication to prevent any disease that could

attack one in the near future, observing particular cultural beliefs to avoid disease attack and regular taking of purgatives to avoid disease attack. It was also found that close networks like relatives and friend's of respondents accompanied to the slum largely influenced in decisions relating to coping strategies adopted. For instance, the tendency to economise the use of a single mosquito coil for a whole week was influenced by a friend. Also, buying food from the same vendor without considering the hygienic condition under which food was prepared was influenced by a relative and the idea of sleeping under untreated mosquitoes net came from a relative. Also, chi-square tests suggest no significant difference between male and female coping strategies to overcome their health challenges in the slum. ($\chi^2= 16.508$, $df=6$, $P = 0.11 > 0.05$). As part of the unconventional methods employed by migrants to overcome their health challenges, the services of informal health service providers (IPS) were often sought. Chi-square test shows statistically significant relationship between income and type of health facility or place for seeking treatment among migrants. ($\chi^2= 61.582$, $df=24$, $P = 0.000 < 0.05$). In addition to the above coping strategies, drug misuse was also encouraged.

The study finally identified no specific policies in place to promote health seeking behaviour among the slum communities, although the health authorities were aware of the outbreak various diseases that often hit the slum. They noted that poor health seeking practices had been identified as a major problem in the quest for better health outcomes among the slum settlements and a major contributing factor to many reported cases of diseases in the area. However, efforts by nongovernmental organisations bring such services including free medical screening at certain times which only meet the health needs of a few of the migrant slum dwellers at Madina.

6.2 CONCLUSION

The study makes the following conclusions based on broad issues on the study's conceptual framework, methodological approach and some key findings:

The health belief model proposition is based on the idea that people are more likely to change their behaviour and adhere to treatments. However, consistent with Maneze (2014), the study has shown that this analysis cannot fully apply to rural-urban migrant slum settings because these are people with multiple simultaneous needs and have reasons for coming to the slum. These motivations for migrating to the urban slums make it difficult for them to engage in health seeking behaviour. The migrants put less priority on health seeking behaviour instead, they adopt unconventional methods of overcoming their health.

Based on the findings from the study, the conceptual framework suggests that in order to avoid a mismatch between context environments and health programme interventions, there is the need by governments, and various stakeholders who are engaged in health programme interventions to carry out a contextual exploration of specific environment situation to be able to establish the exact health seeking behaviour patterns of the specific slum communities so that they are able to formulate need-based policies that lead to expected lifestyle behaviours among the rural-urban slum dwellers. The conceptual framework also believes that by exploring the contextual environment which in the case of this study is mostly dominated by internal migrants, coping strategies adopted by these migrants to overcome their health challenges could also be identified and the necessary policy interventions implemented.

The study has shown that rural-urban migration will continue as long as unequal variations in development across the country exist. As this phenomenon continues, the failure of governments

to implement health promotion programmes across the country, which equip citizens with the necessary knowledge, attitude and practice, it is possible health outcomes in the slum will only worsen. As poor health outcomes are largely attributed to socioeconomic status of people, the unfavorable policies by government have worsened the plight of the migrant slum dwellers. The study also noted that slum might not necessarily be places where people are infested with diseases but rather some diseases might also be imported to slums. This imply that, some migrants might have been battling with some sort of diseases before arriving in the slums. Again, the failure to regulate the nature of work they are engaged in will worsen their well-being due to abuse and over exploitation. The inability of these slum dwellers to afford health care might not necessarily be the only factor posing challenge to health seeking behaviour. For example, it was observed in the study that the absence of attitudinal change on the part of the slum dwellers pose a challenge to health seeking behaviour. It was further observed that besides coping strategies such as the use of self-medication and the utilisation of the services IP's to overcome health challenges, slum dwellers self- developed mechanisms as coping strategies.

The failure by governments across the world to come out with comprehensive policies to address the health needs of migrants slum dwellers have been largely due to the mismatch between specific slum needs and programme interventions.

6.3 POLICY IMPLICATIONS

The findings from this study raise a number of policy issues that are related to migration and health and therefore require the following policy responses:

6.3.1 ADDRESS MORBIDITY ISSUES HOLISTICALLY

Policies and programmes directed towards promoting and preventing diseases among slum settlements in the country especially Madina need a multi- sectoral approach. Highlighting promotive and preventive health care among this sub group of population is the most cost effective path to control diseases among slum communities and places of origin. This also highlights the need for health education programmes on health seeking behaviour to be carried out across the country. There is, therefore, the urgent need for health information to be assimilated into formal educational curriculum at all levels of education in the country. Furthermore, the mass media should be encouraged to disseminate health promotion messages in all parts of the country.

6.3.2 PROMOTE HEALTH SEEKING BEHAVIOUR

One surest way to achieve health seeking behaviour is through health education. Health literacy and awareness creation are key determinants of health behaviours and actions to avoid health risks. A substantial amount of evidence indicates that the urban poor lack the education and awareness of the factors that influence good health outcomes, and this affects the health of slum dwellers (WHO, 2011). Health education programmes should not be limited to urban slums but must be extended to the rural areas. This is because most of the movements to the slums are often made up of rural- urban migrants and who are often trapped in deplorable conditions. There is also the need for community education and awareness creation that ensure support to self-care practices. Thus both areas of origin and the slum dwellers need to be informed about personal hygiene, safe disposal of solid waste, use of toilets, and the possible breeding grounds for germs and vectors such as choked gutters. They also need to be aware of the identification of early

signs and symptoms of infectious diseases. Educating slum residents on the harmful effects of alcohol use, tobacco and other substances can help them stay away from such practices. In creating this awareness, it is also important that they are educated on personal safety and potential exposure to hazards which are likely to result from occupational activities. To achieve these goals, the role of community health workers and other volunteers cannot be ignored. They must be engaged in health awareness and empowerment. Community organisations and social networks among the slum communities could be established with support from the necessary government agencies and Non-Governmental Organisations.

6.3.3 ADDRESS HEALTH SEEKING CHALLENGES

Putting in place a comprehensive policy on health seeking behaviour among slum residents is very important as it serves as a good start in bringing about positive health outcomes. Such comprehensive policy must focus on policy formation in all health care systems and should be based on information relating to health promoting, seeking and utilization behaviour and the factors determining these behaviours. Such behaviours occur within some institutional structure such as family, community or the health care services.

6.3.4 ADDRESS COPING STRATEGIES IN ORDER TO OVERCOME HEALTH CHALLENGES

The inability of the slum dwellers to afford health care means that they must adopt some coping mechanisms to overcome their health challenges, though these mechanisms might not be conventional in nature and might have other adverse effects. There is, therefore the need for policy interventions that will equip the IPs with some training and make them operate within the approved regulations in order to harness the potentials of their services in health care delivery.

Also, traditional medicine should be integrated into the mainstream health care to fulfill the needs of those who prefer herbal medication or cannot afford orthodox treatment.

6.3.5 PRIORITISE NATIONAL HEALTH POLICY

The implementation of national health policies need to target the urban poor like those of Madina. It is important that the principles of primary health care universal access and health equity is enshrined in health interventions allocated to the urban poor. Currently, enrollment into the national health insurance scheme as well as the terms of renewal is an issue that needs to be revisited in order to make it possible for a full coverage of the scheme. A cheaper cost or free enrollment into the scheme for the poor can encourage universal coverage of the scheme and bring about good health outcomes among the rural-urban migrant slum residents.

6.3.6 PROMOTE RURAL DEVELOPMENT SIMULTANEOUSLY

The intricate relations between the rural and urban economies have often led to the migration of the youth from rural areas to the cities and its subsequent urban poverty resulting in serious health challenges. This means that there can be no improvement in the urban cities without concurrent development of the rural areas throughout the country. Policies planners will, therefore, have to ensure that rural development programmes not necessarily limited to rural agricultural developments but which also address other livelihood empowerment programmes are introduced in order to reduce movements of the youths to the city.

6.3.7 RESEARCH AND INFORMATION

The need for evidence-based planning consists of accurate and reliable information. Indicators of urban health such as health seeking behaviours and health outcomes serve as important barometers of the health of underprivileged populations like those of the slums of Madina.

Information systems that provide timely and comprehensive data will help examine evidence based context situations of specific health issues and also inform policy. Since slum communities may not necessarily have similar health conditions, research is therefore needed to find specific context solutions. Appropriate research could help reveal slum context health situations.

6.3.8 IMPROVE OCCUPATIONAL HEALTH OF THE SLUM DWELLERS

Generally, employment in an organised sector of the economy operates under established policies that are designed to protect the safety and well-being of its members and closely monitored by a workers union. In the informal sector, however, such regulations are non-existent. The absent of these regulations lead to various forms of abuse and all forms of harassments and exploitation. There is, therefore, the need for occupational health policies equally promoted in the informal sector to protect the well-being and safety of these sub-groups.

6.4 RECOMMENDATION FOR FURTHER RESEARCH

Having researched into the health seeking behaviour among rural- urban migrant slum dwellers in Madina, it is suggested that a comparative study is conducted to investigate the differences between indigenous slums and urban migrant slums regarding their health seeking behavior.

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APPENDIX I

QUESTIONNAIRE FOR SLUM MIGRANTS HOUSEHOLD HEADS

Dear Sir/ Madam,

I am a graduate student from the University of Ghana (Center for Migration Studies). I am currently conducting a study on the topic, “Health Seeking Behaviour among Rural - Urban Migrants Slum Dwellers in Madina in the Greater Accra Region” in partial fulfillment of requirements for the award of MPhil- Migration Studies. The outcome of the study will help understand the morbidity profile of rural- urban migrant communities and health seeking behavior patterns in order to formulate policies and programmes, and also to implement targeted strategies which are responsive to the needs and priorities of rural- urban migrant slum dwellers. The questionnaire takes about 15 minutes and I would be grateful if you could assist me by answering the following questions. All information that you give shall be kept with the strictest confidentiality.

Thank you.

SECTION A: SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

1. Gender: 01= Male [] 02= Female []

2. What is your age?

01= 18-25 [] 02= 26-33 [] 03= 34- 41 [] 04= 42-49[] 05= 50-57 [] 06= 58+[]

3. Education: 01=No education [] 02= Primary [] 03= Middle/JHS []

04=Voc/Tech/SHS/O’level[] 05= A’ level [] 06= Tertiary []

4. Marital status: 01=Never Married [] 02=Married [] 03=Consensual Union [] 04= Separated
[] 04= Divorce[] 05=Widowed []

5. Current occupation: 01= Government sector [] 02= Trader [] 03= House wife []
04= Domestic worker [] 06= Unemployed [] 07= Head porter [] 08=Others, please specify _____

6. What is your current monthly household income: 01= 10- 50gh [] 02= 51-100gh [] 03=
110-150gh [] 04= 151-200gh [] 05= others, please specify _____

7. How many years have you stayed in this community:01= 1 or less [] 02= 2- 6 years []
03= 7-11 years [] 04= 12-16 years 05= 17+[]

8. Type of house in current settlement: 01= Compound house [] 02= Single family house []
03= Temporarystructure [] 04= Storey building [] 05= Flat [] 06= Others, specify _____

9. Number of persons in current household?

01= 1-3 [] 02= 4-6 [] 03= 7-9 [] 04= 10-12 [] 05= 13-15[] 06= 16 and above []

SECTION B: MIGRATION TRAJECTORY

10. Where did you come from?

01= _____

11. Why did you come to Accra?

01=Further my education [] 02= Seek better jobs [] 03= Ethnic conflict [] 04= Peer pressure []

05= Forced marriage [] 06= Stay with relative [] 07= Stay with friends [] 08= Other (specify) _____

12. Whom did you come with?

01= _____

13. Who financed your coming here?

01= _____

14. What was your previous occupation before you came to Accra: 01= Farmer [] 02= Trader [] 03= House wife [] 04= Unemployed [] 06=Others, please specify _____

15. If you were working, what was your monthly household income before you came to Accra:
01= 10- 50gh [] 02= 51-100gh [] 03= 110-150gh [] 04= 151-200gh [] 05= others, please specify

SECTION C: MORBIDITY PROFILE AMONG RURAL – URBAN MIGRANTS SLUM DWELLERS

16. Have you fallen ill recently?

01= Yes [] 02=No [] *(If no skip to question 19)*

17. If yes to question 16, what type of sickness attacked you?

01= Fever [] 02= Malaria [] 03= Cholera [] 04= Cough [] 05=Diarrhea [] 06= Cold/flu []
07= Others, please specify _____

18. Did you suffer similar kind of disease before you came to Accra?

01= Yes [] 02=No [] *[If yes skip to question 20]*

19. If I may know, how often have you experienced the disease ever since you came to this community?

01= None [] 02= 1-2 times a week [] 03= 3-4 times a week [] 04= 5-6 times a week []

20. Compared with your experience before moving to Accra, how would you rate the frequency of attack in this community?

01= None [] 02= 1-2 times a week [] 03= 3-4 times a week [] 04= 5-6 times a week []

21. Apart from the above disease(s) that attacked you in this community, please mention any other disease that has attacked you?

01 _____

02 _____

22. Would you therefore say that you have not encountered this type of disease until you came to this community?

01= Yes [] 02=No []

23. If I may know, among the diseases you have suffered which ones would you consider chronic even before you came to this community?

01 _____

02 _____

**SECTION D: HEALTH SEEKING BEHAVIOUR AMONG RURAL- URBAN SLUM
MIGRANTS DWELLERS**

24. Please tell me if any what did you do to avoid sickness before and after coming to this community?

01 _____

02 _____

25. If I may know at what stage of your disease did you go to a provider in this community?

01= Early stages and onset of symptoms mild [] 02= Incidence of disease and its symptoms
[] 03= In serious stage of disease [] 04= General practitioners office, emergency room []

26. Please tell me before you came to this community at what time have you also gone to a provider?

01= Early stages and onset of symptoms mild [] 02= Incidence of disease and its symptoms

[] 03= In serious stage of disease [] 02= General practitioners office, emergency room []

27. If I may know how would you describe the frequency of attack of disease ever since you migrated to this community?

01= None [] 02= 1-2 times a week [] 03= 3-4 times a week [] 04= 5-6 times a week []

28. If I may know do you seek treatment only when you are sick?

01= Yes [] 02=No []

29. After receiving treatment do you take preventive measures to avoid further being attacked by any disease?

01= Yes [] 02=No []

30. If yes to question 29, what measures do you take?

01 _____

02 _____

Please indicate your extent of agreement or disagreement with the following statements in relation to how often you visit any treatment place since you came to this community on 1-5 scale: 1 representing “Strongly Agree”, 2 “Agree”, 3”Neutral”, 4 “Disagree”, 5 “Strongly Disagree” (Please tick only one)

	1	2	3	4	5
31. When I fall sick and I have the money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. When I fall sick but I do not even have the money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. When I feel sickness is getting worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. When self medication does not work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. When I am encouraged by a relative/friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. When I get support from a relative/friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: CHALLENGES WITH HEALTH SEEKING BEHAVIOUR

37. Please tell me do you find it difficult in seeking health related behaviour in this community?

01= Yes [] 02=No []

38. If yes to question 37, did you also have challenges in seeking behavior even before you came to this community?

01= Yes [] 02=No []

39. If yes to question 38, please indicate the challenges you face in health seeking behaviour in this community

01= Cost of medication [] 02= Physical impediment[] 03= Health care worker poor attitude [] 04= Limited program education [] 05= Poor/dirty environment [] 06= inadequate rest and sleep[] 07= Distance to facility [] 08= lack of role of] 09 Others, please specify []

40. If yes to question 39, please indicate the challenges you face even before you came to this community?

01= Cost of medication [] 02= Physical impediment[] 03= Health care worker poor attitude [] 04= Program education [] 05= Poor/dirty environment [] 06= Adequate rest and sleep[] [] 07= Distance to facility [] 08= Role of family [] 09 Others, please specify []

Please indicate your extent of agreement or disagreement with the following statements in relation to challenges in health seeking behaviour in this community on 1-5 scale: 1 representing “Strongly Agree”, 2 “Agree”, 3”Neutral”, 4 “Disagree”, 5 “Strongly Disagree” (Please tick only one)

	1	2	3	4	5
41. Language barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Poor attitude of health care staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Affordability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Cultural barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45.Distance to facility

46. In your opinion, do you think one can achieve health seeking behaviour in this community?

01= Yes [] 02=No []

47. If no to question 46, what would you like government to do in order to help address the challenges in this area?

01= Educate our communities on health related issues [] 02= Draw health policies that benefit us [] 03= Educate us on health seeking behaviors [] 04= Affordable and easy access to health care [] 05= Others, please specify _____

SECTION F: COPING STRATEGIES TO OVERCOME HEALTH CHALLENGES BY RURAL-URBAN MIGRANTS SLUM DWELLERS

48. If I may know in times of sickness what do you do to seek treatment in this community?

01 _____

02 _____

49. Please tell me, what coping measures have you put in place to avoid disease attack generally in this community?

01 _____

02 _____

50. If I may know have you also consulted any treatment place or facility?

01= Yes [] 02=No []

51. If yes to question 34, what particular place did you visit?

01= Govt. Hospital [] 02= Private Clinic [] 03= Consult a pharmacy [] 04= Self medication []
05= Quack [] 06= Visit a prayer camp [] 07= Herbalist [] 08=Others, specify_____

52. With regards to what you do to seek treatment, is it different from what you do before you came to this community?

01= Yes [] 02=No []

53. Please tell me did you also indulge in drug misuse in this community?

01= Yes [] 02=No []

54. Any other comments

01 _____

02 _____

APPENDIX II

HEALTH SEEKING BEHAVIOUR AMONG RURAL - URBAN MIGRANT SLUM DWELLERS IN MADINA IN THE GREATER ACCRA REGION INDIVIDUAL AND OPINION LEADER INTERVIEW GUIDE

Dear Sir/ Madam,

I am a graduate student from the University of Ghana (Center for Migration Studies). I am currently conducting a study on the topic, “Health Seeking Behaviour among Rural - Urban Migrants Slum Dwellers in Madina in the Greater Accra Region” in partial fulfillment of requirements for the award of MPhil- Migration Studies. The outcome of the study will help understand the morbidity profile of rural- urban migrant communities and health seeking behaviour patterns in order to formulate policies and programmes, and also to implement targeted strategies which are responsive to the needs and priorities of rural- urban migrant slum dwellers. The interview takes about 15-20 minutes and I would be grateful if you could assist me by answering the following questions. All information that you give shall be kept with the strictest confidentiality.

Thank you.

1) Can you please tell me about yourself?

(Probe for age, why he/she left previous occupation and migrated to Madina, what has it become in terms of household income after migration, current state of occupation as compared to before migration, why they have chosen the current type of accommodation and reason that accounted for congestion in rooms.

2) If I may know, can you please tell me about diseases that are common in this community?

Probe for diseases that he/she suffered, sources of information about disease, i.e where he/she got information about disease. Also probe for what account(s) for disease prevalence in the area? Find out the frequency of occurrence especially reasons behind the figures. Probe for similarities or dissimilarities in sickness before and after migration and the reasons why?

- 3) If I may know, how do you go about health seeking behaviour? (Probe for reasons that account for differences behind health seeking behaviour before and after migration, also probe for the stage at which he/she sought treatment before and after migration and find out reasons behind each stage at which place, also find out why they consult a provider only in times of sickness but not at any other time?)
- 4) Could you please tell me about the challenges in health seeking behaviour in this community? (Probe for reasons behind challenges, find out reasons behind suggestion. Also, find out the reasons behind frequencies.)
- 5) Could you please tell me about coping strategies adopted to overcome health challenges? Probe for the reasons behind the use of a particular treatment option. Find out why there seems to be differences in treatment before migration, also find out why drug misuse)

Thank you

APPENDIX III

HEALTH SEEKING BEHAVIOUR AMONG RURAL - URBAN MIGRANTSSLUM
DWELLERS IN MADINA IN THE GREATER ACCRA REGION
INTERVIEW GUIDE FOR MADINA HEALTH DIRECTORATE

Dear Sir/ Madam,

I am a graduate student from the University of Ghana (Center for Migration Studies). I am currently conducting a study on the topic “Health Seeking Behaviour among Rural - Urban Migrants Slum Dwellers in Madina in the Greater Accra Region” in partial fulfillment of requirements for the award of MPhil- Migration Studies. The outcome of the study will help understand the morbidity profile of rural- urban migrant communities and health seeking behavior patterns in order to formulate policies, programmes and implement targeted strategies which are responsive to the needs and priorities of rural- urban migrant’s slum dwellers. The interview takes about 15-20 minutes and I will be grateful if you could assist me by answering the following questions. All information that you give shall be kept with the strictest confidentiality.

Thank you

- (1) Please tell me, about yourself, (i.e. department, work responsibility and lengths of work at this office)

.....

- 6) Could you please tell me about health related issues among the slum dwellers in this municipality (i.e. the morbidity profile among them)

.....

- 7) If I may know which of the slum communities are most affected in the municipality

.....
8) Please tell me which specific health challenges are faced by those specifically residing in the emerging slums.

.....
9) Are there special provisions made for them in terms of seeking health care?
Yes () or No ()

10) If yes, please tell me about these provisions.....

11) If no, why.....

Thank you