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The Migration Experience and Differential Risks to Sexual and Reproductive Health in Ghana

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Abstract

Background. Though internal migration in Ghana has become increasingly common in recent years, research has not focused on the gendered experiences and perceptions of migration and the association with sexual and reproductive health risks for male and female migrants. *Method*. A qualitative study using semistructured interviews among migrant market workers and market leaders working in Agbogbloshie in Accra, Ghana, was completed in April 2018. Interview domains for the migrant interviews included the following: expectations of migration, current working and living conditions, sexual and reproductive health, access to health care, and self-reported health status. Qualitative data were analyzed using a combination of inductive and deductive coding in MAXQDA. *Results*. Data indicate that migrant workers have a variety of perceptions surrounding their migration experience. In the urban destination, migrants face a number of challenges that negatively affect their health, including poor accommodation, safety concerns, and low levels of social support. Reported risks to sexual and reproductive health were unsafe sexual encounters, such as low condom use and sexual assault. *Discussion*. The negative sexual and reproductive health outcomes among migrant populations in urban poor settings are a result of a confluence of factors, including perceptions of destination locations, working and living conditions, social support, and gender norms. A complex systems approach to understanding the sexual health of migrants is warranted. *Conclusion*. Findings from this research illustrate the complexity of health risks among migrants in Agbogbloshie. Further research is needed to explore the increased vulnerability of migrants compared with nonmigrants in urban poverty and the long-term implications of sexual and reproductive health risks in vulnerable migrant communities.

Keywords

gender, global health, qualitative methods, sexual health, social determinants of health, urban health

Many countries around the world are undergoing rapid urbanization, demographic shifts, and changing gender roles, which are driving rural to urban migration (Abdul-Korah, 2011; Songsore, 2009). The United Nations predicts that by the year 2050, Africa will hold 1.3 billion urban residents, making it the fastest urbanizing continent in the world (Cobbinah & Erdiaw-Kwasie, 2018; Greif et al., 2011; United Nations, 2014). Motivations behind rural to urban migration are often related to the increased income and perceived liberties an urban environment can provide. Migration from rural to urban areas can improve health due to the geographic proximity to health facilities and the potential for improved access to health, financial, and educational resources. However, this does not always remain true for poor rural migrants (Kruk et al., 2016; Patel & Burke, 2009). Once at the destination, risky sexual behaviors coupled with poor living and working conditions, as well as barriers to health care access, including unreliable transportation, unsafe movement at night, and high costs to access quality health care services, may result in negative health outcomes (Adanu & Johnson, 2009; Chuah et al., 2018; Moyce & Schenker, 2018; Pocock et al., 2018; Yu et al., 2019; Zhong

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et al., 2018). This study explores migration narratives including the decision to migrate, conditions at arrival, access to care, social support, and experiences related to their sexual and reproductive lives at their destination among migrants living in an informal settlement in Accra, Ghana.

Migration and Sexual and Reproductive Health

Rural to urban migration is often a matter of survival for the migrants themselves and their families in the rural area. However, migration is associated with a number of sexual and reproductive health risks. Studies have shown that those living in urban informal settlements and migrants may be more likely than those living outside urban informal settlements and nonmigrants, respectively, to engage in risky sexual behavior (Davies et al., 2009; Greif et al., 2011; Li et al., 2007; McGrath et al., 2015; Yang & Xia, 2006), have poor sexual and reproductive health outcomes (Huang et al., 2012; Olawore et al., 2018), and be vulnerable to sexual violence (Abutima & Kevi, 2017; Lowthers, 2018). Risky or unsafe sex can lead to poor reproductive health outcomes such as unintended pregnancy, unsafe abortion, and sexually transmitted infections (STIs) and is a critical and often neglected determinant for morbidity and mortality in developing countries (Glasier et al., 2006). Sexual violence may be higher among migrant women due to the double vulnerability of being both a migrant and a woman (Awumbila & Torvikeh, 2018). Women may be more vulnerable to coercive sex if they suffer from low sexual and reproductive autonomy—that is, low levels of decision-making power over when to have sex and their own fertility. Studies have found that inequitable norms leading to low reproductive and sexual autonomy among women (Darteh et al., 2014; F. N.-A. Dodoo et al., 2014; N. D. Dodoo et al., 2019; Loll et al., 2016) lead to low contraception use (Loll et al., 2019), unintended pregnancy (Abada & Tenkorang, 2012), and STIs (Abada & Tenkorang, 2012; Capasso et al., 2019).

This study drew from the previous work on migration intention and risk tolerance that showed individuals who were more willing to take risks were more likely to migrate (Jaeger et al., 2010). This hypothesis has been expanded to demonstrate that migrants may take more sexual risks compared with people who do not migrate. However, many migrants report that their decision to migrate was for marriage or for well-planned economic reasons (Hannaford, 2016). Therefore, it is possible that the risky migrant hypothesis is exclusive of individuals who migrate due to economic survival or to be with a partner. Other factors at the urban destination may explain more of the risks to sexual and reproductive health than the individual's migrant status. Research shows that individuals with lower and less positive social support may take more sexual risks than those with higher levels of positive social support (Bruederle et al., 2019; Henrich et al., 2006) and that individuals living in urban poverty may have lower levels of social support (Marshall et al., 2014). Furthermore, research has shown determinants of health that often co-occur with migration into urban poverty (e.g., unstable housing, low access to health care, health information) may negatively affect sexual and reproductive health outcomes (Camlin et al., 2018; Davies et al., 2009; Elifson et al., 2007; Zhu et al., 2009). Low access to health care and health information among migrants may be due to high mobility, geographic or transportation barriers, financial barriers, language barriers, or cultural barriers (Camlin et al., 2018; Davies et al., 2009).

The Ghanaian Context

Internal migration in Ghana has become increasingly common in recent years. Nearly half of Ghana's population comprises rural to urban migrants and more than half of migrants are female (Abdul-Korah, 2011; Awumbila & Ardayfio-Schandorf, 2008; Awumbila & Torvikeh, 2018; Teye, 2018). Migration in Ghana is due to a number of push factors (e.g., low agricultural yield due to climate change with loss of income, lack of employment opportunities, leaving forced marriages) and pull factors (e.g., employment and educational opportunities, spouses moving; Abdulai, 2016; Jarawura, 2014). Studies from Ghana provide evidence for both the vulnerability of migrant women to poor sexual health outcomes, including HIV (Cassels et al., 2014) and low reproductive and sexual autonomy among women (Darteh et al., 2014; F. N.-A. Dodoo et al., 2014; N. D. Dodoo et al., 2019; Loll et al., 2016). Although studies have indicated poor sexual and reproductive health outcomes among migrants, research has not focused on the relationship between these outcomes and the motivations behind migration, migrant perceptions of their current living and working situation, and migrant feelings of isolation and social support. This study provides new evidence on the link between the perceptions of migration before and after arriving at their destination, migrant conditions in their destination, migrant feelings of isolation and social support, and the implications for sexual and reproductive health.

Method

Design

An exploratory qualitative study using semistructured interviews among migrant market workers (n = 20) and market leaders (n = 4) working in Agbogbloshie, an informal settlement in Accra, Ghana, was completed in April 2018. Data were collected by trained field staff hired through the Regional Institute for Population Studies at the University of Ghana. Field staff were matched to respondents by gender and were fluent in the languages used in northern and southern Ghana (Twi, Dagbani, and Hausa). Interviewers were trained in the consent and interview methods and completed a pilot study in a neighboring market to ensure the instrument was culturally appropriate and valid. Migrant interview domains included

expectations of migration, current working and living conditions, sexual and reproductive health, access to health care, and self-reported health status. The questions that asked about expectations of migration included "Why did you migrate?" and "What were your expectations before coming to Accra?" Questions regarding current working and living conditions included "Tell me about your life in Accra," with probes for accommodation, food, income; "Tell me about your biggest challenges (problems) since migrating"; and "Tell me about your biggest successes (positive experiences) since migrating." The main questions on sexual and reproductive health included "Tell me about your first sexual encounter"; "Describe your relationship with your spouse/partner(s)," with probes for who makes decisions regarding money, sex, work; and "How do you plan your childbearing with your partner(s)?" The question on access to health care was "How do you usually access health services?" Finally, the question on self-reported health status was "What is your biggest health concern?"

Interview domains for market leaders included market structure ("Please explain the organizational structure of market work."), demographics of the market workforce ("Where do most of your workers come from?"), and major health concerns of the market workforce ("What are the most common health issues you notice of market workers?"). Interviewers were told the areas of the interview where prompts should be conducted. The ethical review boards in the United States, Pennsylvania State University, and in Ghana, University of Ghana, approved this study.

Data Collection

Migrant participants were purposively sampled for an equal gender balance (10 males and 10 females) and a wide range of ages (18–64 years) to capture variation in experiences. Migrants were identified for participation using the snowball sampling methodology. Market leaders were asked to introduce field staff to migrant workers, and migrant workers were asked to introduce field staff to other migrant workers. Four market leaders were interviewed to gain a more detailed understanding of the market structure through the leadership and gain their perspective on the health of their workforce. Furthermore, market leaders were essential to respectfully gain entry into the market community for data collection and to approach workers in the market to interview. The two male (aged 51 and 59 years) and two female (aged 55 and 64 years) market leaders were identified by a community resident, hired as a mobilizer.

Study participants were recruited at the market during the day to ensure that a large number of people were available for enrollment. Field staff approached potential study participants to explain the study and if the individual was interested, they were consented and interviewed at that time. The field staff offered to move to a private location for the interview, but some participants preferred to continue working throughout the interview. Interviews lasted 30 minutes on average.

Data Analysis

Interviews were audio recorded in the local language and transcribed in English. The English transcripts constituted the study data. Qualitative data were analyzed using a combination of inductive and deductive coding in MAXQDA (Fereday & Muir-Cochrane, 2006; Ryan & Bernard, 2000). Transcripts were coded by two of the authors. First, the transcripts were read and reread, while being coded for structural (deductive) themes, based on the interview guide. Next, investigators noted initial emerging codes inductively, which were then grouped into themes and reviewed across the data set. Key themes were identified if they were common throughout the data or if particular information related to migration, social support, and structural risks to sexual and reproductive health was disclosed.

Results

Study results describe the narrative of migrants moving from the rural north of Ghana to an informal settlement in Accra, Ghana's capital. Respondents discussed variation in migration intention, social support, life in the informal settlement, access to health care, condom use, and sexual assault. Migrants in Accra expressed strong hope for better lives prior to migration; however, migrant workers face a number of challenges after migration that negatively affect their health, including poor living and working conditions and low levels of social support. While there are a range of experiences for migrants in Agbogbloshie, some common concerns emerge from their narratives and give a platform for future work and potential health-related interventions. Table 1 includes the characteristics of the migrants who participated in the study.

Sexual and Reproductive Health

To explore health challenges related to behaviors that could increase negative sexual and reproductive health outcomes, participants were asked to discuss their use of condoms, knowledge of STIs, and experience or knowledge of sexual assault occurring in the community. Although several respondents reported knowledge of condoms to prevent transmission of STIs and unintended pregnancy, many respondents reported low condom use. Fidelity was mentioned by both males and females as the primary way to protect against HIV and other STIs. One male migrant stated,

> I have heard of it [the condom] but I have never used it because I don't sleep with girls outside [of marriage]. (Male, age 36 years)

Furthermore, data suggested that the decision to engage in sexual activity and the use of condoms was decided primarily by the male partner as reported by most respondents of

Table 1. Migrant Market Workers' Demographics.

Variable	Categories	Total	Males ($n = 10$)	Females ($n = 10$)
Occupation	Head porter	2	0	2
	Vendor	12	4	8
	Offloads from trucks	6	6	0
Age (years)	18–30	9	4	5
	31–50	11	6	5
Religion	Muslim	13	6	7
	Christian	7	4	3
Marital status	Married	10	6	4
	Divorced/widowed/separated/single	5	2	3
	Cohabitating/boyfriend/girlfriend	5	2	3
Sending location	Northern Region	8	2	6
	Upper East Region	10	8	2
	Upper West Region	2	0	2
Children	None	6	3	3
	One	3	1	2
	Two	2	2	0
	More than two	9	4	5
Social isolation	Reported having friends	11	8	3
	Did not report having friends	8	2	6
	Unknown	1	0	1

both genders. Sexual coercion and assault were reported among the study population. One female respondent reported her first sexual encounter was a sexual assault,

> It was a grown-up man who normally sends me to buy him things. He sent me one day, when I came he gave me a drink not knowing that he drugged the drink so after taking it he raped me. When I woke up, I realized something had happened to me, so I complained to one woman in our house and she followed him and he pleaded that we should forgive him . . . I was 15 at the time. (Female, age 20 years)

A male reported perpetrating sexual assault,

> I have also tried to coerce a girl here once . . . She is from the north and she came to work here, that day it was late and she had no place to lie so I took her in and later at night I did it without her consent. I really regretted that action. (Male, age 40 years)

In the scenario described by the male migrant, he took advantage of the fact that a woman did not have a place to live, which is a common situation in the area. Other study participants reported an awareness of sexual assault in the market with younger migrant women being particularly vulnerable.

> Yes. It [sexual assault] happens here mostly to the young girls who are from elsewhere, but I don't know their tribe and it is mostly done by the mate and trotro [minibus] drivers. When they do that and are caught we try to warn and advise them, but they are not arrested. (Male, age 48 years)

Furthermore, sexual coercion was mentioned in describing sexual encounters that were thought to be consensual. However, the comments tended to normalize coercion.

> The first time I had sex was with my partner and it was so painful. I didn't want to do, but he persuaded me into doing it. (Female, age 24 years)

Among study respondents, low condom use, decisions regarding engaging in sexual activity favoring males, the sexual assault of young women from the north, and normalized sexual coercions were all reported negative sexual and reproductive health outcomes.

Perceptions of Migration

Many of the participants reflected on the hopefulness that imbued their decision to migrate. As with most life decisions, the details were varied and complex. A few women reported moving as a result of their husband moving and they were expected to follow. The majority of migrants reported a perceived economic benefit of migrating to Accra as a driving force in their decision to migrate. One woman said,

> I came here because of work. I know when I come I will get better things to do. (Female, age 35 years)

However, others reported migrating because it seemed exciting or because they were inspired by the new perspectives with which the return migrants came home. One male reported,

> The time I decided to come here I was young and the reason I decided to come is because of the feeling I get when I see those who left for Accra in town. I enjoy that feeling. (Male, age 36 years)

Finally, a female reflected on her migration to Accra as an experience that positively changed her perspective,

> For my life, my eyes didn't open at the north; my eyes opened here in Accra. (Female, age 27 years)

These intangible reasons to migrate including excitement, adventure, and new experience were expressed through these young migrants.

The migrant experience is complex, and migrants report mixed feelings about their decision to migrate. Many migrants reported feeling that migration has been more difficult than originally was imagined, as one female reported,

> Not everyone is born with a silver spoon in the mouth, but we thank God for we get what we eat. (Female, age 50 years)

Coming from poverty in rural areas to living in poverty in Accra presents challenges related to low income and high cost of living where even access to food can be a concern. Even with the challenges that exist in Agbogbloshie, migrants stayed because it was better than returning home,

> Things are not going on well with me here, but there is no alternative. Because back at home, things are worse, that is why I am still here managing little by little. (Female, age 20 years)

While many migrants reported regret or hardship related to migrating, some reported the realization of a goal shown through this statement,

> My life here is okay. Because I have a business even though it doesn't move like before but it is still better than working for someone. My husband and I rented a room, for food too I sell, so life here, I will say I thank God. (Female, age 35 years)

This participant was able to become a business owner, which few are able to accomplish.

Working and Living Conditions

Agbogbloshie is a vibrant area in central Accra. While it mainly functions as a wholesale market, distributing produce to other centers across the country, it is also a residential district, the site of one of the largest e-waste dumps in the world (Srigboh et al., 2016), and a hub for those migrating to Accra from other areas in Ghana. Agbogbloshie is both chaotic and highly organized, with each market area dedicated to a separate type of produce and governed by a strict hierarchy of leaders and "queens" and vendor organizations. All of those interviewed in this study work in Agbogbloshie and most also call it home.

Market leaders describe the market as a difficult place to work due to physically demanding jobs, long hours, and low pay. The positions and leadership are highly gendered and hierarchical. Young women, particularly migrants, frequently take jobs as *kayaye*, or head porters. Head porters carry large containers to assist market customers and carry their wares. It is lower paying than vendor work, frequently marginalized, and lacking in protections of vendor organizations. Men are more likely to work in the scrap business, disassembling machinery or electronics to sell piecemeal. As one of the male market leaders explained,

> The migrants, they come with a purpose. Most of them, because of the life there [in the rural area], the mature and the young, when they come here, they work to make money and save, but the difficulties they also face are there [in the rural area]. (Male, age 59 years)

He went on to describe the brutal process of migration, in instances where "agents" transport large groups of people to Accra, demanding money and making promises of a better economic life. He was sympathetic to migrants and the challenges of trying to save money while in a cycle of debt and poverty and concluded,

> It is more or less like slavery. (Male, age 59 years)

The combination of market hierarchy and migrant vulnerability was described as exploitative, as migrants were described to have few avenues to improve their livelihood.

For migrants, it can be challenging to enter the formal market structure in Agbogbloshie. Typically, getting a job and being successful requires knowing the right people and keeping those people happy. One of the older female market leaders described the long process to get to where she is today, working for more than a decade under a market queen who took her on as a "daughter." Only after she paid her dues, she became a leader and was given a few people to manage. Another market leader explained that relationships are central to the hierarchy,

> Here we have leaders so before you can come here you must know someone. You only come if you know someone here. And we come to the market to sell in turns if it's not your turn you will not be allowed to sell that day at all. (Female, age 55 years)

Due to long working hours, low incomes, and a paucity of affordable housing options, many migrants face challenges in finding decent and safe accommodation. For some, this concern is nagging and pervasive,

> The challenge I faced since coming to Accra is accommodation. Every time even if you are eating you think about your rent so that is a serious challenge for me. (Male, age 43 years)

As mentioned above, Agbogbloshie has both commercial and residential areas, often with blurred lines between the two. One man told us that he prioritized saving money to send home for so long that he was unable to pay for a place to stay, saying

> When I came, I slept outside for 9 years. (Male, age 45 years)

While his case is extreme, it is common for migrants to use their market stalls as a place to live. They sleep in the small areas where they work to save money from additional rent, to protect their wares, and to be ahead of others when early deliveries arrive. One young man explained,

> I have not rented a room, I sleep here [in the market] but I kept my things in my brother's room. But here, if you are to be sleeping at home, you won't get work to do because the trucks come early around 1:00 am or 2:00 am unless you have someone who can inform you whenever the cars are in. (Male, age 29 years)

Men are not the only ones who sleep inside the market, though women face additional concerns of safety when sleeping in such an exposed place. One female reported sleeping in the market,

> The market is not good. For accommodation this [market stall] is where I sleep. The man who brought you here gave me this place to be staying, and for food, it is not a problem because I sell food. I know this place that we are sleeping is too small for us but because this is where I work we are managing it here like that. (Female, age 50 years)

A man explained that sleeping outside may be a risk factor for sexual assault,

> The victims are the migrants, mostly the northern migrants and it is because they don't have a place to sleep. (Male, age 22 years)

The lack of safe accommodation in Agbogbloshie is a prevalent concern and likely contributes to a number of poor health outcomes.

Isolation and Social Support

Perhaps unsurprisingly, many migrants described a sense of isolation in their life in Accra. Eight reported having no friends whatsoever in Accra, and six of these were women. The primary reason that women gave for not having friendships was time. As one woman summed up,

> Me, I don't have friends here because I don't have time here to waste. (Female, age 44 years)

Others cited barriers in communication with people from different areas of Ghana and the friends they do have often come from the same region in Ghana. While some migrants who were interviewed did not report any friendships in their new environment, overall migrants recognized the importance of friendships and benefits of having a social support network in their new home. Some even explicitly linked poor social support to their own poor mental health. Those who have been successful in building friendships and support networks described strategies of seeking out others through sports and other community organizations when they have time. One man even went so far as to change his religion after migrating, saying,

> Because, you know in the north, we have a religion we were following but when you come to a place where you need help from someone, you understand, so now I am a Christian. (Male, age 43 years)

He was able to find both friendship and support in this new community. Worry related to the interconnectedness between social support and health was also evident. A female described her reality if she falls ill,

> What I fear I will face is sickness, if I fall sick here I don't know what will become of me. (Female, age 19 years)

The combination of low social support and poor health, which may become a vicious circle, was an expressed concern in this community.

Access to Health Care

Many respondents reported accessing health care through pharmacies, clinics, and hospitals. About half reported not having current health insurance. Most migrants were enrolled in the National Health Insurance Scheme in the past, but their insurance expired. The participants did not express any major barriers to accessing care. Younger people tended to report fewer health problems and less need to access services; however, no participants reported accessing services when well. One young male reported,

> The first point of call is the drug store, but if it persists we then proceed to the hospital. (Male, age 22 years)

A younger female reported,

> I will buy drugs and take [them]; if there is no change I will go to the hospital. (Female, age 19 years)

The older population in this study who had chronic conditions reported accessing health care to manage the condition. An older migrant reported,

> Anytime I am sick, I visit the hospital for a proper check-up because of my high blood pressure. (Female, age 50 years)

Additionally, while several respondents reported accessing health care through hospitals or clinics, others reported accessing health care through the pharmacy or clinics that do not subscribe to the National Health Insurance Scheme.

Discussion

Findings from this research point to the varied sexual and reproductive health risks among migrants in Agbogbloshie. Risks are likely related to perceptions of migration, poor working and living conditions, low levels of social support, and inequitable gender norms connected to low levels of sexual and reproductive autonomy among migrant women. Economic migration may be reduced through efforts to increase economic opportunity in rural areas in Ghana. However, those who migrate for experiential reasons (e.g., interest in travel, seeking adventure, looking for new experiences) may be less likely to be affected by policy changes to increase economic opportunities in rural areas. The various decisions surrounding who migrates may be associated with different vulnerabilities for poor health outcomes through varied levels of social support and working and living conditions, which may have a synergistic effect on negative health outcomes (Hirsch, 2014). Engagement in sexual risk behaviors among migrants in this study population did not seem to indicate low knowledge of how to prevent negative sexual and reproductive health outcomes but, rather, highlight the fragmented support networks and poor living and working conditions.

Lacking access to safe housing and holding demanding jobs in the market can put migrants at a higher risk for dangerous sexual encounters (Hirsch, 2014; Munyewende et al., 2011; Ondimu, 2009). Access to safe housing and engagement in precarious work are related to household or individual wealth in the sending community as well as migrant social networks in the destination. The low levels of condom use in this population are driven by reported fidelity within relationships and low levels of sexual and reproductive autonomy among women. To maintain dyadic relationships after a disruption in social support due to migrating away from family and the low levels of social support perpetuated through long working hours, men and women may strive to communicate fidelity in partnerships as a way of building trust and supporting that relationship. Asking a partner to use a condom communicates to sexual partners that there are other partners, which can dissolve trust in a relationship. Gender norms surrounding sexual behavior were communicated in several interviews and suggested low reproductive autonomy among females in this population. Low sexual and reproductive autonomy among women creates additional vulnerability for poor health outcomes among women (Reed et al., 2018). Inequitable gender norms fuel unsafe sexual encounters by increasing the risk of sexual violence through normalized language around painful sex and lack of decision-making authority among females regarding when to have sex and whether condoms can be used (Greif & Dodoo, 2011). Fidelity as the primary means to protect oneself from negative sexual and reproductive health concerns will not address nonconsensual sexual encounters. Changing the social norms surrounding female decision making, eliminating sexual violence, and improving the acceptance of condom use and contraception will likely provide some reduction in STIs and unintended pregnancy in this community. Finally, while some studies suggest that increased economic autonomy could improve sexual and reproductive autonomy (Do & Kurimoto, 2012), this has not been found to remain true in Ghana where marital power and agreement with partners about reproductive issues and marital duration are more important (N. D. Dodoo et al., 2019).

Access to health care for Ghana's migrant population has been shown to be lower than nonmigrants (Yiran et al., 2015). Previous studies have shown that Ghana's population working in the informal sector have lower rates of enrollment in the National Health Insurance Scheme mainly due to financial barriers, long wait times, and geographic barriers to health care (Lattof, 2018; Yiran et al., 2015). This study found that migrants do access health care; however, it is more common among older migrants with chronic conditions. Younger migrants do not often access health care and many reported expired insurance cards. Younger migrants reported their preferred health care access point at the pharmacies or self-treatment. Many younger migrants reported only going to hospitals for health challenges that could not be resolved through self-treatment or treatment from pharmacies. This finding is corroborated by a study that found people living in Agbogbloshie were more likely than people living in two other urban locations with low socioeconomic status in Accra to use herbal/traditional medication and to self-medicate (Awuah et al., 2018). This preference for accessing hospitals mainly when their health was in critical condition did not appear to be due to low knowledge on how or where to access health care among migrants in this study. While migrants did not acknowledge barriers to care, they commented on their vulnerability to minor income losses. Therefore, financial barriers to accessing health care likely exist. Finally, while health care access in this community was reportedly available to respondents, it was underutilized due to both long working hours that prohibited taking time to seek health care and viewing themselves as healthy and not in need of health care, which could be a form of risk taking.

Limitations

This study has several limitations. First, due to the response bias inherent in snowball sampling methodology and because those who consented had the time to participate in the study, the most vulnerable migrants may have been missed. It is possible that migrants suffering from more difficult work situations or violence were less likely to participate in this study. Second, engaging migrant market workers in their

workplace may have introduced a possible respondent bias as workers may have been less likely to share negative experiences especially about their working conditions or their sexual and reproductive health when in the market. Third, some of the interview questions asked about previous events such as their migration journey and reproductive lives. These questions may have been affected by recall bias from the respondents. Finally, this research is likely affected by the healthy migrant hypothesis, meaning that migrants who suffer from worse health outcomes may be more likely to travel back home and were therefore not available to participate in this study.

Implications for Policy and Future Directions

This study revealed that the challenges related to maintaining sexual and reproductive health are not only at the individual level but also at the community level and are demonstrated through varied attitudes surrounding migration, poor living and working conditions, low levels of social support, and low reproductive autonomy. The link between expectations of migration, living and working conditions, social support, and sexual and reproductive health should be further explored. Migration status requires a more nuanced definition and migrants hold diverse motivations to leave home, all of which may not be associated with risks to sexual and reproductive health. Migration in Ghana is a key factor in the country's development. In 2016, Ghana created a National Migration Policy to support migration within the development agenda and to establish social protection policies for migrants in urban areas (Ministry of the Interior, 2016). Due to the protections in place for migrants, there may be increased migration in Ghana and the situation for migrants may improve. However, the risks to sexual and reproductive health outcomes may be less due to migration and more due to gender norms in Ghana and the living and working conditions in the informal settlement. Continued research in this area will add to the broader literature on migration, informal settlements, and health in Ghana and will contribute to the continued development of the country.

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References

Abada, T., & Tenkorang, E. Y. (2012). Women's autonomy and unintended pregnancies in the Philippines. *Journal of Biosocial Science*, *44*(6), 703–718. https://doi.org/10.1017/S0021932012000120

Abdulai, A.-M. (2016). Internal migration determinants: Evidence from northern region of Ghana. *Ghana Journal of Development Studies*, *13*(1), 1–17. https://doi.org/10.4314/gjds.v13i1.1

Abdul-Korah, G. B. (2011). "Now if you have only sons you are dead": Migration, gender, and family economy in twentieth century northwestern Ghana. *Journal of Asian and African Studies*, *46*(4), 390–403. https://doi.org/10.1177/0021909611400016

Abutima, T., & Kevi, A. (2017). Internal migration of young women: Current perspectives on Kayayei in Ghana. International Organization for Migration, International Organization for Migration (IOM) Ghana.

Adanu, R. M., & Johnson, T. R. (2009). Migration and women's health. *International Journal of Gynecology & Obstetrics*, *106*(2), 179–181. https://doi.org/10.1016/j.ijgo.2009.03.036

Awuah, R. B., Asante, P. Y., Sakyi, L., Biney, A. A., Kushitor, M. K., Agyei, F., & Aikins, A. D. (2018). Factors associated with treatment-seeking for malaria in urban poor communities in Accra, Ghana. *Malaria Journal*, *17*(1), Article 168. https://doi.org/10.1186/s12936-018-2311-8

Awumbila, M., & Ardayfio-Schandorf, E. (2008). Gendered poverty, migration and livelihood strategies of female porters in Accra, Ghana. *Norsk Geografisk Tidsskrift/Norwegian Journal of Geography*, *62*(3), 171–179. https://doi.org/10.1080/00291950802335772

Awumbila, M., & Torvikeh, G. D. (2018). Women on the move: A historical analysis of female migration in Ghana. In M. Awumbila, D. Badasu, & J. Teye (Eds.), *Migration in a globalizing world: Perspectives from Ghana* (pp. 171–189). Sub-Saharan.

Bruederle, A., Delany-Moretlwe, S., Mmari, K., & Brahmbhatt, H. (2019). Social support and its effects on adolescent sexual risk taking: A look at vulnerable populations in Baltimore and Johannesburg. *Journal of Adolescent Health*, *64*(1), 56–62. https://doi.org/10.1016/j.jadohealth.2018.07.004

Camlin, C. S., Cassels, S., & Seeley, J. (2018). Bringing population mobility into focus to achieve HIV prevention goals. *Journal of the International AIDS Society*, *21*(Suppl. 4), e25136. https://doi.org/10.1002/jia2.25136

Capasso, A., DiClemente, R. J., & Wingood, G. M. (2019). Pregnancy coercion as a risk factor for HIV and other sexually transmitted infections among young African American women. *Journal of Acquired Immune Deficiency Syndromes*, *82*(2), S155-S161. https://doi.org/10.1097/QAI.0000000000002174

Cassels, S., Jenness, S. M., Biney, A. A., Ampofo, W. K., & Dodoo, F. N.-A. (2014). Migration, sexual networks, and HIV in Agbogbloshie, Ghana. *Demographic Research*, *31*, 861–888. https://doi.org/10.4054/DemRes.2014.31.28

Chuah, F. L. H., Tan, S. T., Yeo, J., & Legido-Quigley, H. (2018). The health needs and access barriers among refugees and asylum-seekers in Malaysia: A qualitative study. *International Journal for Equity in Health*, *17*(1), Article 120. https://doi.org/10.1186/s12939-018-0833-x

Cobbinah, P. B., & Erdiaw-Kwasie, M. O. (2018). Urbanization in Ghana: Insights and implications for urban governance. In *E-planning and collaboration: Concepts, methodologies, tools, and applications* (pp. 256–278). IGI Global. https://doi.org/10.4018/978-1-5225-5646-6.ch012

Darteh, E. K. M., Doku, D. T., & Esia-Donkoh, K. (2014). Reproductive health decision making among Ghanaian women. *Reproductive health*, *11*(1), Article 23. https://doi.org/10.1186/1742-4755-11-23

Davies, A. A., Basten, A., & Frattini, C. (2009). Migration: A social determinant of the health of migrants. *Eurohealth*, *16*(1), 10–12.

Do, M., & Kurimoto, N. (2012). Women's empowerment and choice of contraceptive methods in selected African countries. *International Perspectives on Sexual and Reproductive Health*, *38*(1), 23–33. https://doi.org/10.1363/3802312

Dodoo, F. N.-A., Horne, C., & Biney, A. (2014). Does education mitigate the adverse impact of bridewealth on women's reproductive autonomy? *Genus*, *70*(1), 77–97.

Dodoo, N. D., Atiglo, D. Y., Biney, A. A., Alhassan, N., Peterson, M. B., & Dodoo, F. N.-A. (2019). Does financial autonomy imply reproductive and sexual autonomy? Evidence from urban poor women in Accra, Ghana. *African Studies*, *78*(4), 477–495. https://doi.org/10.1080/00020184.2019.1584485

Elifson, K. W., Sterk, C. E., & Theall, K. P. (2007). Safe living: The impact of unstable housing conditions on HIV risk reduction among female drug users. *AIDS and Behavior*, *11*(2), 45–55. https://doi.org/10.1007/s10461-007-9306-8

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and reproductive health: A matter of life and death. *Lancet*, *368*(9547), 1595–1607. https://doi.org/10.1016/S0140-6736(06)69478-6

Greif, M. J., & Dodoo, F. N.-A. (2011). Internal migration to Nairobi's slums: Linking migrant streams to sexual risk behavior. *Health & Place*, *17*(1), 86–93. https://doi.org/10.1016/j.healthplace.2010.08.019

Greif, M. J., Dodoo, F. N.-A., & Jayaraman, A. (2011). Urbanisation, poverty and sexual behaviour: The tale of five African cities. *Urban Studies*, *48*(5), 947–957. https://doi.org/10.1177/0042098010368575

Hannaford, D. (2016). Intimate remittances: Marriage, migration, and MoneyGram in Senegal. *Africa Today*, *62*(3), 93–109. https://doi.org/10.2979/africatoday.62.3.93

Henrich, C. C., Brookmeyer, K. A., Shrier, L. A., & Shahar, G. (2006). Supportive relationships and sexual risk behavior in adolescence: An ecological–transactional approach. *Journal of Pediatric Psychology*, *31*(3), 286–297. https://doi.org/10.1093/jpepsy/jsj024

Hirsch, J. S. (2014). Labor migration, externalities and ethics: Theorizing the meso-level determinants of HIV vulnerability. *Social Science & Medicine*, *100*(January), 38–45. https://doi.org/10.1016/j.socscimed.2013.10.021

Huang, Y.-M., Merkatz, R., Kang, J.-Z., Roberts, K., Hu, X.-Y., Di Donato, F., Sitruk-Ware, R., & Cheng, L.-N. (2012). Postpartum unintended pregnancy and contraception practice among rural-to-urban migrant women in Shanghai. *Contraception*, *86*(6), 731–738. https://doi.org/10.1016/j.contraception.2012.05.007

Jaeger, D. A., Dohmen, T., Falk, A., Huffman, D., Sunde, U., & Bonin, H. (2010). Direct evidence on risk attitudes and migration. *Review of Economics and Statistics*, *92*(3), 684–689. https://doi.org/10.1162/REST_a_00020

Jarawura, F. X. (2014). Perceptions of drought among rural farmers in the Savelugu district in the northern Savannah of Ghana. *Ghana Journal of Geography*, *6*(1), 102–120.

Kruk, M. E., Kujawski, S., Moyer, C. A., Adanu, R. M., Afsana, K., Cohen, J., Glassman, A., Labrique, A., Srinath Reddy, K., & Yamey, G. (2016). Next generation maternal health: External shocks and health-system innovations. *The Lancet*, *388*(10057), 2296–2306. https://doi.org/10.1016/S0140-6736(16)31395-2

Lattof, S. R. (2018). Health insurance and care-seeking behaviours of female migrants in Accra, Ghana. *Health Policy and Planning*, *33*(4), 505–515. https://doi.org/10.1093/heapol/czy012

Li, X., Zhang, L., Stanton, B., Fang, X., Xiong, Q., & Lin, D. (2007). HIV/AIDS-related sexual risk behaviors among rural residents in China: Potential role of rural-to-urban migration. *AIDS Education and Prevention*, *19*(5), 396–407. https://doi.org/10.1521/aeap.2007.19.5.396

Loll, D., Bauermeister, J., Ela, E., Manu, A., Morhe, E., Dozier, J., Harris, L., Dalton, V., & Hall, K. (2016). Reproductive autonomy and contraceptive use among adolescent and young adult women in Ghana. *Contraception*, *94*(4), 416. https://doi.org/10.1016/j.contraception.2016.07.124

Loll, D., Fleming, P. J., Manu, A., Morhe, E., Stephenson, R., King, E. J., & Hall, K. S. (2019). Reproductive autonomy and modern contraceptive use at last sex among young women in Ghana. *International Perspectives on Sexual and Reproductive Health*, *45*, 1–12. https://doi.org/10.1363/45e7419

Lowthers, M. (2018). On institutionalized sexual economies: Employment sex, transactional sex, and sex work in Kenya's cut flower industry. *Signs: Journal of Women in Culture and Society*, *43*(2), 449–472. https://doi.org/10.1086/693767

Marshall, B. D., Astone, N., Blum, R. W., Jejeebhoy, S., Delany-Moretlwe, S., Brahmbhatt, H., Olumide, A., & Wang, Z. (2014). Social capital and vulnerable urban youth in five global cities. *Journal of Adolescent Health*, *55*(6), S21-S30. https://doi.org/10.1016/j.jadohealth.2014.08.021

McGrath, N., Eaton, J. W., Newell, M.-L., & Hosegood, V. (2015). Migration, sexual behaviour, and HIV risk: A general population cohort in rural South Africa. *The Lancet HIV*, *2*(6), e252-e259. https://doi.org/10.1016/S2352-3018(15)00045-4

Ministry of the Interior. (2016). *National migration policy for Ghana*. http://www.migratingoutofpoverty.org/files/file.php?name=national-migration-policy-for-ghana.pdf&site=354

Moyce, S. C., & Schenker, M. (2018). Migrant workers and their occupational health and safety. *Annual Review of Public Health*, *39*, 351–365. https://doi.org/10.1146/annurev-publhealth-040617-013714

Munyewende, P., Rispel, L. C., Harris, B., & Chersich, M. (2011). Exploring perceptions of HIV risk and health service access

among Zimbabwean migrant women in Johannesburg: A gap in health policy in South Africa? *Journal of Public Health Policy*, *32*(1), S152-S161. https://doi.org/10.1057/jphp.2011.36

Olawore, O., Tobian, A. A., Kagaayi, J., Bazaale, J. M., Nantume, B., Kigozi, G., Nankinga, J., Nalugoda, F., Nakigozi, G., Kigozi, G., Gray, R. H., Wawer, M. J., Ssekubugu, R., Santelli, J. S., Reynolds, S. J., Chang, L. W., Serwadda, D., & Grabowski, M. K. (2018). Migration and risk of HIV acquisition in Rakai, Uganda: A population-based cohort study. *The Lancet HIV*, *5*(4), e181-e189. https://doi.org/10.1016/S2352-3018(18)30009-2

Ondimu, K. N. (2009). Labour migration and risky sexual behaviour: Tea plantation workers in Kericho District, Kenya. In F. Thomas, M. Haour-Knipe, & P. Aggleton (Eds.), *Mobility, sexuality and AIDS* (pp. 170–183). Routledge.

Patel, R. B., & Burke, T. F. (2009). Urbanization: An emerging humanitarian disaster. *New England Journal of Medicine*, *361*(8), 741–743. https://doi.org/10.1056/NEJMp0810878

Pocock, N. S., Nguyen, L. H., Lucero-Prisno Iii, D. E., Zimmerman, C., & Oram, S. (2018). Occupational, physical, sexual and mental health and violence among migrant and trafficked commercial fishers and seafarers from the Greater Mekong Subregion (GMS): Systematic review. *Global Health Research and Policy*, *3*(1), Article 28. https://doi.org/10.1186/s41256-018-0083-x

Reed, E., West, B. S., Salazar, M., & Monroy, R. V. (2018). Economic empowerment to improve sexual and reproductive health among women and girls. In S. Choudhury, J. T. Erausquin, & M. Withers (Eds.), *Global perspectives on women's sexual and reproductive health across the lifecourse* (pp. 297–315). Springer. https://doi.org/10.1007/978-3-319-60417-6_17

Ryan, G. W., & Bernard, H. R. (2000). *Techniques to identify themes in qualitative data*. Sage.

Songsore, J. (2009). *The urban transition in Ghana: Urbanization, national development and poverty reduction*. University of Ghana.

Srigboh, R. K., Basu, N., Stephens, J., Asampong, E., Perkins, M., Neitzel, R. L., & Fobil, J. (2016). Multiple elemental exposures amongst workers at the Agbogbloshie electronic waste (e-waste) site in Ghana. *Chemosphere*, *164*(December), 68–74. https://doi.org/10.1016/j.chemosphere.2016.08.089

Teye, J. (2018). *Urbanization and migration in Africa* (United Nations expert group meeting for the review and appraisal of the programme of action of the international conference on population and development and its contribution to the follow-up of and review of the 2030 agenda for sustainable development).

United Nations. (2014). World urbanization prospects: The 2014 revision. https://www.un.org/en/development/desa/publications/2014-revision-world-urbanization-prospects.html

Yang, X., & Xia, G. (2006). Gender, migration, risky sex, and HIV infection in China. *Studies in Family Planning*, *37*(4), 241–250. https://doi.org/10.1111/j.1728-4465.2006.00103.x

Yiran, G.-S. A., Teye, J. K., & Yiran, G. A. (2015). Accessibility and utilisation of maternal health services by migrant female head porters in Accra. *Journal of International Migration and Integration*, *16*(4), 929–945. https://doi.org/10.1007/s12134-014-0372-2

Yu, C., Lou, C., Cheng, Y., Cui, Y., Lian, Q., Wang, Z., Gao, E., & Wang, L. (2019). Young internal migrants' major health issues and health seeking barriers in Shanghai, China: A qualitative study. *BMC Public Health*, *19*(1), Article 336. https://doi.org/10.1186/s12889-019-6661-0

Zhong, B., Liu, T., Chan, S., Jin, D., Hu, C., Dai, J., & Chiu, H. (2018). Common mental health problems in rural-to-urban migrant workers in Shenzhen, China: Prevalence and risk factors. *Epidemiology and Psychiatric Sciences*, *27*(3), 256–265. https://doi.org/10.1017/S2045796016001141

Zhu, L., Qin, M., Du, L., Jia, W., Yang, Q., Walker, M., & Wen, S. (2009). Comparison of maternal mortality between migrating population and permanent residents in Shanghai, China, 1996–2005. *BJOG: An International Journal of Obstetrics & Gynaecology*, *116*(3), 401–407. https://doi.org/10.1111/j.1471-0528.2008.01979.x