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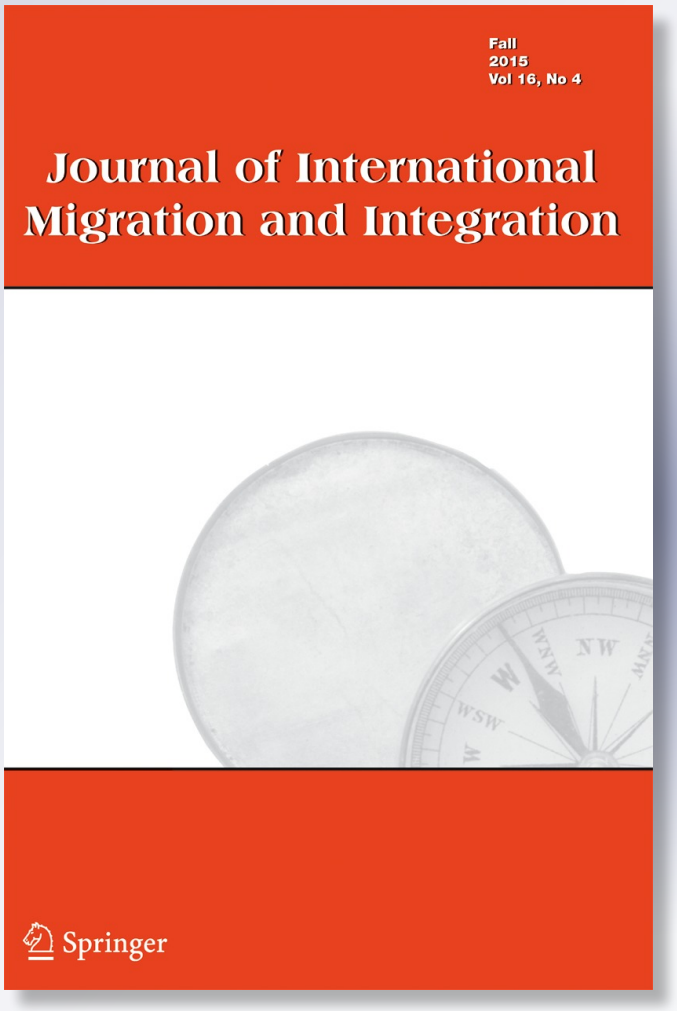

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Accessibility and Utilisation of Maternal Health Services by Migrant Female Head Porters in Accra

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Abstract Accessibility to maternal health care by marginalised groups, such as poor migrant women, has remained an issue of concern in Ghana. While a number of studies have been conducted on the livelihoods of migrant female head porters (*Kayayei*) in cities in Southern Ghana, there is little understanding of their accessibility and utilisation of maternal health services. This paper examines the challenges that the migrant female head porters encounter in the process of seeking maternal health care in Accra. The data were collected through a questionnaire survey on a sample of 70 female head porters and in-depth interviews with key informants and some of the *Kayayei*. The findings indicate that the factors affecting accessibility to maternal health services by the *Kayayei* are unavailability of health facilities in the slums where *Kayayei* live, low-income levels, high cost of maternal health care, long queues and waiting times at modern health facilities, and the perception that traditional medicines are adequate for protecting pregnant women and their babies. It was therefore suggested that government should increase the number of health facilities and strengthen the National Health Insurance Scheme to enhance access to health care by this vulnerable and poor group of people as well as increase health educational campaigns.

Keywords Maternal health care · Migrant head porters · Health financing · Reproductive health

G.-S. A. Yiran · J. K. Teye
Centre for Migration Studies, University of Ghana, Accra, Ghana

G.-S. A. Yiran
e-mail: gloriasheilayiran@gmail.com

J. K. Teye
e-mail: jteye@ug.edu.gh

J. K. Teye · G. A. B. Yiran (✉)
Department of Geography and Resource Development, University of Ghana, Accra, Ghana
e-mail: yiranab@gmail.com

Introduction

Although there is increased global commitment and attention to improving maternal health (Carballo and Nerukar 2001; Machado et al. 2009), a significant number of women, especially in the developing world, continue to die during pregnancy, delivery and puerperium (Mayor 2001; WHO 2011a). Despite the fact that many interventions have been adopted to promote better maternal health, about 580,000 women of reproductive age die from pregnancy and childbirth-related complications each year (WHO 2011b). More than 50 % of these preventable deaths occur in Sub-Saharan Africa, where poverty and other socio-economic factors affect the utilisation of maternal health services by marginalized women (Quaicoe 2005; WHO 2011b).

While women from different backgrounds are at risk of suffering from maternal health complications, there is enough evidence to suggest that, in many parts of the world, the health risks associated with maternal mortality and reproductive health are higher for migrants than natives (Machado et al. 2009). According to Sword et al. (2006), migrant women have various health problems because they are more likely to have low income, low social support and poor health care. As women move to other places, their reproductive and maternal health may be affected by changes in their socio-economic status, sexual behaviour and access to health care in the new environment (Carballo and Nerukar 2001). Migrant women also tend to lack adequate knowledge about maternal and reproductive health services in their new destinations (Tong et al. 1999; Carballo 2006; Dias and Quintal 2008). This may affect their utilisation of these health care services (Puigros et al. 2008). In recognition of these vulnerabilities, the World Health Organization has stressed the need to give priority to health care of women in all migration-related situations (Carballo et al. 1996).

As is the case for many developing countries, high maternal mortality rates have historically been a major developmental challenge in Ghana (WHO 2011b). Although the introduction of National Health Insurance Scheme (NHIS), in 2001, has contributed to improved access to maternal health services in Ghana, maternal mortality rates are still quite high in the country (Colins 2003). It is estimated that between 1,400 and 3,900 women die each year in Ghana due to pregnancy-related complications (Global Press 2011). In 2008 alone, 450 mothers died per 100,000 live births in Ghana (WHO 2011a). Litchfield and Waddington (2003) have argued that the high maternal mortality level in Ghana can only be significantly reduced if interventions target certain vulnerable groups. One of such groups is poor migrant female head porters (locally referred to as *Kayayei*), who have moved from the impoverished northern Ghana to work in the cities in the south. At their destinations in southern Ghana, these female migrants are usually located at market centres and lorry stations (Awumbila and Ardayfio-Schandorf 2008).

One factor which makes migrant female head porters (*Kayayei*) a vulnerable group is poverty. The income generated from the head porting business is not enough to pay the rent of good accommodation (Awumbila and Ardayfio-Schandorf 2008). Consequently, many *Kayayei* have no option than to sleep in makeshift houses such as kiosks and in front of stores and transport stations (Kwankye et al. 2007). In addition to the accommodation problem, the *Kayayei* tend to live in very poor and unhygienic environment which predisposes them to diseases such as typhoid, cholera and dysentery (Quaicoe 2005). These adversities make them susceptible to becoming pregnant

and with its attendant effects. It has been reported that about 50 % of children born to the *Kayayei* at the Korle-Bu Teaching Hospital in Accra have been abandoned by their mothers, as a result of economic hardships (Opare 2003). These show clear cases of high incidence of unwanted pregnancies.

While an understanding of the level of usage of maternal health services among the *Kayayei* will be useful for designing policies to promote maternal health among them, most studies on these poor female migrants were largely limited to the socio-economic challenges they face at the destination (see Opare 2003; Quaicoe 2005; Yeboah and Appiah-Yeboah 2009). This paper therefore examines the livelihoods of *Kayayei* and the extent to which they have access to maternal health services in Accra. Such a topic is considered very significant given what we know that a lack of accessibility to maternal health services may contribute to maternal death, infant mortality and poor health status of mothers. It is hoped that the findings of this paper will also be useful for the formulation of evidence-based health policy in Ghana, even as the country is striving to achieve the Millennium Development Goals on maternal and child health.

Conceptualizing Accessibility to Maternal Health Care Services

A review of the literature shows that different variables can be used to measure accessibility to health care services (Savedoff 2009). Onokerhoraye (1999) asserted that accessibility of health care is primarily dependent on the presence or availability of health care facilities. It has also been argued elsewhere that accessibility to maternal health care is a multi-dimensional concept that can be measured in terms of distance to be covered to get to the health facility (i.e. geographical accessibility) (Miller 2005). Pregnant women are less likely to travel to health facilities that are far from their places of residence (Mekonnen and Mekonnen 2002). Economic empowerment can make distance shorter, as economic resources can make mobility to the health facility easier (Navaneetham and Dharmalinam 2000; Miller 2005). Apart from distance, the waiting time to see a doctor can also affect accessibility to health services. Kollapen (2009:42) argues that the problem of long queues at antenatal clinics makes maternal health inaccessible.

Some researchers have also argued that income levels of pregnant women determine their financial accessibility to maternal health services (Wyss 2003; Miller 2005). Income levels are usually discussed in relation to the cost and mode of payment for maternal health services. Availability of insurance schemes and reduction in the cost of health care may sometimes enhance financial accessibility (Kollapen 2009).

While accessibility and utilisation are closely related, research has also shown that some people may have access to a facility, but they may not want to use it because of personal reasons (Ramasundram 1995). Utilisation of health services is related to acceptability, which can be examined in terms of the expectant mothers' own belief systems that restrict her from using maternal health care services (Peters et al. 2008). Socio-demographic characteristics of women, such as age, education, employment and marital status may affect their utilisation of maternal health services (Mekonnen and Mekonnen 2002). According to Leslie and Gupta (1989), utilisation of modern health care facility is also determined by the woman's cultural background and perception of the cause of the ailment.

Conceptual Framework

This study is largely based on a conceptual framework designed by Peters et al. (2008), which also entails some of the conceptual issues presented above. The framework (Fig. 1) discusses the factors that affect different types of accessibility (i.e. geographical accessibility, financial accessibility, availability and acceptability). To begin, it assumes that the *policy* and *macro-environment* can cause deprivation which will have a trickledown effect on ill health, thereby leading to greater exposure to several vulnerabilities (Peters et al. 2008). This means that, since the policy and macro-environment can either induce poverty or propel riches, they will have an impact on the individual's way of life and, for that matter, health seeking behaviour.

Additionally, the location of a particular service tends to influence geographical accessibility. It is axiomatic that women will use maternal health services, only when those services are found in the communities where they reside. The *Kayayei* are predominantly located in slum areas which do not have maternal health facilities (Dugbazah 2007). This may affect their accessibility to maternal health services. The framework also postulates that the cost of using modern health services and the willingness or ability of the potential users to pay for these services will affect accessibility to maternal health services. High cost of modern maternal health services has the potential of dissuading people from accessing these services and thereby resorting to other cheaper options of health care, such as traditional medicines (Colins 2003; Miller 2005).

Another variable in the framework is the availability of the health services. Equitable distribution of the health resources tends to increase their accessibility to users. In many African countries, however, health services are unequally distributed (Onokerhoraye 1999). Penchansky and Thomas (1981) asserted that availability of health services is determined by the interplay of supply and demand of health professionals. They argued further that accessibility to health care will be negatively affected, if there is a health

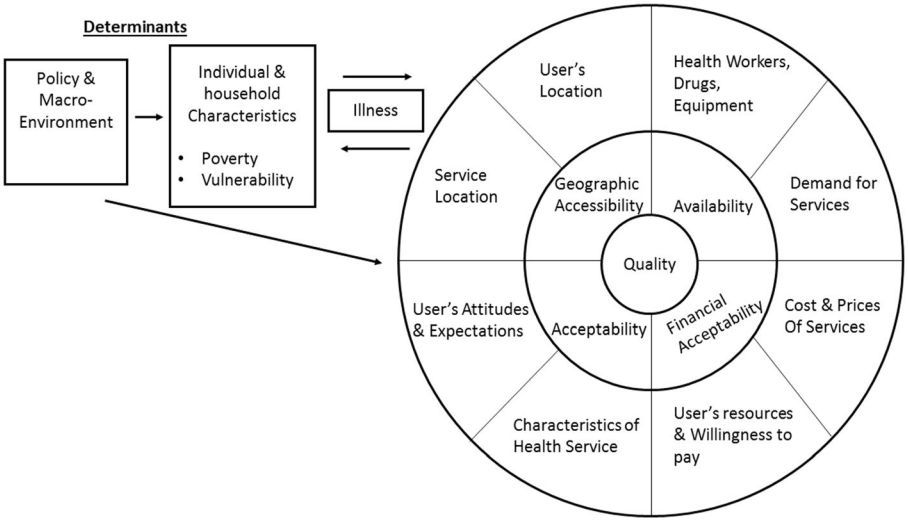

Fig. 1 Conceptual framework for assessing access to health services (adopted from Peters et al. 2008)

facility but the health professionals at post lack the skill to provide the needed care. The type of equipment and services available at a health facility can also affect accessibility (Peters et al. 2008). Acceptability of health care services, on the other hand, is determined by users' attitudes, beliefs and expectations as well as the characteristics of the health facilities.

Quality, which is at the centre of the diagram, is a diffusion of all the other variables discussed above which will amount to either an achievement or a failure of accessibility. Ultimately, accessibility becomes complete when quality is achieved not only in the fields of health care but also in all spheres of life (Joshi 1994). It is important to stress that some aspects of the conceptual framework, such as individuals and household characteristics, illness and vulnerability, were not the main focus of this research and therefore have not been extensively discussed.

Research Methodology

In view of the strengths and weaknesses of dichotomous quantitative and qualitative research approaches (see Tashakkori and Teddlie 2010; Teye 2012), the mixed-method research design was used for this research. This methodological choice was influenced by the nature of the research objectives. Our main aim was to examine the level of access to maternal health care and also to explain the factors that promote or inhibit the use of these services. Following guidelines provided by several mixed-method researchers (see Clarke 2009; Creswell et al. 2003; Teye 2012), we used quantitative methods (e.g. use of descriptive statistics) to examine the levels of usage of maternal health services, while qualitative methods were useful for analyzing the experiences, perceptions and beliefs of respondents regarding the use of maternal health services. This methodological triangulation, thus, helped us to examine the various dimensions of the research problem. This is in line with argument of Devine and Heath (1999:49) that 'triangulation can be used effectively to explore the dynamics of complex social phenomena highlighting the multi-layered and often contradictory nature of social life'. The quantifiable data was collected by means of a questionnaire survey among pregnant '*Kayayei*' and nursing mothers at the Agbogbloshie market and the Madina market in Accra (Fig. 2). These markets were chosen because they are places with very vibrant and brisk trading activities. The two markets are also the locations where the head porting business thrives and also that have greater proportion of *Kayayei* (Awumbila et al. 2008).

Given that the total population of the *Kayayei* in the Greater Accra Region of Ghana was not exactly known, it was not possible to use a statistical formula to determine a sample size. Consequently, a sample size of 70 was chosen. This was large enough for any statistical analysis (see Bryman 2001). In order to select respondents in each area, an ad hoc *Kayayei* listing exercise was undertaken in the localities by research assistants. This was done on a Sunday when most of the *Kayayei* were not working. During the listing exercise, the phone numbers of those listed were collected, and the purpose of the research was explained to them. Only those who agreed to take part in the research were included in the sampling frame. Using the sampling frame for each area, 40 of the *Kayayei* were selected at Agbogbloshie, while 30 were selected at Madina, using a simple random sampling technique. In this process, the research team

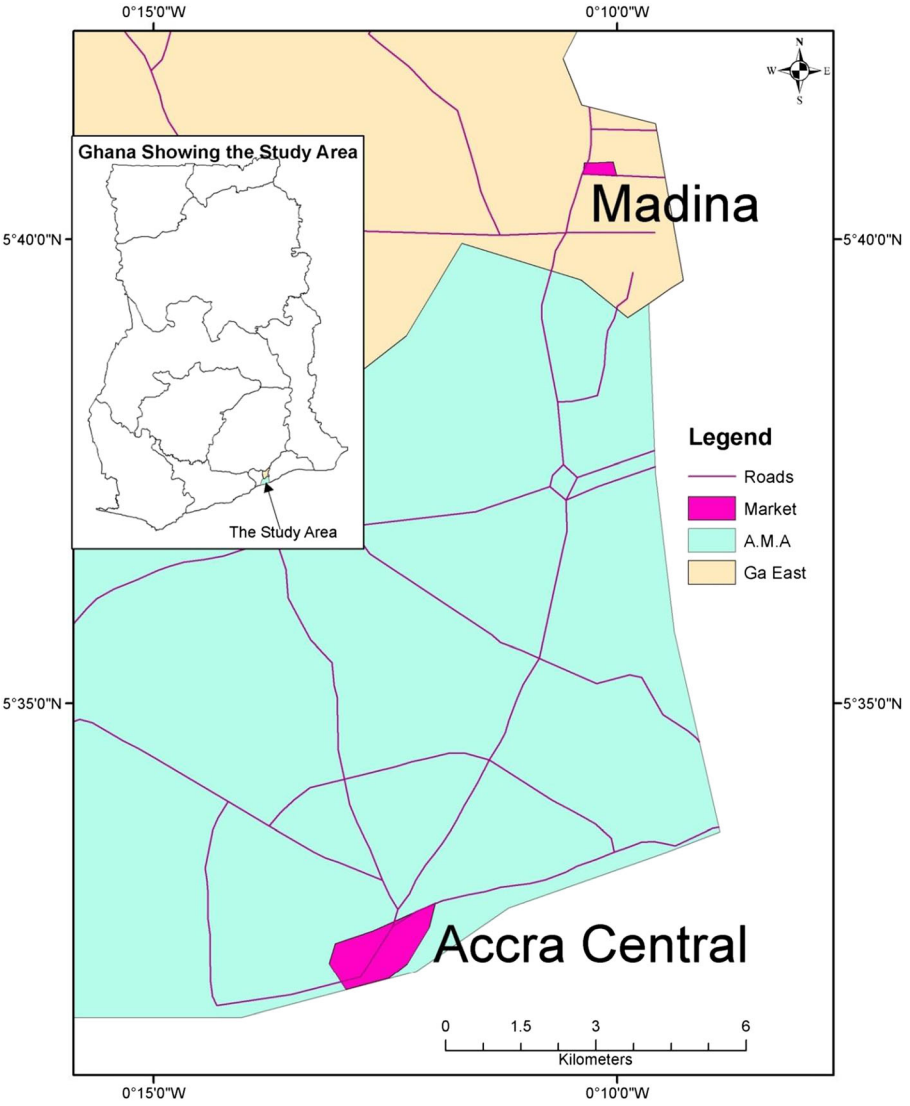

Fig. 2 Map of the study area (composed by Authors 2013)

wrote the names of the listed *Kayayei* on pieces of papers and selected the respondents by the lottery method (i.e. mixing and selecting from a pool without replacement). Research assistants then used the phone numbers taken during the listing exercise to contact the selected *Kayayei* for the structured interviews.

In view of the low level of education among the *Kayayei*, the questionnaires were administered directly in the local languages by research assistants who could speak the northern languages. In-depth interviews constituted the main qualitative data collection method. It was used to obtain data from some health professionals and some of the *Kayayei* on their experiences with the use of maternal health services.

The quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) to generate frequency tables, cross-tabulations and charts. The qualitative interviews were transcribed and subjected to manual content analysis. In some cases, direct quotations were provided to place emphasis and also to clarify assertions. Pseudonyms or nicknames were used in such quotations to protect the identity of the respondents.

Results and Discussions

This section presents the findings on accessibility and utilisation of maternal health services among the *Kayayei*. However, given that the characteristics of migrants' living environment may have significant influence on their health (Kwankye et al. 2007), the section begins with a discussion of the living conditions of the *Kayayei.*

Living Conditions of *Kayayei*

Living environments are known to have direct influence on maternal and reproductive health (Sword et al. 2006). The study shows that the *Kayayei* live in very poor environment which tends to expose them to several vulnerabilities. As shown in Table 1, more than 94 % of them sleep in wooden structures (kiosks). During the in-depth interviews, these marginalized migrants explained that their inability to raise the high rent advances charged by landlords compelled them to sleep in the wooden structures. Our observations revealed that, in some cases, there were as many as ten people sleeping in a small kiosk that is smaller than a standard single bedroom. The high room occupancy is related to 'migrant clustering', which is a result of social networks. The explanation here is that new migrants to the cities rely on contacts in their social network to provide initial accommodation and stable living arrangements (Agarwal et al. 1994; Awumbila et al. 2011). Given that these contacts are usually made through relatives, new migrants end up living and working in areas with old migrants of the same ethnicity (Yaro et al. 2011; Owusu et al. 2008). The old migrants also share their rooms with the new migrants, as it is sometimes difficult for the new migrants to find their own accommodation.

Despite sharing a small wooden structure with many other people, each of them pay as much as GH¢ 2.00 ($1.00) per night which is equivalent to GH¢ 60.00 ($30.00) per month. This amount is about half of the monthly rent for a single room in low-income communities in Accra. However, the requirement for 2-year rent advance payments prevents these female migrants from renting standard rooms in better neighbourhoods. Stated differently, paying GH¢ 2.00 is actually more expensive, but it is convenient to the *Kayayei* because it is paid on a daily basis instead of 2-year advance payment.

Our in-depth interviews further revealed that the poor living environments negatively affect the quality of health of the *Kayayei* and their children. Some of the respondents explained that they are crowded in these wooden structures and therefore do not sleep comfortably. Some respondents also complained of chronic body pains which could be linked to insufficient sleep during the night and carrying of heavy load. As the overcrowded wooden structures do not have places of convenience for the inhabitants, most of these women either queue for the few public toilets or ease themselves in their

Table 1 Distribution of respondents by type of living place

Living place	No. of respondents	Percent
House	3	4.3
Wooden structure	66	94.3
Lorry station/park	1	1.4
Total	70	100

Source: Fieldwork (2012)

rooms and dump the excreta wrapped in black polythene bags at any available open space or in the drains. Our observation of the environment within which the *Kayayei* live also revealed more sanitation problems in the areas. Some of them sit very close to refuse and eat. Unsurprisingly, the common sicknesses reported by them include cholera, diarrhoea and malaria which are associated with poor sanitation in their neighbourhoods.

Also, the homes of *Kayayei* living at Agbogbloshie, in particular, are sited in low-lying areas and are often flooded when it rains. The areas also lack proper drainage systems, and the few available drains are choked with refuse, giving the environment an unpleasant odour. The pools of water left after rains, together with the poor sanitation and chocked gutters, breed mosquitoes that carry the malaria vectors. Consequently, their living environment and their daily activities make the maternal *Kayayei* vulnerable to a host of diseases and sicknesses. Although there was a general awareness of the use of insecticide-treated mosquito nets, most of the *Kayayei* reported that crowding in their rooms makes the use of mosquito nets difficult. The daily work of the *Kayayei* also entailed carrying heavy load and walking all day, and this also pose health risk to them, especially the pregnant women and nursing mothers who carry children at their back (see Fig. 3).

The findings above are consistent with the findings of other studies on female head porters (Kwankye et al. 2007; Yeboah and Appiah-Yeboah 2009). Given that their living conditions and environment expose them to many illnesses, the need to have access to modern health care is very imperative.

Knowledge of Existing Health Facilities

Awareness of the health services in one's locality is a requirement for its consequent usage (Angel-Urdinola et al. 2008). In this study, therefore, an attempt was made to find out if the *Kayayei* were aware of the maternal health facilities in their area. All the 70 respondents indicated that they knew at least one hospital or clinic or pharmacy where they could access maternal health services. They were further asked if they knew about the *free* maternal services introduced by the government of Ghana a few years ago. As shown in Table 2, as many as 57 (81.4 %) of the respondents stated that they were aware of the *free maternal* health services available in the hospitals and clinics in the area.

An attempt was also made to find out how those *Kayayei* who reported knowing about the free maternal health services first got such information. Nearly 73 % reported that they got the information from hospital staff during their first antenatal visit. A few of the respondents also got to know about the existence of these services through news/advert/poster or NHIS officials. This is an indication that the nurses at the

A Pregnant woman carrying load

Two nursing mothers carrying load and children

Fig. 3 Maternal women at work (Fieldwork 2013)

facilities where these people went for their antenatal are doing a lot of counselling, which is very useful to the 'first-time' mothers.

Antenatal Attendance and Barriers to Accessibility and Utilisation of Maternal health care

In response to a question that sought to find out about the antenatal attendance of the *Kayayei*, about 87 % of respondents stated that they have used antenatal services at a health facility (see Table 3). In specific terms, 42 (60 %) had utilised antenatal services at a *hospital*. Another 27 % utilised the antenatal services at a *clinic*. About 5.7 % of the respondents did not attend antenatal clinics, and 4.2 % sought help somewhere. Those who had the antenatal with a traditional birth attendant (TBA) delivered at their place of origin before migrating to Accra.

Those who provided the antenatal services were largely midwives/nurses. In fact, about 73 % of the respondents received antenatal services from midwives/nurses, while about 14 % received these services from medical doctors. Those who never attended antenatal clinic delivered at home with assistance from friends or relatives. It was also revealed that some of the *Kayayei* went to the hospital/clinics occasionally. The results of the data analysis show that a little more than a third (34.3 %) of the respondents delivered their last child at home.

Given that the hospitals and the clinics were the safest places to receive antenatal and postnatal care, the *Kayayei* who reportedly did not go to these facilities were asked to explain why they sought help from elsewhere. One

Table 2 Awareness of free maternal health services

Responses	No. of respondents	Percent
Yes	57	81.4
No	13	18.6
Total	70	100

Source: Fieldwork (2012)

Table 3 Place of antenatal attendance

Facility	No. of respondents	Percent
Hospital	42	60.1
Clinic	19	27.1
TBA	2	2.9
Other	3	4.2
Did not use any facility	4	5.7
Total	70	100

Source: Fieldwork (2012)

reason cited as a challenge to the use of modern maternal health services was long distance to these facilities. The results gathered suggest that most of the health facilities were geographically inaccessible to these poor women. Only about 11.4 % of respondents stated that they lived close to a health facility, implying that most respondents are required to travel long distances to attend antennal and postnatal services. In fact, 60 % of the respondents complained that the long distance to a health facility was a challenge to their use of maternal health services. Some of the women who delivered at home also explained that the distance to a health facility was one of the reasons why they delivered at home, instead of going to the hospital. According to the respondents in Agbogbloshie, for instance, there is only one health facility in Jamestown (a nearby community) where they attend clinical service, and this facility is more than 2 km away from them. Given the fact that these are very poor people cannot hire a taxicab, the long distance to health facilities is a serious challenge to their use of the facilities. These findings support what has been noted in the literature that long distance is one of the factors that affect accessibility to health care service in many developing countries (Ramachandran 1989; Sahn et al. 2003).

The long hours of waiting at government hospitals and clinics also prevented some of the *Kayayei* from using these facilities. In fact, even those *Kayayei* who reported that they have been seeking maternal care from the hospitals and clinics stated that the long hours of waiting is a challenge to their use of such services. It also came out that, as a result of the long hours of waiting, some of the *Kayayei* did not start antenatal attendance till they were in their eighth month, when they could not work again:

> I wanted to go there [hospital] when my pregnancy was just three months old, but I later changed my mind because I didn't get time. You know ehhh….at the hospital I would be required to wait for the whole day before seeing the doctor.… As I needed to work to save some money so that I could use it after giving birth, I only went to the hospital when my pregnancy was in the eight month. The nurses insulted me for staying home so long before coming to the hospital (Rashida, 24-year-old *Kayayei*, individual interview).

It needs to be mentioned that this problem of long delays at the hospitals has been with Ghana for some years now, but the situation has worsen in the recent years. Indeed, the continuous deterioration of the health sector has created a

situation whereby one could spend the whole day at the maternity unit queuing for antenatal service (Akabzaa et al. 2010). It has been reported elsewhere that there were cases when people waited in long queues for hours at antenatal clinics only to be told that the medication prescribed by the doctor was not available (Onokerhoraye 1999). Under such circumstances, these pregnant women can lose confidence in the modern health system and therefore resort to giving birth at home.

Apart from the waiting time at the hospital, some of the *Kayayei* also stated that they could not afford various services of the hospital/clinics because of lack of money to pay for the hospital services. This is related to financial accessibility, which will be discussed more comprehensively later. Again, some of the respondents preferred traditional medicine than that of the hospitals, and this explained why they did not go to the hospitals when they were pregnant. This finding resonates with the argument that belief in the effectiveness of a health service will predict the likelihood of using that service (Rosenstock et al. 1994). In fact, some women believed that they could rely on herbs to protect themselves and their babies. To these women, therefore, there is no need to visit a hospital when one is pregnant. The use of traditional medicine is also consistent with cultural practices in areas where these migrant women have migrated from. In most of these rural communities, there are no health facilities, and therefore, maternal mothers do not attend clinics. *Kayayei*, in their places of origin, have witnessed their mothers go through antenatal and postnatal periods or have gone through it themselves using traditional medicine and therefore do not see hospital attendance as a priority. Some of the *Kayayei* are also used to buying drugs themselves rather than going to hospitals. This is captured in the statement below by Ayishetu:

> In my village there is no clinic and everybody who is pregnant has to use herbs to treat herself when she is not feeling well and is delivered by an elderly person in the house. In recent times, we buy 'white medicine' from people who come with them on their bicycles and we feel ok. So I do the same thing here. When I feel I or my child is not well, I just move to the drugstore and buy medicine. I don't need to go to clinic. So it is my conversation with you now that I am seeing why I should find time to go to clinic to seek medical care when I am not well (Ayishetu, 25-year-old *Kayayei*, individual interview).

Like Ayishetu, a number of our respondents do not go to the hospital because in the rural areas where they have come from, pregnancy is not seen as a health problem or sickness. They do not see the need to go to hospital/clinic unless there is a serious disturbance in their systems.

Health Financing and Financial Accessibility

There is no doubt that financing health care can be a constraint to accessibility to quality health care service (Miller 2005). Given that the government of Ghana had introduced a free maternal health policy, the researchers first attempted to find out if the respondents had ever used the free maternal health services during their antenatal

period. The responses indicated that about 66 % have ever benefited from the free maternal services. The rest stated that they have never used the free maternal services. As stated already, some of them were not even aware of the services. Others were aware of these free services, but they did not use them because they did not go to any accredited health facility for their antenatal services. Some of the respondents also noted that their health needs were beyond what the free maternal health care could provide, and in such situations, they supplemented the extra expenditure from their own income. It also came out clearly during the interviews that some of the women who have used maternal services in the public hospitals were made to pay some amount of money for some of the services. Some respondents noted that, even though the free maternal health services were introduced by the government of Ghana, technically, maternal health services are not completely free since they still pay for some drugs and items needed for the delivery:

> It is said that maternal health is free, but when I went to deliver, I was made to provide examination gloves and many other items before they processed me for delivery and when I was discharged these items were included in my bill and I had to pay. This therefore doubled the cost of delivery (Ramatu, 27-year-old *Kayayei*, individual interview).

This supports the argument made by some researchers that the informal fees that are paid in the hospitals negatively influence the health seeking behaviour of people (Gertler et al. 1988). The charging of additional fees is an indication of the hidden charges that exist in many health facilities (Onokerhoraye 1999). According to Peters et al. (2008), there are cases when health officials may still "illegally" collect money from poor patients, even when services are supposed to be free. In response to questions about these issues, some health officials revealed, during the in-depth interviews, that some poor women wrongly think that once they used free maternal services when they were pregnant, they can still use the facilities after giving birth. It was also explained that free maternal services were only available at government hospitals, and so women who attend other health centres are likely to pay for the services. Another limitation of the free maternal care policy is the fact that it does not cover medicines that are purchased outside the designated health facilities.

Given that the free maternal health care policy does not cover all the health needs of the people, we attempted to gather information on the mode of financing maternal health services. The distribution of respondents according to mode of health financing is shown in Fig. 4. Majority (55.7 %) of the women receive money from their husbands/boyfriends to pay for the maternal health services.

Only 27.2 % of the respondents use the National Health Insurance Scheme to finance their health services. The main reason why a significant proportion of the women did not register under the National Health Insurance Scheme (NHIS) was the lack of money for the premium. Some of them believed that the premium is expensive as they usually have other pressing needs. It was also revealed that some of those who initially registered with the scheme have stopped using it, since they did not have enough money to renew their registrations. Another reason was that during the period, some of them registered with the scheme; they never felt sick, so they felt that their money was wasted. Others stated that most of the health facilities in their vicinity do

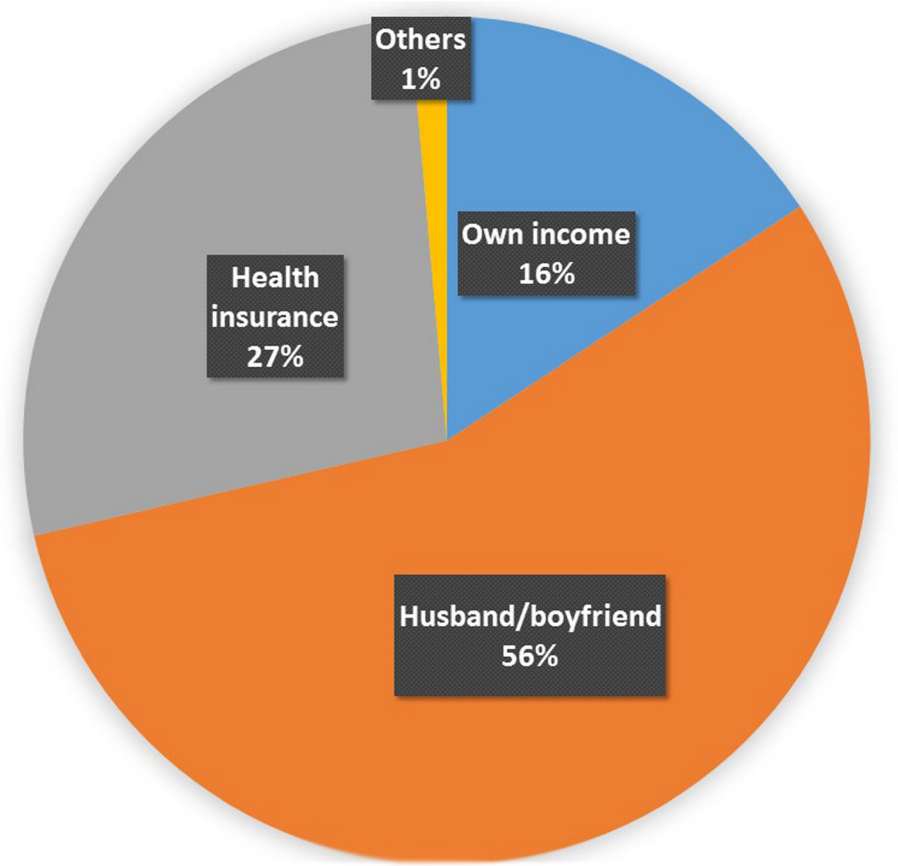

Fig. 4 Mode of healthcare financing by respondents (source: Fieldwork 2012)

not accept the national health insurance card. The respondents also explained that even those of them who had health insurance cover still have to buy some of the drugs with cash, since the health insurance does not cover all the drugs.

An in-depth interview with a health official at the Legon Hospital, a facility that also serves the Madina community where some of the *Kayayei* reside, revealed that the services at the facility are not accessible to poor people like *Kayayei*, since the hospital management had suspended the use of national health insurance. Responding to questions on how much a prospective mother needed to be able to access delivery service, she said that for a delivery, an initial deposit of GH¢ 200.00 ($100.00) is required before the commencement of service. The total cost, however, depends on the complexity of the delivery but is usually more than the deposit charged. The pregnant woman is also required to provide other things like enema pumps, gloves, cloths and sanitary materials, which increase the cost. The cost of delivery is therefore too high for the *Kayayei* because they and their partners are in the low-income bracket. This high cost of delivery at a modern facility explains why about 34 % of the respondents were delivered at home. The findings here therefore lend much credence to the assertion of Peters et al. (2008)

that low income is one of the factors that prevent women from using maternal health services.

Conclusions

This paper examined the level of accessibility and utilisation of maternal health services by migrant female head porters (*Kayayei*) in Accra. Given that living environment also has important implications for maternal and reproductive health (Sword et al. 2006), the living environment of the *Kayayei* was also examined. Consistent with findings reported elsewhere (Quaicoe 2005; Kwankye et al. 2007), most of the migrant female head porters interviewed were living in overcrowded wooden structures, which were located in low-lying slums that were prone to flood. Due to lack of planning in these slums, the sanitary conditions in these neighbourhoods were extremely poor, thereby exposing the migrants to various diseases such as cholera, malaria and typhoid fever. The daily work of the *Kayayei* also entailed carrying heavy load and walking all day, and this also poses health risk to the pregnant women and nursing mothers.

In such an environment which exposes *Kayayei* to many diseases and health risks, unlimited access to maternal health services is obviously desirable. However, the location of these migrant women in deprived slum communities, which lack modern health facilities (Dugbazah 2007), makes it difficult for them to have reasonable access to quality health care. The migrant porters are required to travel more than 2 km either on foot or by car to the nearest facility. The lack of modern health facilities in the slums where these people find themselves is an indication of non-availability of the facilities and services at the user's location which limits their geographic accessibility, as elucidated in the conceptual framework used for this paper.

Similar to scenarios reported elsewhere (Kollapen 2009), the problem of long queues and waiting time at antenatal clinics also makes maternal health inaccessible to these poor migrants. This finding is noteworthy because while it is often assumed that free maternal care can help promote better maternal health, women who have to work in the informal sector to earn daily income may still not utilise free maternal health services, if the long queues and waiting time at these facilities will prevent them from working and earning income which they equally need for survival.

The poor economic situation of these *Kayayei* also makes health care inaccessible to them. The respondents complained of the expensive nature of health services in the country which they saw as a major hindrance to their accessibility to health care. As the free maternal care policy and the National Health Insurance Scheme do not cover all health services, pregnant women may sometimes be required to pay for some services. These kinds of additional costs prevent poor people from using maternal services. This scenario is related to the cost and price component of financial accessibility (Peters et al. 2008). The inability of these women to access maternal health services can therefore be linked to macro-level socio-economic and political structures (see Sibeon 2004) that prevent them from using modern health facilities.

On the basis of these findings, it is recommended that policy makers and major players in the health sector should consider improving access to health care especially to slum dwellers, if Ghana is to move up the ladder of attaining the Millennium Development Goals by 2015. This can be done by making health facilities and services

available and reducing the cost of health through strengthening the health insurance system. The government should institute a mobile health care system that operates in the communities where poor people, especially the female migrants, live to provide antennal/postnatal and other health care services. More educational/public health campaigns should be organised to change the attitudes and negative cultural practices that hinder utilisation of health care. In this regard, the campaigns should focus on the need to attend antenatal/postnatal services. Migrants must also be educated about why it is important to constantly renew their health insurance cards, even when they are not sick. This should be done in the local languages that the migrant female head porters understand and largely on Sundays so as to get wider audience. The government could also recruit people and train them as peer educators who will visit these *Kayayei*, especially on Sundays, to educate them on general health and reproductive issues.

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