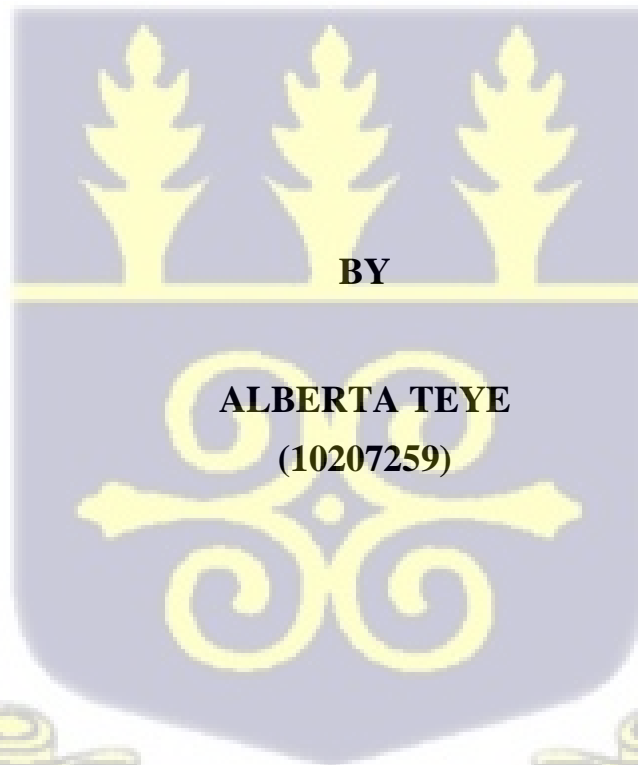


**UNIVERSITY OF GHANA  
CENTRE FOR MIGRATION STUDIES**

**MIGRANTS' AND NON-MIGRANTS' ACCESS AND USE OF  
HEALTH CARE IN GHANA**



**BY**

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,  
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**ACCEPTANCE**

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**DECLARATION**

I, ALBERTA TEYE, hereby declare that, except for references to other people's work, which have been duly acknowledged, this is the result of my own research and it has neither in part nor in whole been presented for another degree.

.....

ALBERTA TEYE  
(STUDENT)

.....

DATE

## **DEDICATION**

This work is dedicated to my mother, Beatrice Doe Boduwa and my father, Joseph Teye Narh of blessed memory, for their dedication and support throughout my academic endeavour.

## **ACKNOWLEDGEMENT**

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## ABSTRACT

The aim of the Sustainable Development Goal three (SDG 3) is to ensure healthy lives and promote the well-being for all humans in both advanced and developing countries. This makes accessing and use of health care a global concern and a basic right of all persons irrespective their migration status or location on the globe. Empirical evidence also reveals an increasing number of international migrants. Studies have shown that developing countries such as Ghana also becoming a transit and a destination place for migrants.

Using a mixed method approach, the study conducted a survey of 116 migrants and 116 non-migrants residing in the Greater Accra Region of Ghana. Ten in-depth interviews and one unstructured expert interview were also conducted with selected migrants and non-migrants from the survey. The data collection was done between November and December 2018. Chi-square tests were used to determine statistical significance between socio-demographic factors, migration characteristics and access to health care. Determinants of access to health care were examined using binary logistic regression models. The qualitative interviews were used to validate and explain the quantitative findings.

The findings indicate that, almost three-quarters (74.1%) of the migrants compared to less than a tenth (7.8%) of the non-migrants have never registered with a health insurance scheme in Ghana. A higher percentage of the migrants (50.9%) compared to non-migrants (33.6%) have no access to health care. Also, access to health care had a statistically significant relationship with migration status, origin of the respondent, the respondent's level of education and the health care need of the respondent. The results also show that both migrants and non-migrants use the pharmacy when they are unwell and do self-medicate using either the pharmacy, herbs or medication from family and friends. The qualitative interview also revealed that, there exists price discrimination against migrants for health care services.

The study, therefore, recommends a further study to explore and investigate issues on price discrimination against migrants in health care use in Ghana and also the migration policy of Ghana reviewed to include matters of migrants' access to health care within the context of Ghana's commitment to regional (ECOWAS and AU) and global development goals.

## CHAPTER ONE

### BACKGROUND

#### 1.0 Introduction

Migration has been a vital part of livelihood in many parts of the world, and it has, in recent years, become an important issue in academic and policy circles (Awumbila et al 2008; Levitt 2003; Bundred & Levitt 2000; Stark & Bloom 1985). Almost every nation can boast of having some of its citizens residing in other countries. This shows the level of freedom the human population has to reside outside their home country provided they have the means to do so.

Migration has now become one of the contemporary ways in which countries interact (Levitt et al 2003). Developed nations have used migration as a means of replacing their ageing population and to solving the problems of their demographic imbalance, while the less developed nations use it as a means to sheared of their surplus labour force supply (Weeks 2011; bijoux et al 2007; Bloom & Canning 2004). Individuals and groups use migration as a means to flee persecution (Moore and Shellman 2004), conflict (Borowiecki 2012), disasters (Piguet 2010), advance their living and to achieve a social status (Adepoju 2010; De Hass 2007; Bauer & Zimmermann 1998). Migrating from one place to another has been made cheaper, faster and relatively easier than ever before (Oderth 2002) as a result of the increasing globalisation, advancement in technology, and transportation system.

Migrants form a unique segment of their population, in the sense that, as they migrate, they do not only acculturate or assimilate, but serve as the link between the origin and destination society through which health risk factors from both sides are shared (Betts 2011). Studies have shown that migratory project or event can have a negative

effect on the health of migrants (Nakash 2012; Virupaksha et al 2014), making migrants a vulnerable group regarding issues relating to their access to health care.

Haour-Knipe and Rector (1996) revealed that factors such as separation from family and partners, alienation and despair that follow stigma and discrimination among other factors in the destination areas increase the vulnerability of migrants to contracting infectious diseases like HIV/AIDS. Other studies also showed that the “very disadvantaged position of women which makes them to opt for migration as a survival strategy also compels them to undertake certain risky behaviours” (Anarfi 2004, p: 5) in their destination areas, exposing them to chronic infectious diseases (Anarfi 2004). These conditions sometimes force them to suddenly and unprepared return home. According to Buckley (2005), illnesses acquired by migrants in their migration do not only affect the individual migrants, but also, their significant others that are left behind, especially their spouses who take up decision-making roles to keep the home.

Though the relationship between migration and health is multifaceted and complex (Zimmerman et al 2011), in the sense that one cannot tell if the health of migrants is influenced by the destination area or the destination area is affected by the migrants’ health. One thing is certain that, in most cases, the health of migrants and the health care conditions of destination areas are interrelated (Davies et al 2009; IOM 2001; Zimmermann 1998). To a large extent, migration and human mobility are a common factor that underpin and drive issues on global health vulnerabilities (Beths 2011, Mott 2004, Appadurai 1996).

One major area of migrants’ vulnerability in the destination area(s) is their access and use of health care (Cuadra 2012; Stanciole and Huber 2009). In most cases, there exist some difference in the health care access and use among migrants and non-migrants. Migrants

sometimes have a restricted access to and use of health care (Cuadra 2012; Stanciole and Huber 2009; Burns et al 2007; Norredam et al 2006). Migrants are in most cases not abreast with public health knowledge in the host community, which sometimes results in their low level of health care access and usage as compared to their native counterparts.

A recent study by Cylus and Papanicolas (2015) revealed that, despite Europe's commitment to move toward universal health coverage, there is still a varied difference in perception of health care accessibility among respondents. There also existed a greater difference in the prevalence of access to health care barriers among the underprivileged respondents of the study compared to the wealthy. Their findings revealed that there is substantial heterogeneity among respondents in relation to their perception of access to health care. The most vulnerable groups (example; migrants and the poor) are more likely to think or feel they will not be able to have access to health care when the need arises.

Broadly speaking, the wealth of every nation is the health of its population (Bloom and Canning 2000) irrespective of their migration status. But, this, is not reflected in the migration policies of nations; they concentrate around issues of trade, immigration enforcement, international aid, security, and labour and hardly include health related issues (Zimmerman et al 2011; Pace & Gushulak, 2010; Stuckler & McKee, 2008 ;).

In addition, the international migration literature is saturated with explaining trends, motivation (De-Hass 2010; Adepaju 2010), causes and effects (King 2012) of the migratory movement with less attention on migrants' access and use of health care. The few studies, that addressed issues relating to the health of migrants have solely revolved around the mental health of migrants, health-seeking behaviour of migrants, sexual health of migrants in the area of HIV and AIDS, illness prevalence and experience among migrants (Agyemang et al 2014; Virupaksha et al 2014; Krause 2008; Zimmerman

2011; Anarfi 2005) with a staid focus on the health of migrants in developed countries. In Ghana, most of the works related to migration and health are works mostly focused on internal migration in Ghana (Yiran et al 2015) with little or no attention to the health of international migrants in Ghana. This, therefore, has left a gap in the literature, in the sense that, most of the literature related to the health of international migrants are driven by and explored within the global north (Developed countries) perspective. But, with a global south (Developing) country such as Ghana, also becoming a destination place for some migrants, it would be interesting to examine and explore international migrants' access and use of health care in Ghana.

### **1.1 Problem Statement**

The aim of the Sustainable Development Goal three (SDG 3) is to guarantee healthy lives and encourage the health care access for all humans in both advanced and developing countries (Griggs et al 2013). This is as a result of the fact that access and use of health care are issues of global concern and basic right of all persons irrespective of their location on the globe or migration status.

Currently, migration is firmly rooted as an important global policy issue of the Twenty-first Century. The ever-increasing international migrants' stock has reached 258 million in 2017 (UN 2018). The same report also revealed that two out of five international migrants (43%) reside in a developing country.

Migration of people and populations is anchored in globalisation, with complex health and well-being consequences for people on the move, the origin, the host communities and for the global community at large. It has been made evident in the literature that, as people move across different geographical space, migration (in whatsoever form, be it internal or international, regular or irregular, documented or undocumented) affects health in

multifaceted ways that are complex in nature (Bhugra, 2004). Eventually, this ends up affecting the way health care is accessed and used especially by the migrants.

It has long been established by Adepoju (2010) that, there is a constant inflow of migrants from other parts of the world into Africa. Adepoju (2010) further revealed that more of the migratory movement of the African population is within the continent rather than outside the region. Some studies have also shown that, though Ghana is traditionally known as a migrant-sending country, in recent times, Ghana is also serving as a transit route for migrants as well as a migrant-receiving country (GLSS, 2010).

According to the 2010 census report in Ghana, there are close to 400,000 migrants living in Ghana (GSS 2014). This is close to 3% of the total population of Ghana similar to the proportion of the international migrant population compared to the world's total population. The Ghana Statistical Service report (2014) also shows that about 60% of the migrant population in Ghana resides in the Greater Accra Region. A study conducted by Quartey (2009), showed that, the Ghana Immigration service issued a total of 32,304 and 35,118 resident permits in 2006 and 2007 respectively. The study further revealed a consistently increasing number of illegal migrants in Ghana.

The study of Yiran et al (2015) has also revealed that factors such as low-income levels, unavailability of health facilities in migrant communities, high cost of health care, long queues and waiting times at formal health care facilities among other factors affect migrants' access and use of health care in Ghana.

Though it is difficult to get updated and accurate data on the migrant population in Ghana, current revelations show that there is a growing community of international migrants in Ghana. Yet, most of the literature on international migrants' access and use of health care is skewed towards and viewed from a global north perspective. The few studies that

addressed issues relating to the health of migrants in the global south were studies done outside Ghana (Buckley 2005; Anarfi 2004; Haour-Knipe and Rector 1996) and only look at how a specific illness (especially HIV/AIDS) affects certain migrant groups neglecting research work on access and use of health care in Ghana in relation to international migration. Little is also known about the access and use of health care of the non-migrant population as well.

This, therefore, has resulted in a gap in the literature, as little is known about international migrants' and non-migrants' access to and use of health care in Ghana. This gap in literature if not unravelled will result in some kind of difficulties in the realisation of a good global health policy especially the Sustainable Development Goal Three. Therefore, in light of the Sustainable Development Goal three, it will be interesting to explore and investigate both international migrants' and non-migrants' access and use of health care from a Global South perspective (Ghana).

## **1.2 Rationale**

Having good health is crucial to the development of every country (Marmot et al 2008; Nussbaum 2003; Bloom and Canning 2000; WHO 2000). This is because health forms the foundation of the human capital development (Bloom and Canning 2000). Any nation with high advancement in other areas like technology, transportation, accommodation and so on, but with a population that is weak and poor in health will in no time start losing the credibility of the advancement in the other areas. This is on the basis that, the human population will depend on good health to be able to enjoy, maintain and build upon the achievements in the other areas of development (Victora et al 2008). But a population's ability to receive and maintain good health is subject to the population's capacity to access and use (Evans et al 1994) the available health care systems that exist within their space.

More so, their satisfaction with the health care system(s) available within their space is of a great importance. And since migrants are a unique component of any population, this study examines the access, use, and satisfaction of healthcare in Ghana based on the migration status of the sampled population in the study.

Findings from the study will not only add to the literature on access and use of health care in Ghana but will also add to the global debate on migration and health. The outcome of this study will also deepen the understanding of the variation(s) that exist among the different populations' (migrants' and non-migrants') access and use of health care in Ghana. In addition, the findings will also provide an essential base for policy on access and use of health care in Ghana. The findings from this study will also provide a solid ground for the evaluation of regional and global health policies in Ghana, more especially the Sustainable Development Goal Three.

### **1.3 Research Questions**

The study seeks answers to the following research questions

- i. How do the international migrants in Ghana view their current health status?  
(The Healthy Immigrants Effect from the view of the migrants)
- ii. Are there differences in the health insurance coverage among migrants and non-migrants in Ghana?
- iii. Is there any difference in access to health care among migrants and non-migrants in Ghana?
- iv. How is the use of health care for migrants and non-migrants in Ghana?
- v. Are there factors that influence access to health care among migrants and non-migrants in Ghana?

- vi. What are the migrants' and non-migrants' evaluation and satisfaction with the health care system in Ghana?

#### **1.4 Objectives**

The study's main aim is to examine the access and use of health care in Ghana in relation to migration status. Below are the specific objectives of the study:

- i. To examine the background characteristics of the study respondents
- ii. To examine health insurance coverage among migrants and non-migrants in Ghana
- iii. To examine access to health care among migrants and non-migrants in Ghana
- iv. To examine the factors that influence access to health care among migrants and non-migrants in Ghana
- v. To examine the use of health care among migrants and non-migrants in Ghana
- vi. To explore migrants' and non-migrants' satisfaction of the health care system in Ghana

#### **1.5 Definitions of Key Terms:**

##### **1.5.1 A Migrant**

International migrants (Immigrants) are referred to in this study as migrants and the words (migrants, immigrants and international migrants) may be used interchangeably. Basically, the study defines a migrant as any person that was not born in Ghana and his or her nationality is also not a Ghanaian and yet has been living in Ghana for at least six months.

### **1.5.2 A Non-Migrant:**

A non-migrant is defined in this study, as any person born in Ghana, and has not changed his/her Nationality to another country. The person must also live in Ghana continuously for at least six months to be qualified for an interview. The word Non-immigrants may be used interchangeably as non-migrants in the study.

### **1.5.3 Access to health care:**

Access to health care is a concept with many dimensions and there is currently no single accepted definition. Some researchers (Harris et al 2011) viewed access to health care as a commodity which can be obtained or not obtained by the interplay between economic powers (Demand and supply). Access to health care was the balance between the demand for and the supply of health care services. The demand for was viewed from the angle of the purchasing power of the individual (Dias, Severo, & Barros 2008).

Other scholars also regarded access to health care as a geographical problem, where the individual in need of health care must overcome a distance to access health care. But this point was argued out by other researchers like Mensah (2007) that, distance is not only physical but can also be socio-cultural. Mensah (2007) argued this point by presenting a hypothetical case of a woman who resides close to a hospital. The woman may not have to overcome the physical burden of distance, but still needs to overcome socio-cultural distance attributed to the ability to cope with the socio-cultural context in which she resides.

Access to health was also viewed by some other scholars as the interplay between agency and structure. Asserting that, access to health care induces agency, meaning, and peoples' ability to freely and independently access health care.

Anchored on the Andersen model and the understanding that, access to health care can be viewed from many dimensions, this study, however, defined access to health care as having a health insurance or health coverage (Domapielle, 2014; Lagomarsino et al 2012). In this study, having a health insurance is not limited to one's registration of a National health insurance scheme (NHIS) provided by the state, but also includes the possession of any private health insurance cover provided by private organisation(s).

A health coverage provided by a workplace or an organisation for an individual and his or her family members is also classified as access to health care. Apart from health insurance provided by the state or insurance companies, if the individual has a health coverage with an institution by virtue of his or her affiliation to that institution, he or she is classified as having access to health care. For example, a student at the University of Ghana has a health coverage with the University of Ghana Hospital by virtue of his or her affiliation as a student of the University of Ghana. Also, the spouse or child of an employee of the University of Ghana may have health coverage with the University of Ghana hospital by virtue of affiliation.

The operational definition of access to health care adopted by this study (Health Insurance and or health coverage by virtue of affiliation) is one that considers the incorporation of both micro and macro factors (Mensah 2007). Macro factors include the availability and provision of health insurance and health coverage by government and private organisations. The micro factor in this definition of access to health care is the individual's acceptance and registration with a health insurance scheme (Private/Public). Having a health insurance cover is viewed by this study as the point where national and local provision of accessing health care meets the individual's acceptance, affordability and preparedness for making use of such provision. This measure of access to health care also,

helps to measure national and local provisions which make room for individuals to access health care with no or minimum financial risk (Nyman 1999).

#### **1.5.4 Use of health care:**

Basically, a person is said to have used health care in Ghana if the person has actually accessed a health facility in Ghana for a check-up, treatment or prevention of an illness or injury. However, in this study, respondents' usual health practice when they are unwell or ill, is used as a measure of health care use.

#### **1.6 Limitation of the study**

A key limitation of this study is that using insurance or health coverage as a measure of access to health care is not an absolute measure of health care financial risk protection or an absolute measure of access to health care. What will happen as a result of this study using such a measure is that the study will underestimate the number of respondents that in actual sense has access to health care 'financially'. This is because those who can afford out of pocket services but are not on any health insurance scheme or covered by any health insurance will be classified by the study as having no access to health care in Ghana. Although they may be able to afford any type of health care at any time.

#### **1.7 Structure of the Study**

The study is divided into nine chapters. Chapter one gives an overview of the background of the study, the problem statement, the justification for the study, the objectives, research questions that the study seeks to answer, definition of key terms, study limitation and the general structure of the study.

Chapter two provides the background-profile of Ghana; this includes the geographical profile of Ghana, the political profile, the economic, demographic, health, and migration

profiles of Ghana. Chapter two also presents the background information of the Greater Accra Region of Ghana, which is serving as the study area.

Chapter three presents a review of current literature about migration and health. The review also included literature on the Healthy immigrants' effect, migration and diseases, access to health care of migrants, migration of health workers in Ghana and an overview of health insurance. Chapter three also includes a review of the theory underpinning the study as well as the conceptual framework that guides the quantitative data analysis of the study.

Chapter four presents the methodological approaches adopted by the study. This chapter discusses the research methods used in the data collection and analysis. Chapter four also discussed, the researcher's positionality, and some challenges encountered in the field of data collection.

The analysed result of the background characteristics of the respondents is presented in chapter five. Chapter Five also presents a deliberation on the Healthy immigrants' effect from the views of the migrants in the study. Chapter Six presents a more rigorous analysis of migrants and non-migrants' Health Insurance status and Access to health care. The relationship between predisposing, enabling, and health care need factors and access to health care are in similar manner discussed in Chapter Six. Chapter Six also discusses the relationship between the migrants' characteristic and access to health care. The binary logistic regression model analysis of the determinants of access to health care among migrants and non-migrants are likewise presented in Chapter Seven.

Chapter Eight presents the analysis of the use, evaluation and satisfaction of health care in Ghana by the migrants and non-migrants. While Chapter Nine presents the summary, recommendations based on the findings from the study and the conclusion of the study.

## CHAPTER TWO

### THE KEY PROFILE OF GHANA AND THE STUDY AREA

#### 2.0 Introduction

This chapter presents a review of relevant background information on the study area, which is Ghana, and specifically the Greater Accra region where most (60%) of the immigrant population reside (GSS, 2014). The background information of the study area is presented through the lenses of migration and health care. Beginning with the geographical profile of Ghana, followed by a brief demographic profile, political profile, and economic profile of Ghana. Since this study focuses on migrants' access to health care in Ghana, it was equally imperative to examine the epidemiology and migration profiles of the nation Ghana in this chapter. The Chapter narrows down to provide a profile overview of the Greater Accra Region in the light of health care.

#### 2.1 Geographical Profile of Ghana

Globally, Ghana can be located just above the equator, within the eastern and western hemisphere. The Greenwich Meridian passes through the main harbour town of Ghana (Tema). The position of Ghana is also to the western coast of Africa, (See Figure 2.1) sandwiched by three French-speaking countries and the Gulf of Guinea (See Figure 2.2), Burkina Faso to the North, Togo to the east, Ivory coast to the west and the Gulf of Guinea to the south.

The total area of Ghana is 239,460 km<sup>2</sup>. Ghana's vegetation is that of coastal, and guinea savanna along the coast and northern parts respectively, and tropical rain forest in the middle belts. There are two main seasons, the raining and the dry seasons in Ghana.

In Ghana, there is an equal number of hours during the day, just as in the night (twelve hours in the day and twelve hours in the night) throughout the year. The average daily temperatures in Ghana, ranging from 30°C (86°F) during the day to 24°C (75°F) at night with a relative humidity between 77 per cent and 85 per cent. However, the northern parts of Ghana can record extreme temperature between 39°C to 41°C during the day. Ghana is currently divided into sixteen regions for political, administrative purposes (See Figure 2.2).

**Figure 2.1: The Location of Ghana on the Globe**



Source: shutterstock.com, retrieved on 13/07/2019

**Figure 2.2: The Map of Ghana showing all 16 Administrative regions**



Source: pulse.com.gh, retrieved on 13/07/2019

## 2.2 Political Profile of Ghana

Before Ghana gained independence from the British Colonial rule in 1957, Ghana was known as the Gold Coast. Ghana had the name Gold coast because of her richness in the mineral Gold (Howard and Howard-Hassmann 1978).

After gaining independence from the British colonial rule, Ghana has had four republic regimes (Gyimah-Boadi 2008). Currently, Ghana's political system operates under a democratic and constitutional rule (Fox et al 2011) with 16 political administrative regions. The political atmosphere in Ghana is considered the most stable within the West African Sub-region and one of the best in the whole of Africa (Boafo-Arthur 2008).

The governance system in Ghana functions under the three arms of government; (i) the Executive, which is made up of the president and the council of state with the president as the head of state and the commander in chief of the Ghana Armed forces, (ii) the Legislative Council (parliament), made up of representative members from about 275 constituencies, (iii) the Judiciary. Constitutionally, the Supreme Court is vested with the powers to rule on the constitutionality of any legislation or executive action at the request of any aggrieved citizen (Uddin and Tsamenyi 2005). The democratic and relatively stable political atmosphere in Ghana has attracted all kinds of migrants from all over the world, especially from neighbouring West African countries.

### **2.3 Economic Profiles**

Ghana is a middle-income country with a relatively stable political system and low crime rate (Engle et al 2011). Ghana is a country rich in diverse natural resources. Precious minerals such as manganese can be found in Nsuta, Bauxite can also be found in places like Awaso, Nyinahini, Kanayiribor and Kibi. Diamond can also be found in Akwatia. Gold, which is one of the foreign exchange-earners in Ghana, can also be found in Tarkwa, Prestea, and Obuasi. These precious minerals are those that attracted the Europeans to Ghana before independence and in modern times also serve as an attraction to migrants from China, India and other parts of the world. Lithium, which is also one of the most expensive minerals in the world and crude oil are recent discoveries in Ghana. These all-

important minerals (Lithium and crude) can be respectively found in the Volta Region and on the high seas along the shores of Ghana (Ascher 1999). Lithium and oil are the two core minerals that attract American and British expatriates to Ghana in recent times.

Agriculture remains the highest contributor (Breisinger et al 2008) to Ghana's Gross Domestic Product (GDP) (20%) and employs more than 50% of Ghana's workforce. Remittances from individual emigrants from Ghana, cocoa and gold exportation are also major contributors of foreign exchange in Ghana (Ablordeppey 2016; Gyimah-Brempong and Asiedu, 2015).

Though reliable energy is a major challenge facing Ghana's economy (Ouedraogo 2013), the economy remains one of the best in the Sub-Saharan African Region (3.6% growth rate). Ghana also appears to be a promising country to make moves in becoming a first world country (Murray 2007). This outstanding economic profile of Ghana makes it an attractive place for people who desire to live and work outside their home countries, yet no attention is paid to the access and use of health care of these individuals.

## **2.4 Demographic profile**

The population of Ghana is growing at a rate of 2.2% with a current total population estimated to be about 29 million in 2017. Though the total fertility rate in Ghana has been relatively stable in recent times, (Gaisie 2013) at about 4 children per woman, the northern regions of Ghana still record high fertility rates (Van der Geest 2011) of about 8 children per woman. However, the Greater Accra Region records the lowest fertility rate of 2 children per woman.

Generally, there is an improvement in the overall mortality rates in Ghana. The infant mortality rate of Ghana fell gradually from 115.62 deaths per thousand live births in 1966 to 43.14 deaths per thousand live births in 2015. The adult mortality rate within the same

year was 32.07 deaths per 100 population. Life expectancy at birth has likewise recorded some noticeable improvement in recent times, as it has increased to 63.03 in 2017 compared to 62.45 in 2015 (see [https://knoema.com/atlas/Ghana/topics/](https://knoema.com/atlas/Ghana/topics/Demographics) Demographics).

The age structure of Ghana is mainly youthful with about 57 per cent of the population under age 60 years. The total fertility rate in Ghana is 4 children per woman with the dependency ratio of about 30.5/1000 population. The literacy rate in Ghana is 76.6 percent for people 15 years and above and the main language spoken apart from the official English language is Twi.

## **2.5 Health Profile of Ghana**

### **2.5.1 Ghana's Disease Burden**

Most scholars argue that the exact position of Ghana on both the demographic and epidemiological transition is not so clear (Mason 2005). However, evidence has long been established that, Ghana is experiencing both demographic (White et al 2005) and epidemiological (Agyei-Mensah and de-Graft Aikins 2010) transitions. The epidemiological experience is such that Ghana is living with both chronic non-communicable and infectious diseases at the same time (de-Graft Akins 2007).

Lifestyle diseases like type 2 diabetes, hypertension, breast and prostate cancer among others, are on the increase (Bosu 2012). Not only that, the incidence of malaria (per 1,000 population at risk) in Ghana was reported at 266 in 2015 (WHO 2016). Infectious diseases like cholera and diarrhoea are still a burden to the health sector in Ghana, with women and children being the most affected (WHO 2010).

### **2.5.2 Mortality in Ghana**

Though the infant mortality rate in Ghana was 43.14 deaths per thousand live births (WHO 2016), however, in 2015, the general life expectancy has gone up beyond 60 years for both

men and women. According to the Ghana Statistical Service, neonatal mortality for 2016 was 25 deaths per 1,000 live births and post neonatal mortality was 12 deaths per 1,000 live births (GSS 2017).

### **2.5.3 System of health care Delivery**

The biomedical health care system in Ghana is made up of the private and public healthcare system (Mills et al 2012). The Government of Ghana is the sole owner of the public biomedical systems which is managed by the Ministry of Health and the Ghana Health Service.

The public biomedical healthcare system has five points of providers: (i) Health posts – which are first-level primary care for rural areas: (ii) Health Centres and Clinics, (iii) District Hospitals, (iv) Regional Hospitals and (v) Tertiary Hospitals.

In general, the health care system in Ghana has experienced significant improvement; many policies have been put in place to improve health care in Ghana to one that is desirable and satisfactory. The Government of Ghana has put in measures to overcome the health challenges in the country by improving the health care facilities and human resources available.

To improve the biomedical health care system in Ghana, the government has also taken measures to improve upon the health care infrastructure. The Government of Ghana introduced a national health insurance scheme in 2003 to bridge the access gap between the poor and the rich. The nationwide health insurance scheme is accepted by all public health facilities and some private health facilities. The operations of private mutual and commercial health insurance are also permitted under the health care system in Ghana. In 2003, the Government of Ghana again introduced a policy to make maternal and neonatal

carefree, for women. The aim of this policy was to improve the health care access of women to reduce maternal and neonatal deaths (Witter et al 2007).

In spite of all the efforts by the Government of Ghana and all the other supporting agencies in Ghana to improve access to health care, the sector still has challenges as the doctor to patient ratio is 1:10,452 with the nurse to patient ratio being 1: 1,025. Some studies have shown that the formal/biomedical health care system in Ghana has challenges. According to Schieber et al (2012), the health care system in Ghana is weak from three broad perspectives: (i) Governance management and organisation (ii) delivery system, pharmaceutical and public health (iii) financing. The study also found a weakness in the health management information system. Poor coordination exists within the various regulatory agencies resulting in higher sales of substandard pharmaceutical drugs.

Nonetheless, people in Ghana basically do not only seek for health and cure within the biomedical health care system, but also from the traditional herbal health care, the contemporary herbal health care service (under the watch of the Manpong Centre for Research into Plant Medicine), faith healers such as shrine priests, Islamic Diviners and charismatic Pentecostal church leaders (de-Graft Aikins and Koram 2017). Ghanaians also seek cure and health from other areas such as naturopathy, homoeopathy, and osteopathy (Dako-Gyake et al 2013; Ngom et al 2003; Awusabo-Asare and Anarfi 1997). Based on empirical accounts, for which of these health care services will be used, by anyone with a condition depends on different factors (Donkor and Sandall 2007). The perceived cause of illness, the cost of treatment, the nature of the illness (chronic or infectious, Terminal or nonterminal), the agency for a cure among others will determine whether a person will seek treatment from the biomedical services or not. For most of the chronic illnesses, diagnoses are first done at the hospitals, but the search for a cure is done through all the health systems available depending on the individual's knowledge of the cost of treatment

within the biomedical system and his/her ability to afford, as well as his or her knowledge of the cause of illness. For instance, an individual that thinks that his/her chronic illness is spiritually caused by enemies (Badasu et al Unpublished) or sin will seek treatment from faith healers or traditional herbal healers, probably in addition to biomedical treatment. Someone may also have empirical evidenced base knowledge of the cause of his/her illness, but will resort to seeking a cure from other areas other than the biomedical system if he/she cannot afford the biomedical treatment or in desperate need for a cure. What is unknown is the difference that exists between migrants and non-migrants in terms of their access to and use of health care in Ghana. And this is what this study in a way seeks to address.

## **2.6 Migration Profile of Ghana**

International migration in Ghana has been more of emigration in the early 1990s (Anarfi et al 2003). Around that time, Ghanaians generally migrated to other regions within Africa, though few emigrated to places like the United Kingdom outside Africa. Currently, Ghanaians can be found in more than thirty-three countries in the world. The emigration profile of Ghana is such that, the majority of Ghanaian emigrants return to Ghana (IOM 2009).

In spite of the fact that the net migration of Ghana reveals more of emigration, evidence has also shown that Ghana is also a migrant-receiving country. Ghana has experienced an increase in the influx of migrants in recent times. The majority (68.3%) of these migrants are from other countries of the Economic Community of West African States (ECOWAS) as labour migrants (GSS 2014). Since the return to constitutional rule in 1992, and the fast-growing economy after the 2000s, Ghana has once again become attractive to international migrants and students from neighbouring West African states, other parts of Africa, Asia and Western Europe (GSS, 2013; IOM, 2009). The migrants in Ghana

comprise students, commercial migrants, economic migrants, labour migrants, tourists, and visitors, as well as refugees and asylum seekers.

According to the 2000 population and housing census report, there were 740,191 migrants in Ghana (GSS 2005). A study by Anarfi (2007) showed that, the migrant stock of Ghana was 614,000 in 2006. The 2010 census report also showed that 398,585 people were living in Ghana as migrants. A study conducted by Quartey (2009), showed that the Ghana Immigration Service issued a total of 32,304 and 35,118 resident permits in 2006 and 2007 respectively.

Though the net migration in Ghana is characterised by emigration and the recorded migrant population reduced since the early 2000s, it is still wealth studying. This is because the migrant population in Ghana per the latest census in 2010 report, is close to 400,000 (GSS 2014). And this is close to 3% of the total population in Ghana similar to the percentage of international migrant stock when compared to the world's population. Three basic factors accounted for the reduction in the recorded migrant stock of Ghana. The first is, the lack of proper migration data in Ghana. In reality, there are more non-Ghanaian nationals in Ghana than the records can show. The second factor accounting for the reduction in the recorded Ghanaian immigrant stock is the increasing number of the illegal immigrant population. The study of Quartey (2009) revealed that, 1,035; 7,922; and 19,082 illegal migrants were identified and deported by the Ghana Immigration Service in 2001; 2004 and 2009, respectively. The third factor accounting for the reduction in the recorded number of migrants in Ghana is the voluntary returning of some refugees to their home countries. The West African Sub-Region has experienced relative peace in the 21st century as compared to the late 20th century. The recent relative peace in these countries has resulted in a reduction in the number of people that are forced to move to Ghana as refugees and asylum seekers.

In the latter part of the 20th century, Ghana received new categories of migrants, namely, refugees and asylum seekers from Togo, Liberia, Sierra Leone, Sudan, the Democratic Republic of Congo, Angola, and Ivory Coast, due to repressive political regimes, wars and conflicts in these countries (Essuman-Johnson, 2011). In 1993 there were about 150,000 refugees and migrants seeking asylum in Ghana (Anarfi et al 2003). This Figure reduced to 34,950 in 2007 and further reduced to 18,000 in 2008. As mentioned earlier, more refugees returned to their countries of origin as a result of the relative peace in the sub-region. Between 2008 and 2009, 7,500 Liberian refugees were repatriated from Ghana, based on the refugees' own self-will to return to their home country. About 3,500 Togolese were also repatriated in 2007 (Quartey 2008).

In the quest to understand migration issues and formulate proper policies regarding the subject, the Centre for Migration Studies was established in 2006, in the University of Ghana. The Centre was mandated to undertake research, teach, train, build capacity, assess policy development and dissemination in the area of migration research. The Centre for Migration Studies played a key role in the development of the migration policy of Ghana.

In April 2015, Ghana launched a National Migration Policy (the first in the ECOWAS Region) to help manage its migration related issues within the context of national development as well as sub-regional, regional and global interests (MFARI, 2016). The policy addresses different types of migration issues. It includes issues on migration within, into and out of Ghana.

The policy also addresses crosscutting issues such as migration and health, migration and security, migration and development among others. The link between migration and health concentrated heavily on addressing the health challenges that the nation can be exposed to

as a result of immigration, with little consideration of the health challenges faced by immigrants found within the boundaries of the country.

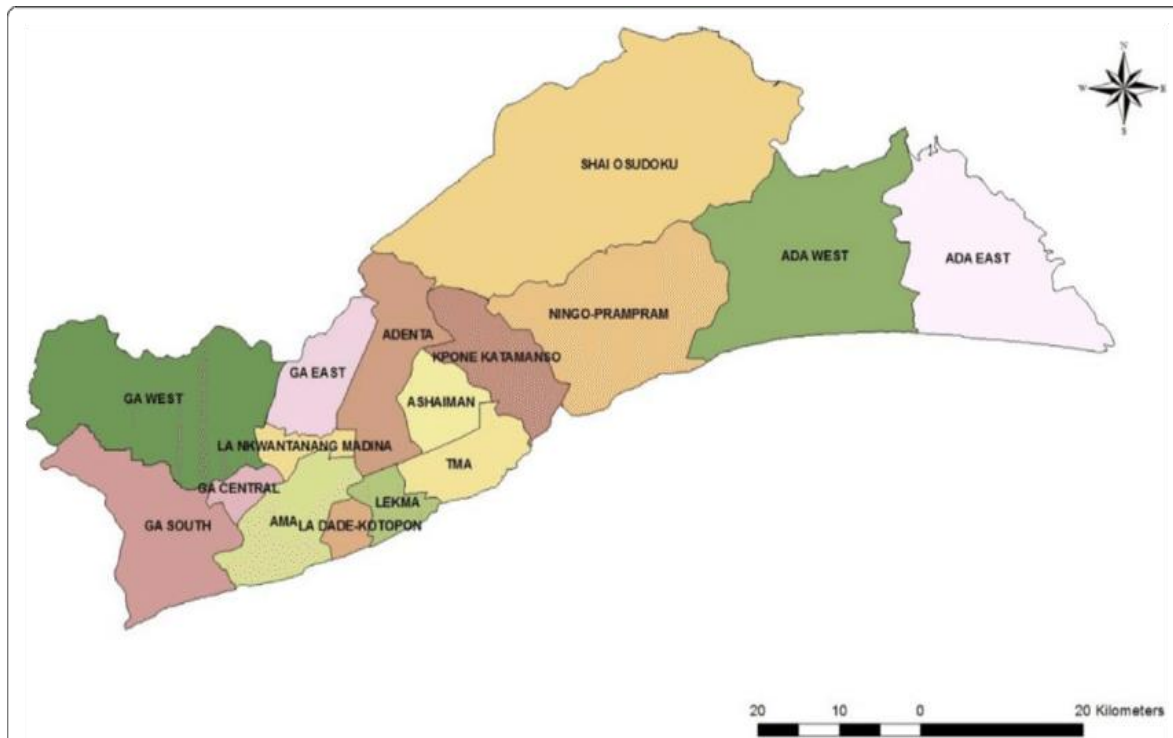
## **2.7 The Greater Accra Region of Ghana**

The Greater Accra Region is Ghana's smallest region in terms of land size (See Figure 2.2). It lies in the South East of the country along the Gulf of Guinea and has coastal savannah, a little forest area inland towards the Eastern Region in the Ga-West District, and miles of beautiful coastline especially in the rural parts of the region.

The capital town of this region also serves as the administrative and political capital of Ghana. Though Accra is small in terms of land size, it is the largest city in Ghana. The Greater Accra Region is the most rapidly urbanizing region in the country. Its rapid urbanisation started in the early 1980s. Most (60%) migrants from other countries in Ghana usually reside in the Greater Accra Region (GSS 2014).

Accra also harbours a greater share of the health care work as well as health facilities. Accra Metro, Adenta Municipality, Ashaiman Municipality, Dangme West District, Lejokuku-Krowor Municipality, Tema Municipality, Ga East, West and South District serve as the administrative sub-health districts in the Greater Accra (Greater Accra Region Annual Report, 2008; see Figure 2.3). A study conducted by Obuobi et al (1999) showed that about 55% of private-sector health care providers are found in the Greater Accra Region. With the private pharmaceutical sector consisting of retail pharmacies, wholesale pharmacies, and combined retail and wholesale pharmacies. Granting the study of Obuobi et al (1999), pharmacies served as the foremost point of call between the public and the healthcare team. Most people in the Greater Accra Region engage in self-medication and self-care

**Figure 2.3: The map of the Greater Accra Region of Ghana showing Sub-districts.**



Source: Researchgate.net,, retrieved on 13/07/2019

## 2.8 Summary

Summarizing, the chapter notes key profiles of Ghana and an overview of the Greater Accra in the light of migration and health care. Geographically, Ghana can be located just above the equator, within the eastern and western hemisphere, with a population growing at the rate of 2.2%. Ghana is relatively stable politically and economically as compared to other countries in the Sub-Saharan Region and has a relatively low crime rate. Ghana is the first country in West Africa to launch a National Migration Policy.

Currently, Ghana is not only seen as a migrant-sending country, but also a migrant-receiving country with the majority of the immigrants in Ghana coming from the ECOWAS Sub-Region. Generally, the health care system in Ghana has experienced significant improvement, yet with a greater percentage of Ghana's health care workforce

and facilities concentrated in the Greater Accra. The economic and political stability coupled with the relatively low crime rate in Ghana has attracted all kinds of migrant (documented, undocumented, economic migrants, refugees, migrants in transit, tourists and many more) to settle in Ghana, making Ghana a migrant receiving country.

## CHAPTER THREE

### LITERATURE REVIEW AND THEORETICAL UNDERPINNING OF THE STUDY

#### 3.1 Introduction

This chapter presents a review of the literature and the theoretical concept underpinning the study. The first part of the chapter reviewed the literature; starting with the literature on the “Healthy Immigrants’ Effect” followed by the literature on “migration and diseases”. Literature around “migration and mental health”, “migration and access to health care” and “health workers and migration in Ghana” were also reviewed. An overview of health insurance too is presented in this chapter. This was done because health insurance and health coverage provided by workplaces and institutions were used as a measure of access to health care in this study. The section also presented a pictorial summary of the migration and health literature in the form of a flowchart (Figure 3.1). The flowchart summarised the migration and health literature under three broad headings which includes the area of study or subtopics under the migration and health literature. The other two headings are the methodological approach in terms of the study population commonly found in the literature and the key findings that emerges from the literature.

The second part of this chapter concentrates on the theory adapted by the study. The Andersen theory is reviewed in this chapter. How Andersen’s theory was applied globally, regionally (Africa) and locally (Ghana) by other studies is also considered in the chapter. The section on the theoretical underpinning the study was ended with a diagrammatic representation of the Andersen’s Health Utilisation Model. The second part of the chapter also contains the conceptual framework of the study, which is based on Andersen’s model and the literature reviewed.

### **3.2 The Healthy Immigrants' Effect**

Some studies have shown that newly arrived immigrants in the destination areas have healthier health status, compared to the native-born population (Lu et al 2017; McDonald and Kennedy 2004). However, as the immigrants spend time in the destination countries, they end up engaging in unhealthy practices and live a stressful life. In the short term the health status of the immigrants and that of the native population attains an equilibrium, but in the long term, the health status of the immigrants worsens. This notion is termed the “Healthy Immigrants’ Effect” (HIE). The “healthy immigrants” effect is attributed to the fact that potential migrants normally practice healthy behaviours prior to their migration to the host nation(s); the host countries also discriminate against migrants by screening out and making rules that prevent physically weak and feeble migrants from entering. In addition to the above, migration in itself is selective in the sense that, in most cases, individuals in good physical shape and the affluent do migrate as compared to the scrawny and less wealthy.

Most of the studies about the “Healthy Immigrant’ Effect” were at first carried out in the United States and Canada. McDonald and Kennedy (2004) found that there is a strong evidence of the existence of the “Healthy Immigrant’ Effect” in the incidence of chronic conditions for migrants to Canada, but the evidence of the “Healthy Immigrant’ Effect” was weak for the self-reported health status of the migrants. Migrant adolescents or teenagers were also found to have better health than their counterpart non-migrant adolescents in Canada according to Kwak (2016). The findings from Domnich et al (2012) revealed that, though most studies suggest a better health for newly arrived immigrants, the “Healthy Immigrant’ Effect” is not evident among refugees due to the poor living conditions that exist in refugee camps.

The results from Lu et al (2017) showed that the selective effect of the “Healthy Immigrants’ Effect” is not the same for different destination areas. According to their findings, the newly arrived immigrants to Canada are less likely to be overweight, less likely to be obese, and are unlikely to be living with any chronic non-communicable disease as compared to their colleagues (non-migrants) in the United States.

When the health behaviours, health outcomes and socioeconomic characteristics of migrants were examined for explaining migrants’ self-selection and adaptation of healthy behaviour by migrants, Kennedy et al (2006) found that there existed strong evidence of positive selection effect for all the areas under study. Ginsburg et al (2016) applied the “Healthy Immigrants’ Effect” to the study of internal migration in West Africa, East Africa and South Africa regions and found that migration was an important variable in explaining the variation in mortality.

But, in contrast to the traditional notion of the “Healthy Immigrants’ Effect”, Constant et al (2015) found that immigrants to Israel, arrive with poorer health status as compared to their counterpart native population and get their health improved as their (migrants) period of stay in Israel increases. These may be attributed to the relatively better health system that exists in Israel, which is also relatively easily accessible to migrants. Most migrants arrive in Israel in search of better medical care, and as their length of stay in Israel increases, their health status advances. This is quite contradictory to the traditional view of the “Healthy Immigrants’ Effect”.

However, what is lacking in most of the studies related to the “Healthy Immigrants’ Effect” is that the theory is not tested from the point of view of the immigrants themselves. What some of the studies did was to use data on the health status of the migrants and the native population under study. Some other studies also used the self-reported health

conditions or status of the migrants. But the views of the migrants on their health status in the light of the “Healthy Immigrants’ Effect” has been left out from the literature. Whatever the state of the notion of the “Healthy Immigrants’ Effect”, it will be interesting to know what migrants think about their health in relation to their migration status. This is because, the theory may assume that, the health status of migrants is affected or not affected by their time of stay in the destination areas but the migrants themselves may think otherwise. This aspect of verifying the theory is missing in the literature on the “Healthy Immigrants’ Effect”.

### **3.2.1 Migration and Disease infection**

A great amount of the literature pointed out that, migration and the spread of infectious diseases are linked (IOM 2020). The spread of global health crises and pandemics like Ebola and the Novel Corona Virus 2019 (VONVID 19) was majorly fuelled by factors rooted in migration and human mobility (IOM 2020).

The literature also points out that, migration does influence health outcomes, especially of the individual undertaking the migratory event. For instance, according to the IOM’s (International Organization for Migration) 2012 to 2017 health promotion strategy for East and Southern Africa, migration affects health at different levels. According to the report, migration is a contributing factor to the high prevalence of communicable and infectious diseases in the Eastern and Southern African regions.

Prior to that, some studies conducted by Martens and Hall (2000) pointed out that, the different forms of population mobility are a major contributing factor that could increase malaria risk in the developing regions and account for the re-emergence of the disease. According to Martens and Hall (2000), the vector responsible for the transmission of

malaria can be introduced in another country which initially had no such disease by means of an international flight.

A sizable amount of the literature on migration and disease infection has also shown an irrefutable link between HIV/AIDS and migration. For instance, Lagarde et al (2003) revealed that internal migration is responsible for the spread of HIV from urban to rural West Africa. According to the study, sub-Saharan Africa received the world's hardest hit by HIV/AIDS as a result of the risky sexual behaviours exhibited by the region's youthful mobile population. The study further revealed that short-term migration was associated with a higher frequency of risky sexual behaviours such as having a casual sexual partner or partners in origin and having more than one sexual partner in the destination area.

According to Anarfi (2004), vulnerable Ghanaian women who used migration to Ivory Coast as a coping strategy had no choice but to return to Ghana after testing positive to HIV/AIDS. According to the study, these vulnerable women, upon contracting the deadly HIV disease, are forced to return home unprepared.

Buckley (2005) also found that HIV/AIDS does not only affect the migrants who contracted the disease in their migratory event, but also disturbs the lives of their "significant others". Women who are wives of migrant men who contract HIV/AIDS in their migratory event are sometimes infected with the virus by their migrant husbands. Even when the wives of the affected migrants are not infected by the disease, they are suddenly pushed into decision making roles as their husbands get terminally ill or as they are killed the disease. This new role taken by the women in most cases puts a lot of stress on these women (Buckly 2005).

Some studies have also shown that migrant workers together with their sexual partners have higher levels of HIV/AIDS infections than the general population with border towns

having the highest rate of infection (Crush et al 2007; Crush 1999). According to these studies, roaming buyers and sellers, and long-distance truck drivers have shown to be at higher risk to contract HIV infection

### **3.2.2 Migration and mental health**

Studies have suggested that the link between human mobility and the mental health status of people is multifaceted. According to Clark and Hall (2011), migrants are exposed to difficult conditions such as discrimination, financial crisis, human rights abuse and many others (Clark and Hall 2011). All these unpleasant encounters in the destination areas have the potential of affecting the psychosocial and mental health status of migrants.

The literature has largely demonstrated that migration in most cases is hazardous to mental health (Pernice et al, 2000). According to the World Health Organization (2001), contrary to the expectation of migrants and their families, migration in most cases does not bring enhanced well-being. Rather, migration often results in making migrants to lose conscious of their health thereby compromising it. The migrants compromise their health by living unhealthy lifestyles which expose them to poor mental health conditions. According to the World Health Organisation (2001), the unpleasant psychological, mental experiences that migrants undergo forfeits the assumed gains of migration.

Specifically, the study of Ödegaard (1932), found higher hospital admission rates for schizophrenia among Norwegians who had migrated to the United States than those who stayed in Norway. Smith et al (2003) also found in their study that, there existed worsened mental health problems among the migrant adolescents compared to the natives in their study. The difference was much higher when compared with the migrants' descendants born in the destination areas (Nakash 2012).

According to Virupaksha et al (2014), internal migrant children in Turkey encounter serious problems in their new schools. These migrant children are faced with difficulties such as discrimination, problem adjusting to the new system, language barrier among others. These experiences encountered by the migrants impact their lives negatively. This resulted in the migrant children having poor attendance and academic performance compared to the local children. When compared, the health status and lifestyle of the older population of Thailand, the older people who had at least one their children migrated from the family had very poor physical and mental health status compared to those that had none of their children migrating. The poor physical and mental health conditions exhibited the older people with at least one child migrating include exposure to chronic diseases, poorer perceived health status and very poor health-seeking behaviour and accessing services (Adhikari et al 2011).

For researchers like Carta et al (2007) migration affects mental health. Carta et al. 2007 noted that emigration involves more than changes in climate, language, culture, status, and social relations. Every migrant who migrates experiences effective loss with the possibility of depression arising from this loss.

Other studies, though, did not explicitly dispute the existence of a relationship between migration and mental health, have argued that, the relationship can rather be positive for migrants. For instance, Bhugra (2004) argued that the origin of depression can often lie in a sense of snare and defeat. Persons who feel entrapped by limited job and social opportunities in their home countries may, therefore, emerge out of depression when new opportunities open through migration. The net effect, in the long run, is a realistic matter, demanding attentive reflexion to self-selection.

In addition, some studies have also shown that migration has a number of effects that may heighten mental health. Though there is limited evidence from the Global South (Das et al, 2007), the debate is centred around the claim that, migrants may experience an unfathomable sense of accomplishment in the short-term by remitting their new-found prosperity to their family members, place of origin and religious bodies at home (Foliaki, 1998). Migrants may also have their mental health status enhanced based on a change in environment, which allows them to overcome the weight of social limitations that caused them not to live to their full potential of happiness in their countries of origin.

For Stillman et al (2009) migration is found to lead to improvements in mental health, particularly for women and those with poor mental health. Stillman et al (2009) in their study revealed that, Tongans who successfully migrated to New Zealand had a better mental health status than whose migration attempts were not successful.

However, other studies as Bhugra (2004) also revealed that the link between migration and mental health is vague with studying the common mental illnesses such as anxiety and depression. This claim is based on the fact that, some studies have found a higher incidence of depression and anxiety among migrant groups than among natives, while the opposite is also through in other studies as well. Mixed results were found among migrants to New Zealand. The mental condition of Pacific Island migrants in New Zealand was as low as that of Southeast Asian refugees and significantly lower than that of British migrants (Pernice and Brook 1994). What is unclear about these findings are the socio-demographic characteristics of the study participants. More would have been revealed if qualitative interviews were conducted to unearth some other reasons for the low mental performance among the migrants. Also, Graves and Graves (1985) found that Pacific Islanders have significantly fewer psychosomatic symptoms of health problems than European New Zealanders.

Notwithstanding the limited nature of the literature on the mental health of migrants, the existing literature has revealed that migration can both positively and negatively affect the mental health of migrants. Many a times, the negative effects of migration on mental health may be due to lack of preparedness, difficulties in adjusting to the new environment, the complexity of the local system, language difficulties, cultural disparities and adverse experiences. There existed a few works of literature which also point to conflicting results of the effect of migration on mental health.

What is unclear in some literature is the background characteristics of the different migrant groups and their mental health status. Most of the literature concentrated on quantitative analysis of the mental health of migrants. It would have been interesting to have a mixed-method analysis of migrants' mental health, to unearth some issues about migrants' mental health.

### **3.2.3 Access and use of health care among migrants**

Based on a review conducted by Biswas et al (2012), undocumented migrants across Europe have different treatment for access and use of health care. The study revealed that health care is more acknowledged in some countries like the Netherlands, while health care is more restricted for undocumented migrants in Denmark and Sweden.

The study of Zihindula et al (2015) also revealed that, though there existed the recognition of the right of all forced migrants (refugees) to access health care, the actual access and use of health care services by refugees remains a challenge. Affordability of drugs and acceptability of the forced migrants by the community and health care workers served as a key hindrance to accessing health care by the refugees across the region.

One can be tempted to assume that, because Europe happens to be one of the developed regions in the world, migrants who find themselves in this region of the world are safe

with regard to their access to health care. This erroneous assumption can be based on the fact that European countries have very effective and efficient health care delivery systems. On the contrary, Dias et al (2008) showed that, among their study participants, 3.6 per cent stated not knowing where to go if faced with a health problem. Approximately 20 per cent of the respondents reported that they had never used the National Health Service. Among the participants that ever used the health services, 22.4 per cent reported they were unsatisfied or very unsatisfied with its use. The use of health services was in like manner found to be significantly associated with length of stay and country of origin among migrant women.

A different study conducted in Thailand also shows that there is a difference in the Health care use and satisfaction between the native-born population of the Thailand-Myanmar border and the foreign-born population of the area.

#### **3.2.4 Health workers and migration in Ghana**

A notable part of Ghana's health care system is the migration of Ghanaian trained health professionals to developed countries in Europe and the United States. This was called the brain drain of the nation's health labour force. Studies have shown that the phenomenon cuts across gender and can be found among both nurses and doctors. A study conducted in the 1990s (Dovlo 1998) examined the movement of the health workers from the angle of health sector reform and deployment, and on training and motivation of human resources.

Another study in the early 2000s (Dovlo and Nyanator 2001) also examined the migration of the University of Ghana medical school graduates to advanced nations. The exodus of these health professionals in their numbers has negatively affected health care delivery in Ghana. Some scholars termed this as a brain drain on the economy of Ghana (Kissick 2012), though scholars, mainly from the advanced nations are of the view that it can lead

to brain gain in the long term. The factors associated with this phenomenon vary from low wages, low remunerations, inadequate opportunity to upgrade and poor replacement policy for equipment (Anarfi; Quartey and Agyei 2010).

In a more recent study conducted by Boafo (2016), a higher percentage (48.9%) of Ghanaian nurses have the intention to migrate out of the country. The study found that workplace violence is a key determinant of nurses' intention to migrate.

A study conducted by Teye; Setrana and Acheampong (2015) revealed that, in spite of policies put in place by the Government of Ghana to discourage trained health professionals from moving out, a greater percentage of doctors (60%) and nurses (28%) still have the intention to migrate. The study attributed the inability of the respondents to migrate to strict immigration rules adopted by the destination countries.

The Government of Ghana, through its Ministry of Health and Health Service, consistently has put in measures to retain Ghana's trained health professionals. The situation is currently better than what pertained in the early 1990s, though the sector still has challenges.

However, the health care workers that migrate out of Ghana do not migrate for a lifetime, but have the intention of returning to the country, and in most cases, they return to settle in Ghana. The study of Adzei and Sakyi (2014) also affirms that, health care workers and professionals who migrated out of Ghana mostly return to Ghana. According to the authors, pull factors serve as necessary conditions for the returning of these professionals. In addition, there are other factors such as; social and financial benefits to the home country, achieving goals for travelling, skill improvement and spousal consideration that serve as sufficient conditions for the return of the health care workers and professionals to Ghana.

The emigrant health workers in the diaspora and those that return to Ghana, most of the time, enhanced their skills while living abroad. These individuals return home and contribute to the health sector in Ghana, with the skills gained abroad and sometime also contributing financially to the health sector development (Newland and Plaza 2013). These contributions enhance the health sector in Ghana, which makes it one of the attractive ones in the West African sub-region.

### **3.2.5 Health Insurance**

Insurance is a contract by which a state or a company called the insurer, undertakes to provide compensation for specified loss, damage, illness to a party called the insured upon the payment of a specific premium (Roth and Kunreuther 1998). While insurance is normally a contract of indemnity, that is, restoring an individual to his former state, health insurance is mainly undertaken to cover medical expenses (Donaldson and Gerard 1993) of the insured and often paid directly to the health care service provider. Health insurance is observed as a means by which individuals cope with the financial burden of illnesses and diseases to make health care accessible and affordable.

Health insurance could be provided by a private company or by the government, which usually have nationwide coverage. Some insurance covers transcend national boundaries and are international. The international health insurances are normally used by expatriates and transnational migrants (Schoen et al 2000). Some countries in Europe and America have a mandatory health insurance coverage system which includes migrants.

In Germany, for instance, the refugees Health Care System takes place in the form of a statutory examination to exclude infectious diseases. Also, health insurance cards have been issued to refugees. This card allows refugees to get more of the one hour a week of medical consultation in the municipal emergency accommodations. This provides an

opportunity for low threshold access to primary care and a bridging function to the integration into the regular health care system.

In recent times, many African countries have incorporated in their health care systems the provision of health insurance for their citizens. The motivation behind these moves is to eventually move towards the adaptation of universal health coverage. This is done for National Health Insurance to be incorporated into the national health agenda of the various countries. The impact of the national health insurance scheme in Africa has been of a great intervention concerning access to health care, but some countries still face challenges in the implementation, management and sustainability of national provision of health coverage (Jehu-Appiah et al 2011)

The Government of Ghana since the early 1950s has used national health insurance schemes as a means of ensuring equitable access to health care in Ghana (Jehu-Appiah et al 2011). Different successive governments have introduced different health insurance schemes in Ghana, intending to improve access to health care and ensure equity in access and use of health care.

The first president of Ghana (President Kwame Nkrumah) after independence introduced a system of free health care. This type of health insurance was only accessible in public health facilities. This system of health care insurance was terminated after the overthrow of President Nkrumah. After this period, Ghanaians were made to pay some fee for health services provided in a public health facility. The fee-free nature of the Ghanaian health insurance system continued to dwindle until the 1980s and 1990 where the cash and carry system came into operation.

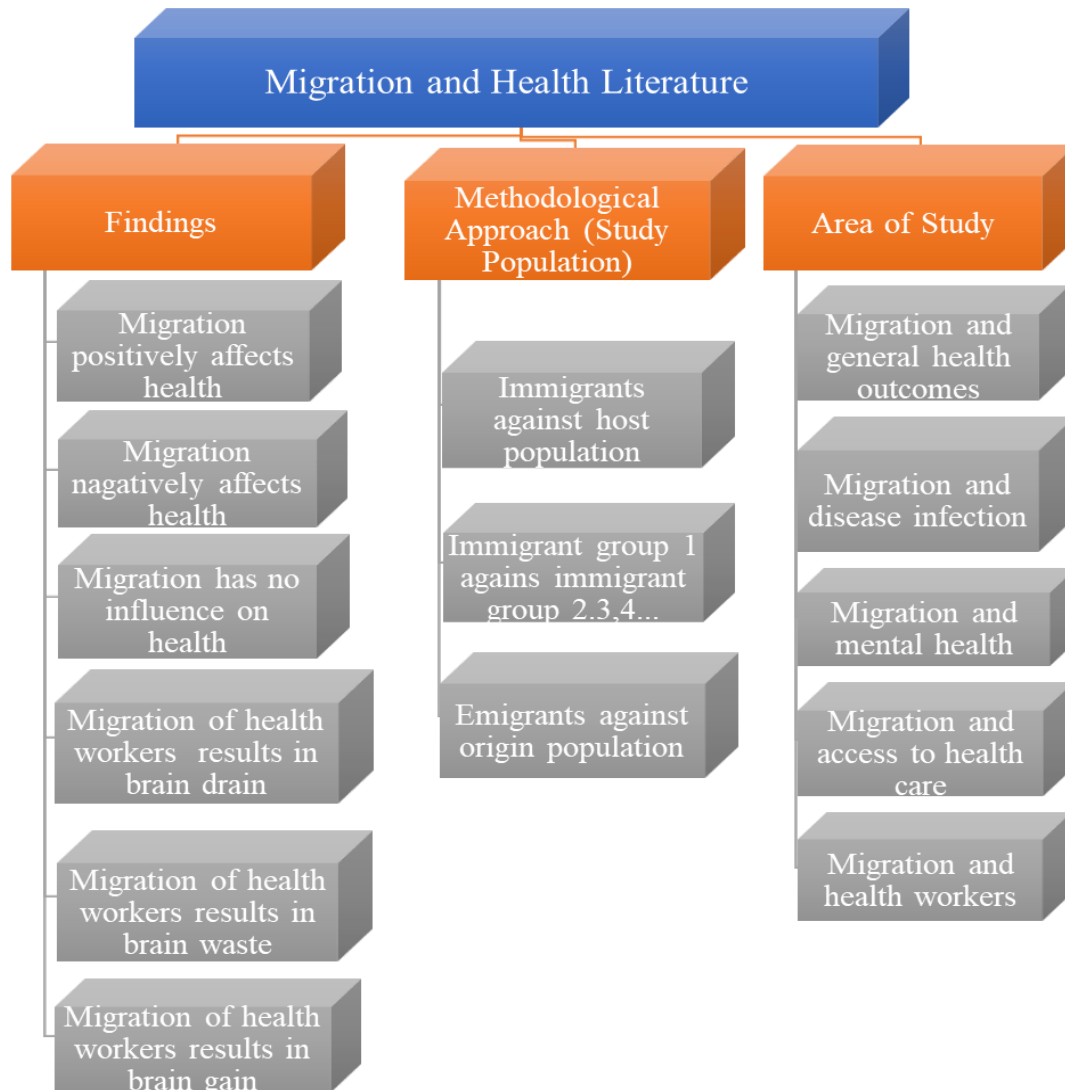
In 2003 the Government of Ghana introduced the National Health Insurance into the Ghanaian health care system. The aim was to push Ghana back onto the track of universal

health coverage and also to provide acceptable care to the poor in society (Witter et al 2007). Notwithstanding, the National Health Insurance Scheme is faced with challenges. The introduction of the National Health Insurance Scheme in Ghana was to support the poor, but the Government of Ghana, lacks the necessary resources to make the provision of Health care for the poor completely free (Gajate Garrido and Owusu 2013). Most of the challenges faced by the National Health Insurance Scheme of Ghana has been challenges faced by the National Health Insurance Authority. The National Health Insurance Authority has been charged by the government with the mandate of oversight responsibility for the success of the scheme (Addae Koranche 2013). The National Health Insurance Authority also has the mandate to regulate the activities of private health insurance schemes as well.

Antwi, Zhao and Koranteng (2014) found that there exist gender inequalities in claims of the Ghana National Health Insurance. According to Antwi, Zhao and Koranteng (2014), younger men prefer to go to the hospital for treatment compared to older men. But among the women, it is those with basic education that choose to use hospital than those with higher education.

Currently, there are different types of health insurance schemes in Ghana. The National Health Insurance (NHIS) together with other private health insurance schemes are in operations in Ghana (Otoo et al 2014). Individuals in Ghana, have the freedom to choose which insurance scheme they prefer to be on. The private health insurance schemes in Ghana include health insurance provided by insurance companies as well as the rising trend of health insurance provided by telecommunication operation companies. Examples of health insurance covers provided by telecommunication companies include Airtel-Tigo insurance and AYO-MTN health insurance.

**Figure 3.1: Flowchart of the Literature**



**Source: Author's Construct; June 2017**

### 3.3 The Theoretical Underpinning of the study

Generally, theorising access and use of health care can be complex (Mensah 2007). This is because, access and use of health care cannot be seen as a direct product of economic rationality or geographical integration of distance as posed by some scholars like Harris et al (2011). As argued by Mensah (2007), accessing health care can be broader than just

micro or macro factors. One cannot limit access and use of health care to only economic variables, nor geographical variables.

With this observation in mind, the study adapted Andersen's model (1973) of access and use of health care. The Andersen's model is a conceptual framework developed in 1968 with the aim of revealing factors and variables that influence one's use or access to health care. The framework is basically a behavioural model that provides a measure of accessing health care (Andersen 1968). According to Andersen's model, health care access and use are basically influenced by three major factors. The factors are predisposing factors, enabling factors and need factors.

The predisposing factors, according to the model are firstly, socio-demographic and cultural factors such as age, sex, the individual's education, marital status, occupation, ethnicity, social network, social interaction and culture and secondly, health beliefs of the individual which include, his/her values, attitudes and knowledge about health care.

The enabling factors have to do with the logistics aspect of obtaining care. This can be at the personal or family level, which can be in the form of the income of the individual, health insurance, source of income, travel, the extent and quality of social relationships. The enabling factors, according to the model can also be at the community level in the form of, availability of health personnel and facility and waiting time. Other additional factors such as genetics and psychological factors also act as enabling factors that influence health care access and use.

According to the model, the need factors are those factors that serve as functional and health problems that create the need to access or use health care. This includes the individuals perceived or evaluation of the need to access or use health care (Andersen

1995). However, some studies have indicated that the best measure for this factor is to use the variable “perceived need”.

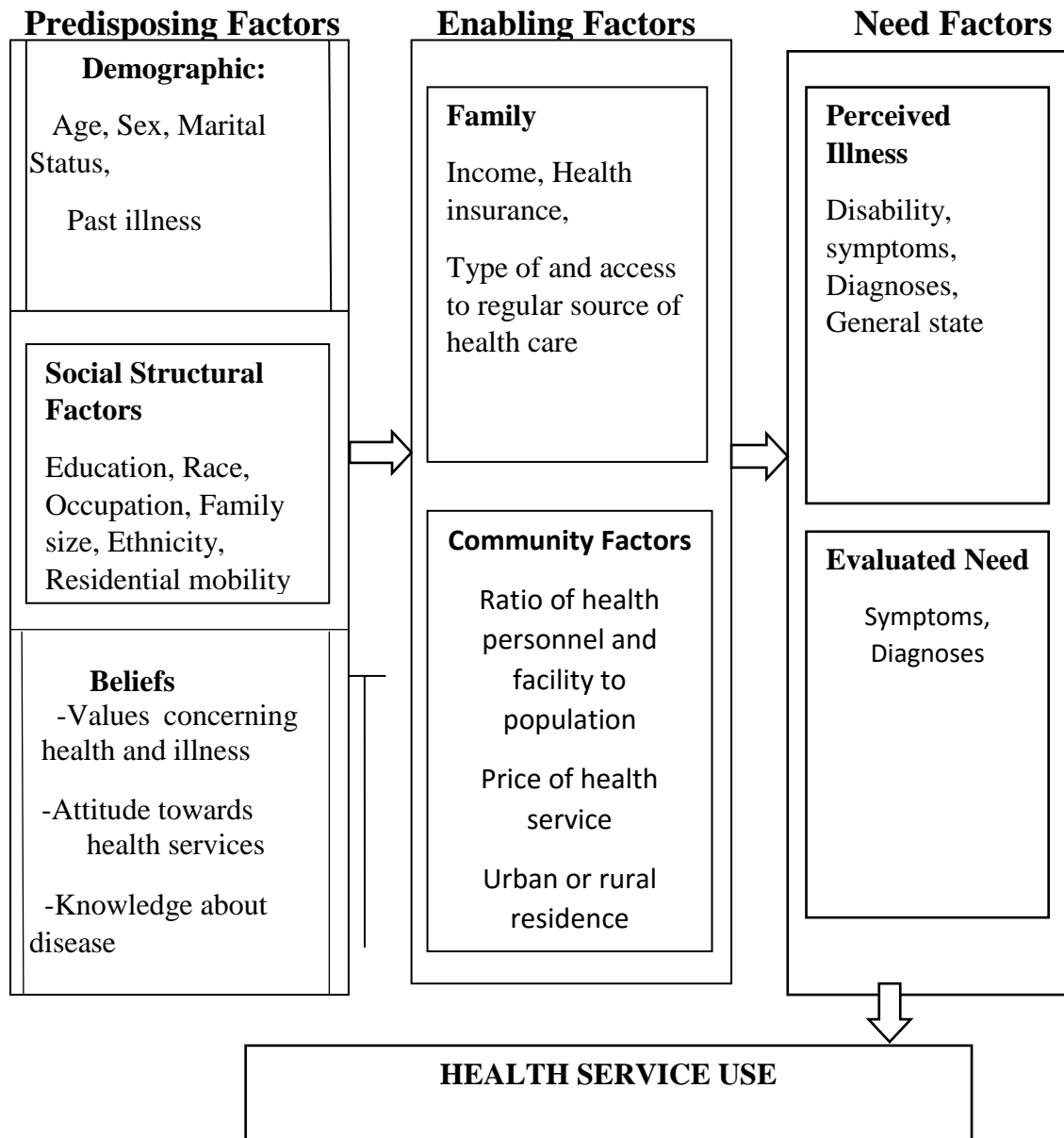
The Andersen’s model before reaching its final status has undergone four different stages. The first stage, which was developed in 1968 was criticised on different counts by different scholars. For instance, according to the model in the first stage, there exists an indirect relationship between the variables under the three categorisations (predisposing factors, enabling factors and need factors). Notwithstanding, this position of the model has been contested on the grounds that, a variable like health belief (part of the predisposing factors) may not necessarily affect personal or family resources (part of the enabling factors), and the need for health care may not depend on enabling factors and social structure (Yang & Hwang, 2016). The initial model was also criticised that it lumped socio-cultural factors with individual predisposing factors.

Based on this and other criticisms, the first stage of the model was revised in the 1970s to include health care system as another factor that influences health care access and use (Andersen, Kravits, & Anderson, 1975; Aday & Andersen, 1974; Andersen & Newman, 1973; Andersen, Smedby, & Anderson, 1970). According to the 1970s revised version of the theory, organisation, resources, and health policies are variables under the health systems that influence the use of health care. At this stage of the model’s development, consumer satisfaction was indicated as an outcome variable, making access and use of health care intermediate variables.

One of the strengths of the Andersen’s model is the comprehensive evaluation of the influence of individual, national and global factors on health care use. According to the Andersen model, health care use is not only influenced by individual need factors, but also national policies, interventions and how health care delivery is organised by institutions

(Reibling and Wendt 2008). The model further stressed the influence of global standards, policies and measures on national policies and its influence on health care access and use.

**Figure 3.2: Diagrammatic Representation of Andersen’s Health Utilisation Model**



Source: Andersen & Newman (1973)

### **3.3.1 Application of the Andersen Model in contemporary Studies**

The Andersen's model has been widely applied in recent studies that have both driven policy and research. For instance, an initial search by Batisch, Gohl and Lengerke (2012) on works that have used the Andersen model yielded a result of about 328 works. Based on their (Batisch, Gohl and Lengerke 2012) review's inclusion and exclusion criteria, the review took into consideration 16 of the works. The findings show that different versions of the Andersen's model were used by different authors in the studies under review with a greater percentage (more than half) using the 1995 version of the Andersen's model. The findings also indicated that some studies in the review used more than one version of Andersen's model.

Smith and Scheid (2014) used the Andersen Model in studying the Race Concordance Doctor patient relationships. With the use of a stratified-random sample of adult beneficiaries of primary health care, the study found that blacks use less primary care but also have more emergency care visits. The key finding of this study was that race concordance was not a significant factor in determining primary care or emergency room use.

After the application of the Andersen model, Evashwick, Rowe, Diehr, and Branch (1984) recommended that greater attention needs to be paid to adapting access frameworks like the Andersen's model to understand how processes of health delivery influence access to health care. This is because, in their work, they found that the traditional access frameworks are invaluable in encouraging a focus on historical measures of access.

In Nigeria, the Andersen model was used to examine how need factors, predisposing and enabling factors influence adolescents to visit reproductive health centres and found that,

close to half of the participants (43%) are not aware of any reproductive health centre (Ezinwanne 2016).

Various studies (Amegbor 2017, Awoke et al 2017; Kuuire et al 2015; Hervey 2014) have also applied the Andersen's model to works in the Ghanaian setting. A master's thesis awarded at the University of Nevada, Las Vegas (Harvey 2014) also used the Andersen model to investigate the socioeconomic and cultural factors that are associated with health service use in Ghana. This study applied the Andersen model to the Ghana demographic and health survey and found that the predisposing factors like age, sex education and other factors like religion are associated with health service use in Ghana.

Awoke et al (2017) also applied the Andersen's model to investigate what factors are associated with the use of a private or public health facility among adults in Ghana. The finding revealed that increasing age, wealth and education are associated with the use of a private health facility. Particularly pointing out that, an upward movement in the predisposing and enabling factors, increases the probability of one's use of a private health facility. Their findings also showed that co-morbidity is also a significant predictor of one's use of a private health system.

Using a cross-sectional data collected in 2011, Kuuire et al (2015) applied the Andersen model in examining the health-seeking behaviour of adults in poorly resourced areas in Ghana. The findings from this study showed that, the national health insurance scheme in Ghana which was intended to bridge the gap between the rich and the poor in terms of health access and use is not realised in their study area. The findings revealed that poor adults enrolled in the National Health Insurance are less likely to seek treatment in a health facility as compared to the rich that are enrolled in the National Health Insurance. This finding is interesting, because why would someone not seek treatment from a health

facility, though the person will not be directly paying for the service by virtue of his/her enrolment on the National Health Insurance Scheme. Could this be explained by the poor nature of those adults? Or could it be that their illnesses were not covered by the National Health Insurance Scheme? Or “these people” have some other explanations, that only an in-depth interview can unveil. All the same, this is one of the reasons why this study is not adapting the Andersen model only as a measure of numeric facts and figures, but also combining with qualitative interview data as a means of explanations to unmask the meanings behind these Figures.

The gap in the Andersen’s model as observed, by this study is that the model did not give a clear definition of what it means by, ‘access or use’ of health care. This resulted in the studies that applied the model not having a uniform definition of what access to health care should be. Some of the studies equated access to use or equated the use of health care to its access. However, the two (access and use of health care), for this study, are not the same. In order to avoid vague interpretation of access and use of health care this study in chapter one, defined what it means by, ‘access to’, and ‘use’ of health care.

### **3.3.2 Conceptual framework of the study**

The conceptual framework of the study (see Figure 3.3) is based on the literature review and the Andersen’s model of health care access and use. The conceptual framework (Figure 3.3) guided the quantitative data analysis of study in finding answers to the research questions. Migration characteristics, predisposing factors, enabling factors and need factors are the independent variables in the framework. Access and use of health care are also serving as the dependent variables. Perceived barriers to access to health care are part of the conceptual framework as they sometimes serve as intermediate variables.

From the framework, migration characteristic, predisposing factors, enabling and need factors directly affect health care access, use and satisfaction. For the purpose of this study, the migration characteristics under investigation are, migration status, origin of the migrant, type of migrant, duration of stay, whether the migrant has a close friend or relative in Ghana. An individual's migration status can affect the person's access, use and satisfaction of health care. A wide-range of studies conducted in the more advanced countries have shown that migrants normally have difficulties in accessing and using health care (Zihindula et al 2015; Cuadra 2012; Stanciole and Huber 2009; Dias et al 2008). This happens as a result of a language barrier, poor perception of health care in the destination areas and sometimes, the undocumented nature (Biswas et al 2012) of some migrants hinders their access and use of health care. In this study, however, it is expected that, a greater percent of the non-migrants will access and use health care than migrants, as well as documented migrants accessing and using health care facilities in Ghana than the undocumented migrants. The migration Characteristic of the migrants can also affect other independent variables like the enabling and need factors. But it's not necessarily the predisposing factors. For that reason, the arrow leading from migration characteristic to the independent variables does not apply to predisposing factors, but only enabling and need factors (See Figure 3.3).

The predisposing factors also include age, sex, level of education and marital status. Average monthly income, occupation and employment status are the only enabling factors under investigation in this study while perceived health status, having an injury or illness in the 12 months prior to the interview and living with a chronic disease are the need factors under investigation.

Deducing from the Andersen model, age can influence an individual's access or use of health care. However, age sometimes does not work in isolation in influencing an

individual's access and usage of health care. Age predisposes people to certain ill-health conditions which will force them to access and use health care. Studies have shown that the aged population of any society is more at risk of chronic illness conditions like hypertension, diabetes, arthritis and others. In the conceptualisation of this study, age is expected to have an influence on the health care use of both migrants and non-migrants. Similar expectation focused on sex. The sex of the individual is used as a predisposition of the individual's gender. The study expects to have more females than males accessing and using health care. Though the study expects that sex and age will influence access to health care, the researcher has no expectation of the direction of the influence.

Level of education is also expected to have an effect on health care use and access. A greater percentage of the respondents with post graduate education are expected to have access and use health care more than the respondents with no education.

There are factors that enable an individual to access and use health care. Such factors include the individual's average monthly income, occupation and employment status. The individual's membership of valid health insurance and having a health facility owned by the individual's place of work can also serve as an enabling factor to access and use health care. An individual that works in a place that owns a health facility like individuals employed by the University of Ghana or Ghana Ports and Harbour Authority will access and utilise health care more compared to individuals that are employed by a workplace that does not have a health facility.

The last group of independent factors is the need factors. Living with a medical condition automatically creates the need for someone to access or use health care as compared to an individual that is not living with any medical condition. Persons living with hypertension,

diabetes, cancer or any other chronic illness will have their regular check-up, so will use more health care compared to persons that are not living with any chronic illness(es).

The study also conceptualises that, these primary factors (predisposing, enabling and need factors) sometimes work through the individuals perceived barriers to accessing health care. An elderly person, living with a medical condition may not access or use health care if he/she perceives that, he/ she is unable to do so. Probably because of discrimination or lack of trust for a particular health care system.

### **3.4 Summary**

This chapter actually looked at, the literature around migration and health, migrants' access to health care, and the theoretical conceptualisation of the study. The summary of the literature can be seen in Figure 3.1 while the summary of the theoretical concept can be seen in Figure 3.2 as the conceptual framework of the study.

From Figure 3.1, the areas of the literature reviewed include; the general health outcome of migrants (“healthy migrant effect” and “migration and disease infection”), “migration and mental health”, “migration and access to health care” and “health workers and migration in Ghana”. The Figure 3.1 also showed that, from the literature, the authors either study migrant population against a host society or studying different migrant groups in the host community (migrant group 1 against migrant group 2) or studying an immigrant population against the origin population. A brief overview of health insurance was also conducted.

The findings from the literature cannot be pinned to one direction. Some literature showed that migration has an influence on the health of migrants while others are of an opposite view. There exists a divided view among the sections of the literature that are of the view that migration can affect health. One group showed that migration has a positive effect on

the health of the migrants while others say migration affects the migrants' health in an adverse way.

But generally, from the literature, immigrants arrive in the destination areas healthier and stronger than the native populations as a result of the positive self-selective nature of migration and entering rules and regulations of the host community. This notion is termed as the "Healthy Migrants' Effect". However, the literature also revealed that migrants grow weaker in health with the passage of time spent in the destination area(s) due to unhealthy lifestyles and stress in the destination areas (Lu et al 2017).

The literature also points out that, migrants are mostly affected by infectious diseases like HIV/AIDS. The effect of the HIV/AIDS infection also hits the significant others of these migrants (Buckley 2005). Migrants particularly undocumented migrants in the literature are seen as having challenges in their destination areas with issues connected to access and use of health care (Biswas et al 2015).

Nonetheless, the study identified that the literature on migration and health are mostly works conducted with migrants in the developed countries traditionally known as migrant receiving countries. For instance, Germany, Canada, the United State, United Kingdom (Constant et al 2015; Bhugra 2004b; Bloom and Canning 2000). Few studies have looked at the health of migrants in some developing countries in Africa (Buckley 2005; Anarfi 2004). However, these studies focused greatly on the health of internal migrants. Some addressed the health issues of international migrants, but the focus again was not on access to health care rather on migrants living with infectious diseases like HIV/AIDS.

The study also identified that the literature on the Healthy Immigrants Effect, left out the views of the migrants on the subject.

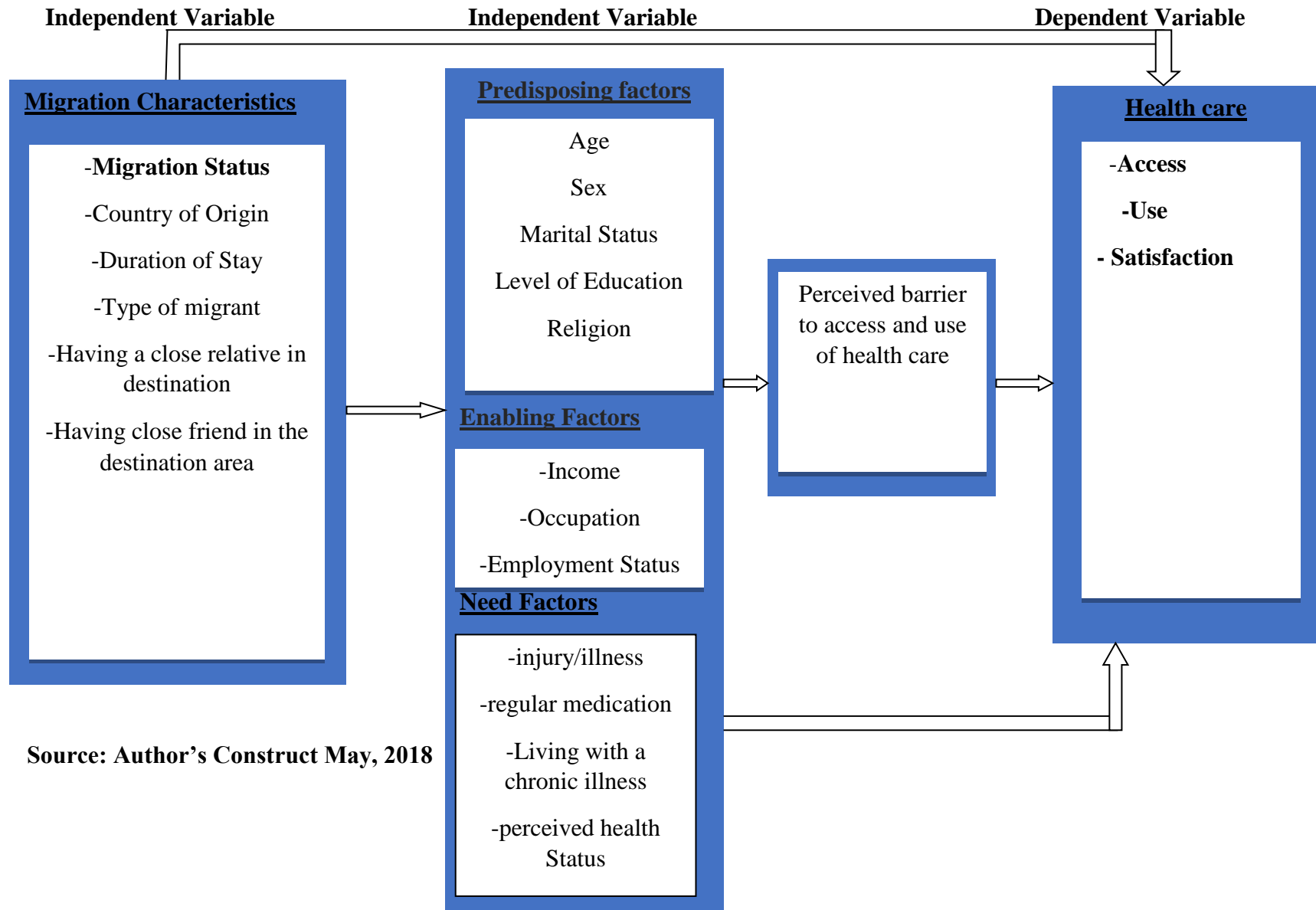
The literature also showed that Ghana lost most of her health care workers and professionals to advanced nations (Kissick 2012) as a result of low incentives in the service in Ghana as compared to the gains in the advanced worlds ( Anarfi; Quartey and Agyei 2010 ; Dovlo 1998 ). Though the government of Ghana has put in a lot of measures to discourage the health care workers from migrating, some still have the intention to migrate (Boafo 2016). In most cases, their inability to do so is as a result of strict immigration measures adopted by destination countries (Teye, Setrana and Acheampong 2015). Nonetheless, the professionals that migrate return to Ghana, sometimes with better skills (Adzei and Sakyi 2014) to strengthen the health care system in Ghana. The return health professionals contribute to the development of the health care sector in Ghana with their knowledge, skills and finances.

The theoretical conceptualisation of the study is also considered in this chapter. Andersen's model is reviewed and adapted as the theoretical guide of the quantitative data analysis of the study, in this chapter. The Andersen's model is seen as the most ideal for a study on migrants' access and use of health care in Ghana because;

- (I) the Andersen's Model's conceptualisation of access and use of health care incorporates all levels of analysis (individual level, societal level, national and global level of analysis),
- (II) the Andersen's model has been used by most studies in the African and Ghanaian context and proved appropriate.

Based on Andersen's model and the literature review, the study constructed a conceptual framework (see Figure 3.2), which guided the quantitative data analyses of the study.

Figure 3.3h Conceptual framework



Source: Author's Construct May, 2018

## CHAPTER FOUR

### METHODOLOGY OF STUDY

#### 4.0 Introduction

This chapter presents the methodology of the study. The first section covers the study design, followed by the source of data/target population. The inclusion and exclusion criteria are also discussed in this section. The method of quantitative and qualitative data collection and analyses are presented in sections 4.3.1 and 4.3.2 respectively.

Also, the chapter covers sections on the sample size and techniques used in the study. Measurements of the main variables used in the study are presented in the chapter. The chapter also presents a brief section on the researchers' positionality and field challenges.

#### 4.1 Research design

The study employed mixed research methods, techniques, (Triangulating qualitative and quantitative methods) as the approach for answering the research questions of the study. The mixed research method is an evolving methodological and procedural approach originating from the Social Sciences (Wisdom and Creswell 2013), which has recently migrated into some traditional and hard-core science fields such as health and the medical sciences (Bowling 2014; Green and Thorogood 2013; Saks and Allsop 2012; Morgan 1998). In recent times, the mixed research method approach has been accepted as the best method for investigating complex phenomena (Homer et al 2008).

The mixed research method approach used in this study involved the systematic integration and amalgamation of both quantitative and qualitative data within this single doctoral thesis as a sustained program of research investigation (Creswell 2013). The foundation for adopting this methodological approach is that such synergy allows the researcher to make a more holistic and robust use of data than would have in a separate

quantitative and qualitative data collection and analysis (Wisdom and Creswell 2013). Collecting qualitative data to support the quantitative data in this study provided validation and in-depth understanding of the findings arrived at in the quantitative analyses, creating a solid ground for drawing conclusions on health care access and use among migrants and non-migrants in Ghana.

The quantitative research methods approach was largely used in this study. However, for an in-depth understanding of the meanings (Ivankova et al 2006; Gaskell and Bauer 2000) behind the quantitative results, in-depth interviews were also conducted with both Ghanaians and Non-Ghanaians. The last research question was heavily interrogated using qualitative research methods.

The quantitative method as a tool mainly used by the positivist philosophy has its foundation of science tied to logic and mathematics. The quantitative method is burdened with the search for “human causal relationships”. Knowledge gained from the use of a quantitative research method is built upon objective facts (Galtung 1969) anchored on the pillar of “unity of scientific method”. It also provides knowledge that is free of the researcher’s values and usually good for generalization (Nicol 2003). The use of quantitative approach also makes it possible to make predictions out of a research finding (Teye 2012). To harness these and other advantages of quantitative analysis, the objectives of the study were also investigated using this method.

However, because knowledge gained from quantitative (positivist) approach is mainly based on the size and proportion of quantitative figures, and more often than not, lacks the ability to provide reasons and meaning behind the figures (Atieno 2009; Gaskell and Bauer 2000). This makes it very difficult for some policies built solely on researches that use this approach to yield the desired results. Policies based on this approach alone

sometimes fail because of a lack of understanding of the local context of the research findings (Atieno 2009; Creswell 2013).

The qualitative research method, on the other hand, is one of the tools used by any post-Positivist philosophers such as the critical theorists, the phenomenologists, feminists among others (Galtung 1969). The qualitative approach, though not good for generalisation and prediction (Teye 2012; Atieno 2009), provides knowledge as presented by the different versions of reality. It helps to explain in detail, experience(s) and perception(s) that are difficult to do with numbers as in the quantitative (positivist) approach (Taye 2012). The qualitative research method also gives the researcher the opportunity to immerse him/herself in the researched community (Gaskell and Bauer 2000). Qualitative research methodology, according to Gaskell and Bauer (2000), gives an opportunity to both the researcher and the researched community to construct the meaning of a particular phenomenon. It also helps to study social phenomena such as, emotions, thoughts and perceptions that are difficult to quantify.

In the quest of the opportunity for the researcher to personally immerse herself in the research, and get the in-depth understanding of the quantitative results and especially since the answers to the last research question and the objective cannot be easily provided using quantitative methods, qualitative methods were employed in order to meet this intellectual demand.

Both methods (quantitative and qualitative) though accepted as Social Science research methods have their strengths and shortcomings when used individually (Taye 2013). Notwithstanding, the two methods can be used in ways to supplement and complement each other where possible (Creswell 2013) and also provide validation for each other. Using the two methods together in this research, helped to maximize the advantages of

both methods (while suppressing to the possible best, the limitations of the two methods). For instance, in this study, individuals (both migrants and non-migrants) were asked what they usually do when they are unwell. The import of the question was to understand how individuals use health care services when they need it. But it is difficult to understand what the answers of the respondents will be in a pre-coded quantitative form. This in a way called for asking the same questions in an in-depth interview with the respondent, to allow the respondent to express himself on the questions without any limitation to the answers. This also allowed the respondent to answer the question without being provided with a leading answer. The same way also the researcher gets the opportunity to probe further on the answers provided by the respondents. This in a way prevents the researcher from making personal judgements of the answers, but probe the answers to understand well the exact message or information the respondent has to provide with regard to the question.

Some studies have shown that triangulating methods (using both qualitative and quantitative methods in this context) in a single research can be costly (Teye 2012); time consuming (Teye 2012; Lieber and Weisner 2010 in Tashakkori & Teddlie 2010 Eds.), very challenging with regard to how the researcher can interpret the data and integrate the findings (Teye 2012; Wisdom et al 2012; Sandelowski 2003 in Tashakkori & Teddlie 2010 Eds). They, however, also demonstrate that the advantages of triangulating the two methods outweigh its challenges and the benefits of using only one of them.

Using the two methods together in this study was very challenging, in terms of time and cost. Notwithstanding, the qualitative interviews helped to explain why the study participants use the pharmacy and do self-medication than to go to the hospital when they are unwell. Using the two methods in this study was also very helpful in the sense that, while the quantitative data provide evidence of the differences in the access and use of

health in relation to migration status, the qualitative interviews also gave the researcher the opportunity to in-depth interrogate people within the various migration status groups on their health care access and usage.

#### **4.2 Sources of Data/ targeted population**

The study used both primary and secondary data. The primary data include responses to questionnaires administered to respondents and in-depth interview with study participants. The secondary data include data gathered from books, journals and articles that are relevant for the study.

The study targeted non-Ghanaian nationals resident in the Greater Accra Region, who have lived in Ghana for at least six months and also Ghanaian nationals residing in the same area where a migrant is found. The Ghanaians are those who have not travelled outside Ghana in the last 6 months. The study area is the Greater Accra Region because about 60 per cent of migrants in Ghana can be found in this region, while the other 40 per cent can be found in the other 15 regions (GSS 2014)

The qualitative component of the data was drawn from ten individuals (Appendix A) with life stories and one expert. A semi-structured interview guide was used for the interviews with the ten participants while the interview with the expert was unstructured.

##### **4.2.1 Inclusion criteria**

The study focused on both migrants and non-migrants in the Greater Accra Region. The respondents were people of the legal age of 18 years and above for both migrants and non-migrants. Migrants who have lived in Ghana for at least six months qualified to participate in the study

#### **4.2.2 Exclusion criteria**

The study excludes individuals that have not attained 18 years. Individuals who are not Ghanaian born, but have naturalised to become Ghanaians are also excluded from the study. Individuals with dual citizenship were also excluded from the study. Individuals who are Ghanaian born, but have changed their nationality were also excluded from the study. Migrants that have spent less than six months in Ghana were also excluded from the study.

### **4.3 Key Ethical considerations**

#### **4.3.1 Confidentiality**

The researcher assured the study participant of full confidentiality. The participants were also assured that, the researcher will not share any of the study's records, notes or audio recordings, with anyone outside the research team. The participants were made to know that the data is basically for academic purpose only and they will not be identified with anything that is written about the study. They were also made to know that they do not have to tell anyone they were taking part in the study if they do not want to.

#### **4.3.2 Risks**

The study perceived that a possible risk of taking part in the study will be that, people outside the research team may find out or try to link the responses in the study to some of the participants. To try and make it so this will not happen the study decided not to write down the names or other information that could identify the participants when writing down their responses. The study also used pseudo names to link the answers during the interview to the analysis in the study. These pseudo names did not include any personal information about any of the participants that could make anyone outside the research to

identify them. All these were clearly communicated to each study participant before the data collection.

#### **4.3.3 Benefits**

The study participants were made to understand that, they may not benefit directly from taking part in the study. However, it is the hope of the researcher that, whatever lesson(s) that comes out of the study will help formulate policies that will improve the general access and use of health care for both migrants and non-migrants in Ghana

#### **4.3.4 Voluntary Participation**

Participation in the study was voluntary, no study participant was forced to take part in the study. It was also communicated to the study participants that taking part in the study is strictly voluntary and they have every right to withdraw from the study if they wish to do so. They were also told that they can withdraw at any point of the study if they feel they are not comfortable with it without necessarily providing an explanation.

#### **4.3.5 Ethical clearance**

The study gave full attention to all Ethical protocols. Voluntary participation, informed consent, confidentiality, and respondent and data protection were strictly adhered to at all stages of the thesis both on field and off field. Ethical clearance was given by the University of Ghana Ethics committee for the Humanities (See Appendix H)

#### **4.4 Method of quantitative data collection and analyses**

The Data were collected between November and December 2018 from ten communities within and around Accra. The communities include Accra Central, Alajo, Legon, Weija, Osu, Tema, Tetteh Quarshie, New Aplaku, New Bortianor and Valley View/Oyibi.

The Quantitative data were mainly gathered electronically using The Census and Survey Processing System (CSPro) data entry tool. CSpro is a software package for entering, editing, tabulating, and disseminating quantitative data. This software package was used firstly to reduce cost in printing questionnaire and secondly to skip the time of data entry in the event when data are collected using printed questionnaire. The questionnaire was designed using this software and then installed on three Android phones for data collection.

The questionnaire had seven models (sections) which include, (1) socio-demographic background of respondents, (2) migration profile of respondents, (3) health coverage and access to health care (4) respondents' use of health care, (5) respondents' health condition (6) respondents' evaluation of health care in Ghana and (7) some supplementary questions (See Appendix F).

Some respondents (about 30% of the migrants) requested a hard copy of the questionnaire, filled them at their convenience and submitted them later on. The hard copy data were also later entered using the CSpro data entry tool.

The data gathered/entered using CSpro was later exported as an SPSS file and analysed using SPSS version 23. The analyses focused on the description of the data and the drawing of colorations and relationships among the variables in the data. The analyses included but not limited to univariate, bivariate and multivariate analyses of variables. This involved the cross-tabulation of variables and running of logistic regression models to establish relationships.

#### **4.4.1 Method of qualitative Data collection and analyses**

The qualitative data were mainly gathered using semi-structured in-depth interview guide for the selected migrants and non-migrants that responded to the survey questionnaire. An

unstructured interview with the ‘in-charge’ of the University of Ghana Hospital’s records department was also conducted. The hospital was one of the hospitals mentioned by most of the migrants as where they access health care. The interviews were recorded with the permission of the participants. However, two of the migrants preferred note taking to an audio recording of interviews. An Android phone was used for the recordings. The audio recorded interviews were immediately transferred on to the study’s computer and deleted from the phone after every interview with a participant. This was done to avoid mishandling of the recording since the phone is used for other purposes.

The data were transcribed using express scribe. Express scribe is a transcription software for transcribing audio file which helps to reduce the turnaround time during transcription. The transcribed data were thematically analysed manually. With “access”, “use” and “evaluation/satisfaction” as the organising themes.

The transcribed data were first coded and a coding frame was developed (Appendix B). The coding frame was theoretically conceived and guided by themes identified in the quantitative analysis and existing literature. The analysis was also informed by “Attride-Stirling’s (2001) thematic network approach” (Appendix D). According to this approach, thematic analysis can be usefully presented as thematic networks, which is a vigorous and highly profound tool for the organisation and presentation of qualitative analyses (Teye 2013)

## **4.5 Research sample size and sampling technique**

### **4.5.1 Determination of Sample size**

Using Miller and Brewer formula for sample size determination

$$n = \frac{1}{1+N(\alpha^2)}$$

Where n= Sample Size

N = Sample size (total number of migrants in the Greater Accra)

$\alpha^2 = 0.05$  at 95% significant level

N = 60% of migrants in Ghana (GSS 2014)

N = 60% by 375000

N = 225000

$$n = \frac{225000}{1+22500(0.25)}$$

$$= \frac{225000}{1+562.5}$$

$$= 399.2 \approx 400$$

Based on the number of migrants in the Greater Accra region, the sample size for the migrants is 400 using the formula by Miller and Brewer. However, the study actually sampled 116 migrants in addition to 116 non-migrants because of time constrain and language barrier.

#### **4.5.2 Sampling Procedure**

Firstly, the snowballing technique was used to identify the non-Ghanaian nationals (migrants). For the purpose of equal representation of respondent's background characteristics, different groups (Ghana Immigration Service office, migrant associations, migrant dominating areas, migrant dominating trading centres and tertiary institutions) were visited and contacted for the first list of potential respondents. In all, a list of 600 migrants living in the Greater Accra Region were generated. 68 names of migrants were deleted from the list because they were living in Ghana for less than 6 months. A second

list made up of 514 migrants was generated. For equal chances, 200 migrants were randomly sampled from the 514 migrants to form a third list which was used for the study.

In the randomization, the names of the migrants were keyed into the computer and rearranged alphabetically. The rearranged names were then numbered. All the names with odd numbers were selected for interview. If a name selected for interview declines the interview, that name is replaced with the next name

At the end of the data collection, 116 migrants out of the numbers that were contacted had a successful participation in the study. The rest could not grant interviews either because they could not speak English or any Ghanaian language and there was also no one to interpret. Most of the migrants that fell into this category were Chinese and French-speaking migrants. Others could not participate in the study because they were either not interested or very busy at the time of the study. An equal number of Ghanaians as migrants were selected for an interview from the same neighbourhood where a migrant is interviewed.

Ten individuals that responded to the quantitative questionnaire with life stories in relation to the study objectives were selected for an in-depth interview for the qualitative analyses after reaching meaning saturation. One unstructured expert interview with the ‘in charge’ of the record office of the University of Ghana hospital was also conducted.

#### **4.6 Measurement**

In line with the study objectives, methodology, theoretical and conceptual framework, two sets of research apparatus were employed. The quantitative data collection employed a standardised questionnaire (Appendix F) to elicit information from respondents. About eight socio-demographic characteristics that were known to have an influence on migration and access to health care were considered. However, only five socio-

demographic characteristics/variables were used in the analysis presented in this study. The socio-demographic characteristics used in the study are (1) Age, (2) Sex (3) Marital Status (4) Level of Education and (5) Average Monthly Income. These variables and their respond choices are exhibited in Table 4.1.

Age was originally measured in complete years but was then recoded into 10-year groups starting from 18-27 to 68+ for the purpose of simplifying the analysis.

Also, the marital status variable was originally measured to have six responses, which are: 1) Never married, 2) Married, 3) living together/consensual/informal, 4) separated 5) divorced and 6) widowed. But the marital status variable was recoded to have only three responses. 'Married' and 'living together/consensual/informal' were put together and coded as 'married/living together'. 'Separated', 'divorced' and 'widowed' were also coded together as 'Out of marriage' while never married still stood alone as 'never married'.

Access to health care was measured in this study by a respondent answering 'Yes' to any of these two questions in the third section of the questionnaire (Appendix F): (i) Are you affiliated to a workplace/ institution with a health facility that you are entitled to access by virtue of your affiliation without paying directly? (ii) Are you affiliated to an institution or workplace that gives you a health coverage? "and or" answering "currently registered" to the question "are you currently registered on health insurance?"

**Table 4.1: Socio-demographic characteristics and response choices**

<b>Background Variables</b>	<b>Respond Choices</b>
<b>Age</b>	Completed Years
<b>Sex</b>	1. Male 2. Female
<b>Marital Status</b>	1. Never Married 2. Married 3. Living together/consensual/informal 4. Separated 5. Divorced 6. Widowed
<b>Level of Education</b>	1. No education 2. Primary 3. Middle/JSS/ JHS 4. Voc/Tech/Commercial 5. Senior secondary/ senior high 6. Post Sec Diploma 7. Bachelor Degree 8. Postgraduate 9.9) other (Please specify)
<b>Average Monthly income</b>	1. No income 2. <GHC 300 3. GHC 300-499 4. GHC 500-799 5. GHC 800-999 6. GHC 1000-2999 7. GHC 3000+

Source: Study Questionnaire

#### **4.7 Positionality**

The researcher's position as a Ghanaian working on access and use of health care among migrants and non-migrants in Ghana may not have any influence on the data. However, the researcher during the data collection was six to seven months pregnant of which the researcher is of the view that this position may have influenced the data collection. For instance, because of the pregnancy during the time of data collection, a final year Nigerian student (Beulah Sunday Ukpong) from the Valley View University was trained to assist in the data collection.

As the researcher, I realised that it was relatively easier to arrange an interview(s) with migrants and students from and around Valley View University. The respondents from the Valley View University were also more receptive as none of them turned us away. The researcher is of the view that this might be as a result of having a student from among them assisting in the data collection. The data collection assistant was also familiar with the locations around the Valley View University, which made it easier and faster to locate respondents for interview. Figure 4.1 shows the research assistant (Miss Beulah Sunday Ukpong) from the Valley View University interviewing a migrant. Figure 4.2 also shows the researcher interviewing a Ghanaian (non-migrant).

The researcher's position as a pregnant woman also influenced the data in this way. During the data collection, some respondents were reluctant to respond to the questionnaire, but quickly did so after seeing the researcher. For instance, one Chinese Businessman interviewed in Makola Market told the assistant he was busy. He actually decided to respond to the questionnaire and became more receptive after I asked him 'what time should we come back'? He then realised I was with the assistant and asked if he could see the questions. He then arranged to sit with us and responded to the interview. I strongly believe he was moved to grant us the interview because he saw my pregnancy

after asking him ‘what time should we come back’. I knew we would not have been able to interview him if the assistant was alone that day.

So, my position as a Ghanaian may not have any obvious influence on the data, but my position as a pregnant researcher during the data collection may have. First, by making me get an assistant for the data collection and secondly moving some respondents that the study could have potentially missed responding to the study.

**Figure 4.1: Research assistant interviewing a migrant**



Source: Field work, Nov-Dec 2018

**Figure 4.2: Researcher interviewing a respondent**



Source: Field work, Nov-Dec 2018

#### **4.7 Field Challenges**

Apart from finance and time that was a challenge during the data collection we could not also interview potential respondents because of the language barrier. For instance, some Chinese and Ivorians that were recruited for an interview could not respond to the study because they could not speak English nor any Ghanaian language.

One Ghanaian lady also refused to allow us to interview a Chinese she was working with on the basis that, many do come to them in the name of research, but she has not seen any profit coming from those researches. This happened after we arranged to interview the Chinese man. He is a trader at the Makola Market. After we got there, he said he will respond to the questions if his assistant who was a Ghanaian agrees. The assistant, refused, though we showed her documents to prove we were students.

Some participants also refused to be recorded, jokingly saying what if you are investigative journalists. They still refused even after showing documents and identity cards to prove we were students. These among many are some painful encounters and challenges we faced during the data collection.

## CHAPTER FIVE

### SOCIO-DEMOGRAPHIC AND MIGRATION CHARACTERISTICS OF RESPONDENTS

#### 5.1 Introduction

This chapter is on the socio-demographic (Predisposing and enabling), need factors and migration characteristics of the respondents. The chapter also presents a section on the analysis of the study's objective one (the Healthy Immigrants' Effect from the views of the migrants). The chapter is divided into five main sections. The first section is devoted to describing the predisposing, socio-demographic characteristics of the respondents. These characteristics include age, sex, marital status and level of education. The second part of the chapter focuses on the enabling factors of the respondents. The enabling factors discussed are occupation, employment status and average monthly income. The third strand of the chapter is devoted to the health care need factors of the migrants and non-migrants in the study. The factors, predisposing enabling and need factors are first described among the total sample (both migrants and non-migrants) of 232 respondents and separately among migrants and non-migrants.

The fourth section of the chapter is dedicated to analysing key migration characteristics of the respondents. This is because migration characteristics of the respondents are also considered as independent variables in the conceptual framework of the study. The variables considered in this section of the chapter are, the origin of the migrant, duration of stay, type of migrant, intention to permanently stay or return, and whether the migrant has a close friend(s) or family/relative (s) in Ghana.

The last section of this chapter discusses the analysis of the " Healthy Immigrants' Effect" from the view of the migrants.

## **5.2 Socio-Demographic (Predisposing) Characteristics of Respondents**

The socio-demographic characteristics of respondents are important variables in the analysis of health care and migration-related issues. The socio-demographic characteristics constitute the predisposing and enabling factors in the conceptual framework of the study. The first socio-demographic variable considered in this chapter is age, followed by sex, level of education and the marital status of the respondent.

### **5.2.1 Age-Sex Distribution**

Age and sex are vital variables in the analyses of any topic associated with migration (Birchall 2016, Zaiceva 2014). The age of an individual as indicated in Section 3.2.0 (the theoretical underpinning of the study) is important when analysing issues related to access and use of health care (Andersen 1968). This is probably because older people are more susceptible to chronic diseases (Shlipak et al 2006) than younger populations. This, therefore, is expected to reflect in subsequent sections of the study that older respondents will have access and use health care in Ghana more compared to the younger respondents. On the other hand, studies have shown that there is an inverse relationship between the age of an individual and migration (Zaiceva 2014).

This section is devoted to the frequency analysis of the ages of the respondents. The age variable was measured in the study by asking respondents to indicate their age in complete years. The study computed the mean age of the respondents first, among the total sample (Migrants and Non-Migrants together) then separately among migrants and non-migrants (See Table 5.1). A chi-square test was also carried out to examine the statistical relationship between age and migration status. The age variable was then recoded into 10-year groups starting from 18-27 to 68+ to simplify the analysis (See Table 5.1).

From the analysis, the mean age of the total sample of the study is 31 years. The mean age of both the migrants and the non-migrants have been 32 years (ages have been rounded up to the nearest whole numbers; See Table 5.1). Mean age of the migrants is less than the mean age of international migrants (39 years) in the United Nations' 2017 migration report (Kobler and Lattes 2017). Also, the non-migrant group and the migrants' group having the same mean age could be explained by the fact that the non-migrants were selected from the same community where the migrants are found. It could mean that people in the same community could share a similar demographic characteristic.

The chi-square results showed no statistically significant relationship between age and migration status of the study respondents ( $P > 0.05$ ). A plausible explanation for this could be because the migrants that were used to generate the first list of respondents were purposely targeted.

However, the results of the analysis as shown in Table 5.1 reveals an inverse relationship between age and the proportion of respondents in the various age groups. However, this inverse relationship is more prominent in the migrant group. This is probably because younger people are more likely to migrate compared to older people. Further analysis also indicates that more than half of the respondents (52.2%) from the total sample fall within ages 18-27 years. At the same time, less than half (44 per cent) of the non-migrants falls within ages 18-27 years. The same result also showed that far more than half of the migrants (60.3%) fall within ages 18-27 years. This could point to the age selectivity of migration (Shaw 1975) and also because education is one of the factors that attract other young Africans into Ghana.

The analysis further confirmed that 12.5 per cent of respondents in the total sample, 17.2% respondents among non-migrants and 7.8 percent respondents among the migrant group

falls within ages 38-47 years. The results also indicated that only 0.9% of respondents among the migrants' group and 3.4% of non-migrants' group are aged 68+. This implies that a relatively small proportion of the respondents are in the age category that needs health services.

According to Andersen's model, an individual's sex is also a factor that predisposes the individual to access and health care. Females, especially those in their reproductive years typically need health care services than males of the same ages. Some studies have also shown that gender or sex also influences migration (Birchall 2016).

The study analysed the sex of the respondents first among the total sample and separately among migrants and non-migrants. The results, as shown in Figure 5.1 revealed that a little above half (50.4%) of the respondents among the total sample are females while less than half (49.6%) are males. The results also show that there are more females (54.3%) than males (45.7%) among the non-migrants. Meanwhile, the 'migrants only' sample has more males (53.4%) than females (46.6%). According to the chi-square test results of the study, the differences reported are not statistically significant ( $P > 0.05$ ).

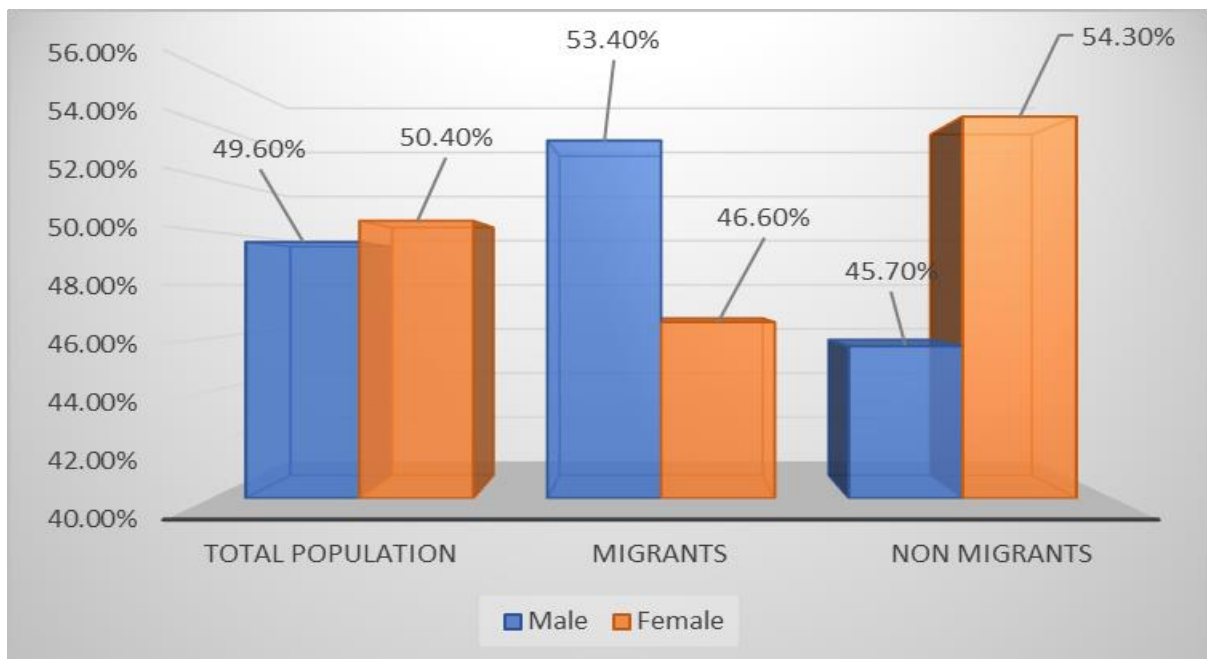
Though some studies suggest that, more and more women are independently migrating across international borders (Dobrowolsky 2016), the finding in this study agrees with the United Nations' 2017 migration report. According to the report, 'Women comprise slightly less than half of all international migrants' (Kobler and Lattes 2017).

**Table 5.1 Age Distribution**

Age group	Total Sample Mean Age= 31.12		Non-Migrants Mean Age=31.62		Migrants Mean Age=30.62	
	Number	%	Number	%	Number	%
18-27	121	52.2	51	44	70	60.3
28-37	50	21.6	29	25	21	18.1
38-47	29	12.5	20	17.2	9	7.8
48-57	16	6.9	7	6	9	7.8
58-67	11	4.7	5	4.3	6	5.2
68+	5	2.2	4	3.4	1	0.9
Total	232	100.	116	100	116	100

Source: Survey Nov-Dec 2018 (P = 0.063)

**Figure 5.1 Sex Distribution**



Source: Survey Nov-Dec 2018 (P = 0.149)

### 5.2.2 Level of Education

Education is one of the predisposing factors postulated by Andersen’s model (1968) as a factor that influences an individual’s access and use of health care services. The study

used a standardised question by the Ghana Statistical Service (Appendix F) to obtain the highest level of education attained by respondents.

According to the results, as shown in Table 5.2, all the migrants have attained some form of formal education above primary school level. Exactly 1.7 percent of the non-migrants have no education, forming 0.9 per cent of the total sample with no education. The results also reveal that about two out of every three of the migrants (69.9 per cent) has either a bachelor or post-graduate degree. Also, 6.9 per cent and 3.4 per cent of the migrants and non-migrants respectively, have vocational or technical education, this amounts to 5.2 per cent of the total sample having a vocational or technical education. The chi-square test result also shows that the differences reported in the level of education in relation to migration status are statistically significant ( $P < 0.05$ ). The finding confirms what was found in Fargues (2017), that international migrants in most cases are over-educated compared to non-migrants. Fargues (2017) also explained that migration is selective towards the educated both in the origin and destination countries

**Table 5.2: Level of Education**

Level of Education	Total sample %	Non-Migrants %	Migrants %
No education	0.90	1.70	0
Primary	2.60	5.20	0
Middle/JSS/JHS	8.60	14.70	2.60
Voca/Tech/Comm	5.20	3.40	6.90
SHS/SSS	10.80	12.90	8.60
Post Sec Diploma	14.70	17.20	12.10
Bachelor	38.80	31.00	46.60
Postgraduate	18.50	13.80	23.30
Total	100	100.00	100

Source: Survey Nov-Dec 2018 (P =000)

### 5.2.3 Marital Status

Among the factors described by Andersen's model (1968) as predisposing factors to access and use of health care is 'marital status'. This was confirmed by other studies, Pandey et al (2019) and Joung et al (1995) found that there is a relationship between marital status use of health care.

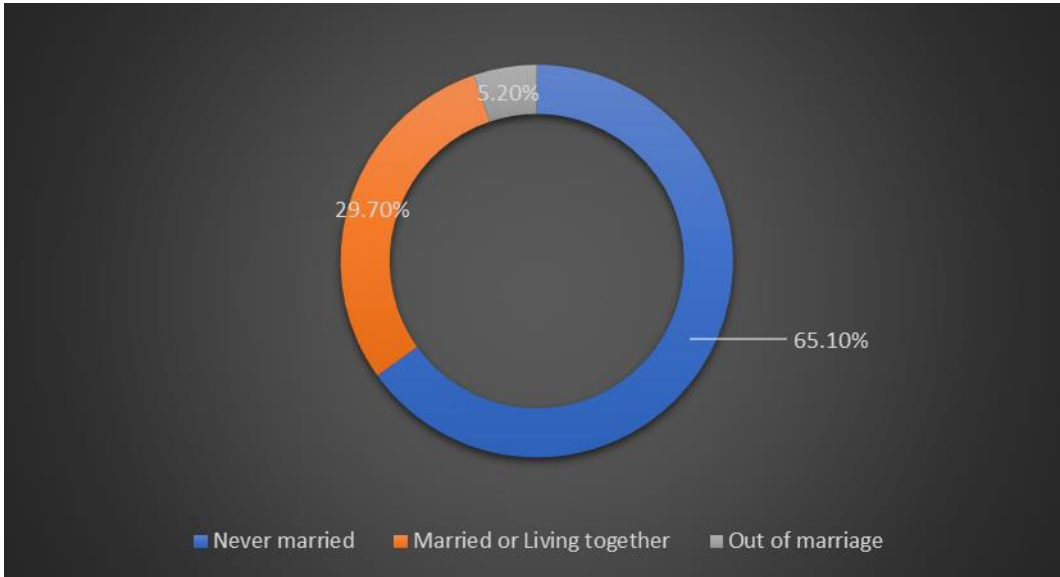
In this study, marital status is one of the background variables, and it is considered to have an influence on the access to and use of health care of the migrants and non-migrant respondents. The study adopted a standard question (What is your marital status?) used by the Ghana Statistical Service in measuring marital status. The respondent is expected to select or choose one of the following responses to indicate their marital status: 1) Never married, 2) Married, 3) living together/consensual/informal, 4) separated 5) divorced and 6) widowed.

Notwithstanding, for simplification of analysis, the variable for marital status is re-coded to have only three responses. 'Married' and 'living together/consensual/informal' were put together and coded as 'married/living together'. 'Separated', 'divorced' and 'widowed' were also coded together as 'out of marriage' while never married still stood alone as 'never married'.

A frequency analysis of marital status was run on the data for the total sample (both migrants and non-migrants together) and separately for migrants and non-migrants. The analysis revealed that 65.1%, 29.7% and 5.2% of the respondents are respectively 'never married', 'married/living together' and 'out of marriage' (See Figure 5.2). Not only that, the results as shown in Figure 4.3 reveal that 68.1 per cent of the and migrants 62.1 per cent of the non-migrants have 'never married', while 30.2% and 29.3% in like manner are 'married/living together'. Also, about 1.7% of migrants and 8.6% of non-migrants are 'out

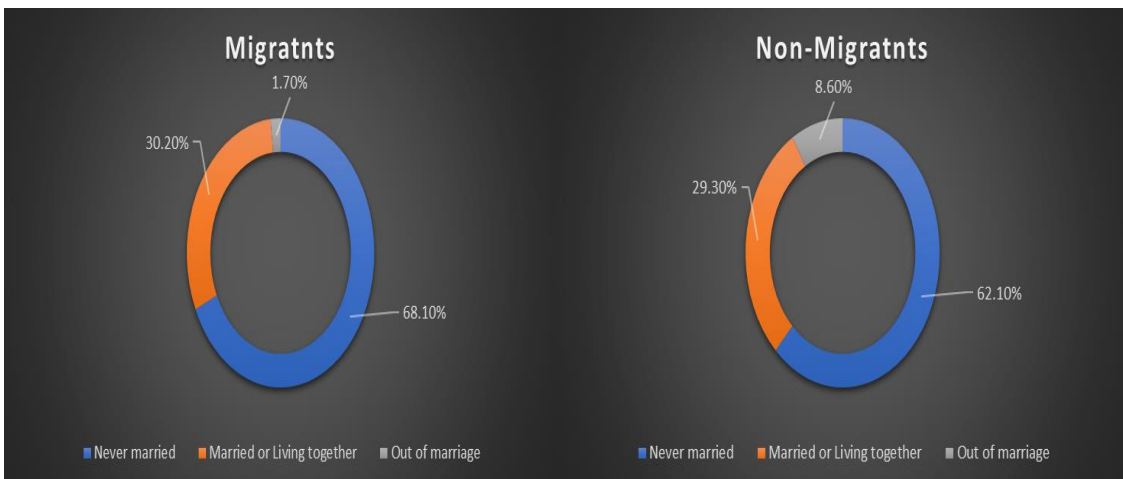
of marriage'. The results of the chi-square showed that the difference in the results is not statistically significant ( $P > 0.05$ )

**Figure 5.2: Marital Status of the total sample**



Source: Survey Nov-Dec 2018

**Figure 5.3: Marital Status of migrants and non-migrants**



Source: Survey Nov-Dec 2018 ( $P = 0.059$ )

### **5.3 Enabling factors of migrants and Non-migrants**

This section of the study discusses the distribution of the enabling factors among migrants and non-migrants. The enabling factors discussed in this section include the occupation of the migrants and non-migrants in the study. The employment status and the average monthly income of the migrants and non-migrants are also discussed in this section.

#### **5.3.1 Occupational and employment Distribution**

Among the enabling factors conceptualized by the study is the occupation of the study respondents. Some studies have shown that the occupation of an individual, can affect the individual's decision to migrate or not to migrate. There are also variations in the employment status among migrants and non-migrants in the destination areas.

The results of the analysis show that Six per cent of the total sample had no occupation. The analysis further indicates that 15.1 per cent of the total sample is engaged in sales and trading while 15.9 per cent is into services (Table 5.3). The majority of the total sample of the study are students.

The results of the analysis continue to show that, a slightly greater percentage (6.9%) of the migrants compared to the non-migrants (5.2%) have no occupation. Meanwhile, a higher percentage of the non-migrants (16.4% and 20.7%) compared to the migrants (12.1% and 11.2%) are into Professional/Technical and services respectively. None of the migrants in the study are engaged in agricultural or household and domestic work. The greater percentage (40.5%) of the migrants in the study are students while the greater percentage (20.7%) of the non-migrants in the study are into the provision of services (Table 5.3). The chi-square analysis shows that the differences in the distribution among the occupation of the migrants and non-migrants is statistically significant ( $P=0.00$ )

Besides, the qualitative data analysis also revealed that the participants are mostly students and from Ivory Coast and Nigeria. Below is how some of the participants explained their occupation in Ghana:

*"I am here to study English and go back... my institution has no health facility. I don't know if foreigners could also register for the Ghanaian national health insurance"... I will go back, when I am done with my English studies and I go back it will help me get a good Job* **(Lola, female age 19, Ivorian student).**

*"I came to Ghana for about a year and a half ago, I came to study English. The school is just before the hostel... Yes, the school is here in Alarjo K junction"... I will not return permanently to my home country but will also not like to stay in Ghana. My aim is to go to the United States, I am only here to learn English. When I am done with my studies I will move on.* **(Robert, Male age 24 years, a student from Ivory Coast)**

*"I am a Biomedical Engineering student at the Valley View University, I came to Ghana 5 Years ago. I first did a Diploma in Biomedical Engineering and now doing the degree"* **(Forlake, Female age 25, Nigerian student)**

*"Well, I am on a scholarship to do my PhD in Public health here at the University of Ghana. I was working before I left for Ghana, I am in my final year and I will go back to Nigeria as soon as I am done".* **(Amala, Female age 38 years, Nigerian Student)**

Deducing the from the analysis, the students from francophone neighbouring countries are mostly in Ghana to study English to better their chances of employment in their home countries as in the case of Lola, and also to enhance their chances of moving to advanced English-speaking countries as in the case of Robert. In the case of the Nigerian students,

they are mostly in Ghana to study health-related courses as in the cases of Amala and Forlake.

The findings further revealed that one out of every five (20%) of the total sample is employed in a part-time job while far more than half (64.7%) are engaged in a full-time job with 15.3 percent of the total sample not employed. The chi-square test results indicate that the difference in the employment status that existed among the migrants and the non-migrants is statistically significant ( $P=0.00$ ). A greater percentage (28.3%) of the migrants compared to the non-immigrates are in part-time employment while the opposite is true for the percentages employed in full-time jobs. Below are how some of the qualitative interview participants explained their employment status:

*"I came to Ghana in 2006, I was doing a restaurant business, but now I am selling shoes in here at Makorla Market. The restaurant business is not for me, this one is my own". (Mr Sue, Male, aged 45, Chinese businessman)*

*"I am not working. I am on a scholarship, provided by the World Health Organization" My job is in Nigeria, here in Ghana, I am only here to do my PhD" (Amala, Female aged 38, Nigerian student)*

*"I sell credit in my room, I also do some cleaning work for the Valley View University, I will not be paid cash, but the pay will be credited to my fees in dollars. It helps to balance the rise in the dollar when I am paying my fees for the next semester" (Borla, female aged 24, Nigerian student).*

From the qualitative interview conversations, some of the migrant students do not engage in any employment like in the case of Amala but Borla is engaged in part-time employment of selling call credit cards and also working for the school.

### **5.3.2 Average monthly income**

Included in the conceptual framework of the study is 'income', standing as an independent or enabling variable that influences an individual's access and use of health care. In Andersen's model (1968), 'income' is treated as a factor that enables the individual to access and use health care. In this study, 'income' was measured by asking the respondents to give their average monthly income. The responses range from 'No income' to earning '3000+'. In between these two responses are 'less than 300', '300-499', '500-799', '800-999', '1000-2999' all measured in Ghana Cedis.

The results as displayed in Table 5.3 show that less than two out of ten (18.1%) of the total sample, earn no income while a little over one out of ten (12.1%) of the total sample earns less than 300 Ghana Cedis. About 9.5% earns '500-799' and about 9.1% earns 3000 and above Ghana Cedis.

A more detailed analysis shows that a greater percent (20.7%) of the migrants compared to the non-migrants (15.5%) earn 'no income'. While 12.1% of all the sections (among migrants and non-migrants) earn less than '300' Ghana Cedis. While 12.1% of all the sections (among migrants and non-migrants) earn less than '300' Ghana Cedis.

**Table 5.3 Distribution of Enabling factors**

	Total sample	Non-migrant	Migrants	P-Value
	%	%	%	
<b>Occupation</b>				0.00
No occupation	6	5.2	6.9	
Professional/Technical	14.2	16.4	12.1	
Managerial	9.9	11.2	8.6	
Clerical	2.6	1.7	3.4	
Sales/Trading	15.1	19	11.2	
Agriculture-self	0.4	0.9	0.00	
Household and Domestic	0.9	1.7	0.00	
Service	15.9	20.7	11.2	
Skilled manual	5.2	7.8	2.6	
Student	26.3	12.1	40.5	
Other	3.4	1.7	1.7	
<b>Employment Status</b>				0.00
Employed, part time	20	12.2	28.3	
Employed, full time	64.7	81.6	46.7	
Not employed	15.3	6.1	25	
<b>Average Monthly Income</b>				
No income	18.1	15.5	20.7	
Less than 300	12.1	12.1	12.1	
300-499	21.1	25.9	16.4	
500-799	9.5	11.2	7.8	
800-999	6	3.4	8.6	
1000-2999	24.1	25.9	22.4	
3000+	9.1	6	12.1	0.16

Source: Survey Nov-Dec 2018

#### 5.4 Health Care needs Factors of the Respondents

This section of the chapter focuses on the need factors of the respondents. Three variables in the data were used to represent the factors that make a respondent need health care.

The results of the analysis revealed that less than one out of every five (19.8%) of the respondents are living with a chronic illness while about four out of every five (80.2%) of the respondents have no chronic illness (Table 5.4). Approximately 14 per cent of migrants are living with a chronic illness while a little more than a quarter (25.9%) of the non-migrants are also living with a chronic condition. Eighty-six per cent and seventy-four per cent of the migrants and non-migrants respectively had no chronic condition. The chi-

square test results also show that the differences presented in relation with migration status are statistically significant. This means that comparatively more of the non-migrants compared to the migrants will need health care. This in a way, points to the healthy migrants' effect discussed in the literature in Section 3.1.0. According to the healthy migrants' effect theory, migration is selective towards individuals that are healthy. However, one cannot explain if the migrants in the study arrived in Ghana as healthy people or became healthy after they arrived in Ghana.

The analysis (Table 5.4) continues to reveal that approximately three out of every five (62.9%) of the respondents had no injury nor illness throughout the past 12 months preceding the interview. Also, 28.4 per cent and 6.5 per cent of the respondents, respectively, had illness and injury in the past 12 months preceding the interview with 2.2 per cent having both illness and injury within the same period. About 60 per cent and 56.9 per cent of migrants and non-migrants respectively, had neither illness nor injury in the 12-month period preceding the interview.

Furthermore, the analysis showed that 36.4 per cent of the respondents in the total sample, 44.8% of migrants and 27.6 per cent of non-migrants rated their health status as at the time of the interview as, 'very good' (Table 5.4). Meanwhile 37.9 per cent, 31.9 per cent and 44 per cent of the total sample, migrants and non-migrants respectively rating their health status as 'good'. Less than 3% of both migrants and non-migrants rated their health status as 'poor'.

**Table 5.4: Need Factors of respondents**

Need Factors	Total sample		Migrants		Non-Migrant Only		P-Value
	Number	%	Number	%	Number	%	
<b>Living with a chronic illness</b>							0.021
Yes	46	19.8	16	13.8	30	25.9	
No	186	80.2	100	86.2	86	74.1	
<b>Had an injury/illness</b>							0.012
No illness/injury	146	62.9	80	60	66	56.9	
Illness	66	28.4	26	22.4	40	34.5	
Injury	15	6.5	10	8	5	4.3	
Both illness and injury	5	2.2	0	0	5	4.3	
<b>Perceived Health status</b>							0.033
Very good	84	36.2	52	44.8	32	27.6	
Good	88	37.9	37	31.9	51	44	
Moderate	49	21.1	24	20.7	25	21.6	
Fair	8	3.4	3	2.6	5	4.3	
Poor	3	1.3	0	0	3	2.6	

Source: Survey Nov-Dec 2018

### 5.5: Migration Characteristics/Profile of the Migrants

The socio-demographic and health care need characteristics discussed in the previous sections are not the only variables that influence an individual's access and use of health care. In the instance where the person is a migrant, other variables reflecting the person's migration characteristics also affect the person's access and use of health care. The conceptual framework (Figure 3.2) exhibits some of these variables.

This study considers migration status as a key variable that influences access and use of health care. The study, therefore, gathered data on some other variables to form the migration characteristics of the respondents. Among those variables are the origin of the migrant, the type of migrant, the duration or length of stay in Ghana, whether the migrant has a close relative in Ghana, whether the migrant has a friend in Ghana, whether the migrant at the time of the interview, has the intention to permanently return to his or her

home country and the last but not the least, whether the migrant at the time of the interview has the intention to permanently stay in Ghana.

As stated in the methodology (Chapter 4), the study interviewed an equal number (116) of migrants and non-migrants. The results as shown in Table 5.4, reveal that, close to 6 out of every 10 migrants (58%) are from other West-African countries, about 21.6 percent are from other African countries with 20.7 per cent being migrants from non-African countries. This finding is in line with the 2010 census data which shows that the majority (68%) of migrants in Ghana are from other Western African countries (GSS 2014)

Furthermore, 21.6 per cent of the respondents have been in Ghana for less than a year as at the time of the interview. While the majority (67.2%) has spent between '1 to 10 years' in Ghana, with 6.9 per cent and 4.3 per cent of the migrants living in Ghana for a period of between '11 to 20 years' and '20 years and above' respectively.

The results as shown in Table 5.5 further revealed that a relatively small percentage (2.6%) of the migrants in the study are refugees. This could be a result of the recent (2007,2010, 2012, 2018) voluntary repatriation of refugees from other West-African countries. The voluntary repatriation happens to be a result of the relative peace that the West African sub-region has in recent times.

Also, about 22.4 per cent of the migrants in the study are 'Documented expatriates' with half (50%) being 'Documented Students'. 'Other documented' migrants like businessmen and women, spouses of other migrants and Ghanaians, also constitute about 13.8%. Undocumented migrants that took part in the study were about 11.2%.

From the analysis, 56.9% of the migrants said they have a close relative in Ghana while 43.1 per cent said they do not have a close relative in Ghana. Approximately four out of five (78.4%) of the migrants said they have a close friend in Ghana.

Not only that, the analysis showed that, a little more than 2/5 (41.4%) of the migrants at the time of the interview has the intention to permanently return to their home country. While about three out of every ten (33%) of the migrants have no such intention of permanently returning to their home country, with about a quarter (25.9%) of the migrants not sure of their decision to permanently return to their home country. In addition, 16.4 per cent of the migrants at the time of the interview have the intention to permanently stay in Ghana. More than half of the migrants (56.9%) said at the time of the interview they have no intention to permanently stay in Ghana and 26.7 per cent are not sure of the decision to permanently stay or not to stay in Ghana.

Some qualitative interview participants, when asked if they will like to permanently return or stay in Ghana, did not give a straightforward answer as was pre-coded in the quantitative interview but said:

*“I will not return permanently to my home country but will also not like to stay in Ghana. My aim is to go to the united states, I am only here to learn English. When I am done with my studies I will move on”.* **(Robert, Male, aged 24 Ivorian student)**

*“Well, I love Ghana, will like to stay because my husband is a Ghanaian but we will visit my home town from time to time, last month we were there”.* **(Kafokafo, Female aged 36, a trader from Togo)**

*“I will go back to Nigeria but I will love to visit Ghana again because I have friends here in Ghana”.* **(Borla, female aged 24, Nigerian student)**

**Table 5.5: Percentage Distribution the Characteristics of Migrants**

<b>Profile</b>	<b>Number</b>	<b>%</b>
<b>Origin</b>		
Other West-Africans	67	57.8
Other-Africans	25	21.6
Non-African	24	20.7
<b>Duration of Stay</b>		
< 1 year	25	21.6
1-10 years	78	67.2
11-20years	8	7.0
20+	5	4.3
<b>Type of Migrant</b>		
Refugee	3	2.6
Documented Expatriate	26	22.4
Documented Student	58	50.0
Other Documented	16	13.8
Undocumented	13	11.2
<b>Have a Relative in Ghana</b>		
Yes	66	56.9
No	50	43.1

Source: Survey Nov-Dec 2018

**5.6 Healthy Immigrants' Effect from the views of the migrants**

The health status of migrants has been an issue of debate in the literature. Some studies have argued that the health status of newly arrived immigrants is better and one to be desired (McDonald and Kennedy 2004) than the health status of indigenes of the destination area. Other studies have gone ahead to argue that the health status of migrants is not only better than the health of the native population of the destination area, but also better than the health status of the native population of the origin area.

Though some studies have also demonstrated that the healthy immigrant effect is not applicable to immigrants in areas that they have studied (Constant et al 2015), the views of the migrants in comparing their health status with when they first arrived and with the native population of the origin and the destination areas has not been explored.

This section of the study explores the views of migrants on their current health status, comparing it with when they first arrived and with their age cohorts of the origin and the destination areas. In doing this, the study asked the migrants the following questions:

- i. Comparing your current health status with when you first arrived in Ghana, how would you describe your health status?
- ii. Comparing with your age cohort in your home country, how would you describe your current health?
- iii. Comparing with your age cohort in Ghana (Ghanaians), how would you describe your current health status?

The findings revealed that, approximately four out of ten (44%) of the migrants are of the view that their current health status is not different from their health status when they first arrived in Ghana (Table 5.6). Nearly 32 per cent of the migrants are of the view that, they were healthier when they first arrived in Ghana than now. About four out of every five (20.7%) of the migrants are of the view that, their current health status in Ghana is better than when the first arrived in Ghana (Table 5.6).

The qualitative data analysis showed that, some of the migrants cannot remember, however, those that did compared their health status based their it on their experiences of when the first arrived in Ghana and when they visited the origin countries. Those that have in a long time not visited their origin country said they cannot say anything about their health. Below are some of the quotes from the analysis

*“I think my health is still the same as when I first came it is only three years ago, and I have not been feeling sick when I was in Nigeria, and is the same thing here in Ghana” (Borla, female aged 24, Nigerian student)*

*“I am better now, because when I first arrived in Ghana, I could not eat your food. And I did not know any place where they sell Nigerian stuff. When I try to eat the food sold in the cafeteria, I was not able, I felt sick, but now I can eat all the Ghanaian food except Banku that one I don't like the way it sticks in my hands. My immune system is strong” (Forlake, Female aged 25 years, Nigerian student).*

*“I cannot say anything about what you are asking now. You see, if I had known I would have taken notice, but Me I am fine, is only that when I came, I had a dog bite in the first week. I will not forget” (Mr Sue, Male, aged 45, Chinese business man).*

The findings point to the fact that, though studies may suggest that, the health status of immigrants can be impacted by the destination area the views of the migrants regarding these issues show that, they base their judgement on their experiences of which a greater percentage (44%) of them are of the view that their current health status is the same as when they came.

The findings, as revealed in Table 5.6 show that, the greater percentage (36.2%) of the migrants cannot compare their health status with their age cohorts in the origin areas, whereas a little over 30 per cent are of the view that their health status is the same as their age cohorts in the origin areas (Table 5.6). Roughly 21 per cent are of the view that, health status of their age cohort is better than theirs with only about 12 per cent of them having the view that they are healthier than their age cohorts (Table 5.6).

The qualitative data analysis revealed that, the participants that do not visit the origin countries or did visited in a very long time are not able to give a direct answer to this question.

*“When I left I have visited only once, these are difficult questions. I can’t even remember the health conditions of most of my friends so, how can I compare”* (**Mr sue, Male aged 45, Chinese business man**)

The findings further revealed that, the migrants in comparing their health status with that of their age cohorts in Ghana, nearly one out of every four (25.9%) of them are of the view that, their health is the same as their Ghanaian equals (Table 5.6). Below is how Lola and Bruno explain their views:

*“We are all the same, no difference between us”* (**Lola, female, age 19, Ivorian student**).

*“Me and my Ghana brothers are all the same”* (**Bruno; Male age 31 from Chad**)

The findings suggest that in spite of the different views held by scholars (Lu et al 2017; Kwak 2016; Constant et al 2015; McDonald and Kennedy 2004) concerning the health status of immigrants, when the views of the migrants themselves are considered in the debate, a new and a more dynamic perspective concerning the healthy immigrants’ effect could be reached. This is because the migrants when questioned about their current health status from the perspective of the “Healthy Immigrant Effect” based their responses on their health experiences in Ghana. Their experiences and responses could emanate from the differences in their duration of stay in Ghana as some could not compare their arrival health status to the current one. Differences in the frequency of visitation to origin country could also account for the difference in responses.

**Table 5.6: Healthy Immigrants’ Effect from the views of the migrants**

Comparing current health status with:	Number	%
<b>when first Arrived in Ghana</b>		
Currently Healthier	24	20.7
Healthier Than	37	31.9
Same	51	44
Cannot Tel	4	3.4
<b>age cohorts at the origin</b>		
I am healthier	14	12.1
They are healthier	25	21.6
We have Same health Status	35	30.2
I cannot Say	42	36.2
<b>age cohorts in Ghana</b>		
I am healthier	23	19.8
They are healthier	14	12.1
We have Same health Status	30	25.9
I cannot Say	49	42.2

Source survey Nov-Dec 2018

### 5.7 Summary

Summarising the chapter, this chapter presented the socio-demographic (predisposing and enabling factors), need factors, of respondents, the migration characteristics of the respondents and the “Healthy Immigrants’ Effect” from the view of the migrants. The predisposing characteristics considered include age, sex, marital status, and level of education. The enabling factors discussed in the chapter also include, the occupation of the respondents, the employment status and average monthly income. The three health care need factors considered are whether the respondent is living with a chronic illness, whether the respondent had an injury or illness in the 12-month period preceding the interview and the respondents’ own perception of their health status.

Also, presented in this chapter are the analyses of the key features of the migrants in the study. The characteristics or features considered are the migrants’ origin, duration of stay in Ghana, the type of migrants, whether the migrants have close relatives or friends in

Ghana and last but not the least, whether the migrants at the time of the interview have any intention to permanently stay in Ghana or return to their home countries.

The last part of the chapter focusses on the discussing of the “Healthy Immigrants’ Effect” from the view of the migrants. The migrants were asked about their current health status, comparing it to when they first arrived in Ghana, their age cohort at the origin area(s) and their age cohort in the destination area.

The findings in this chapter show that, far more than half of the migrant population is relatively younger compared to the non-migrant population (52% migrants and 44% non-migrants within age 18-17 years). The result also demonstrates that there are more females (54.3%) than males (45.7%) among the non-migrants. While the ‘migrants only’ sample has more males (53.4%) than females (46.6%). Far more than half (69.9%) of the migrants has either a bachelor or post-graduate degree. A greater percentage of the migrants (68.1%) compared to the non-migrants (62.1%) are never married.

The majority of the total sample (26.3%) and among the migrant population (40.5%) are students. No migrant is engaged in Agricultural or household and domestic work.

The students from neighbouring French speaking countries are normally in Ghana to study English to enhance their employment opportunities in the home countries or to aid them to further migrate to advanced English-speaking countries.

The migrants are mostly engaged in part time employment while the non-migrants also mostly engage in full time employment. The analysis also shows that close to 58 per cent of the migrants are from West-African Sub-Region, with about 21.6 percent also coming from other African countries. About 20.7 per cent of the migrants are from non-African countries and about 11.2% of the migrants are undocumented. The qualitative result also

shows that there is no straightforward answer to a respondent permanently returning or staying in Ghana.

The chapter also revealed that, some of the migrants are unable to remember the state of their health when they first arrived in Ghana, however, those that did based their comparison on the experiences they had when they first arrive. And though the theory on the Healthy Immigrant effect suggests that, migrants are healthier when they first arrive and then the native population of both the host and origin societies, the majority (445) of the migrants are of the view that their current health status is not different from when they first arrived. Also, the percentage of migrants that are of the view that the health status of their age cohort at the origin is better than their health (21%) is greater than the percentage (12%) of those that think their health status is better than their age cohort at the origin area.

## CHAPTER SIX

### HEALTH INSURANCE AND ACCESS TO HEALTHCARE SERVICES

#### 6.1 Introduction

This chapter is devoted to the analyses of the health insurance status of respondents and their access to health care. The chapter has three main parts, the first part is dedicated to the analyses of the respondent's health insurance status and categorisation. The second part of the chapter also focuses on access to health care among the respondents. The analysis for the first two parts of the chapter was also carried out among migrants and non-migrants. A chi-square test was also used to test the statistical significance of the differences that may exist between the migrants and non-migrants.

The other part of the chapter analysed the relationship between selected background characteristics (predisposing, enabling, need factors of the respondents and migrants' characteristics) and access to health care. A section of the thematic network of access to health care is also presented in this chapter (Figure 6.8)

#### 6.2 Health insurance status and categorisation among migrants and non-migrants

The study used health insurance (public or private) and having health coverage as a measure of access to health care. The three questions that were used to measure access to health care are described in the methodology section of the thesis. The respondents both migrants and non-migrants were asked if they are currently registered on any health insurance scheme in Ghana. The aim of asking the respondents this question, was to find out, the respondents' health insurance status. The pre-coded response options for this question are: (1) Yes, currently registered (2) No, never registered (3) No, previously registered and the last response option is (4) 'don't know'.

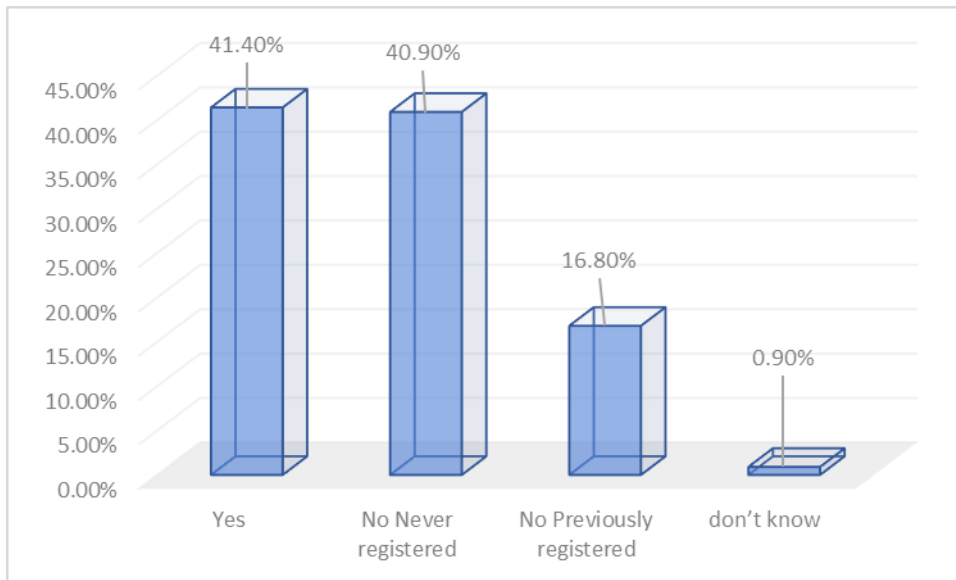
This section of the thesis presents the results on the current health insurance status of the respondents and the type or category of the scheme they belong to. The results as shown in Figure 6.1 reveals that less than half (41.4%) of the respondents are currently registered with a health insurance scheme in Ghana. This means that using health insurance as a measure of access, less than half of the study population can be said to have access to health care. This also implies that as at the time of the interview, less than half (41.4%) of the study population could access health care. The results of the analysis also show that 40.9 per cent have never been registered on any health insurance scheme in Ghana while 16 per cent were previously registered. Also, 0.9 percent responded that they don't know if they have ever been registered with a health insurance scheme in Ghana or not. The obvious interpretation of the answer "don't know", is that either they have never been registered or they were previously registered but currently are not. Or, it could also be that they were irritated by the question or the import of the question which sought to know about their current health insurance status.

In addition, more than seven out of every ten (74.1%) of the migrants compared to two out of every twenty-five (7.8%) of the non-migrants have never registered with a health insurance scheme in Ghana (Figure 6.2). These findings, though similar to Dias et al (2015), a greater percentage of migrants (74.1%) in this study compared to 20 per cent in Dias et al's (2015) study have never registered with a health insurance scheme in their host communities.

The results further revealed that eight out of every twenty-five (32%) of the non-migrants have previously been registered with a health insurance scheme in Ghana, while less than one out of every fifty migrants (2%) have previously registered with a health insurance scheme in Ghana. Furthermore, the results of the chi-square test also indicate that the differences in health insurance coverage among migrants and non-migrants are statistically

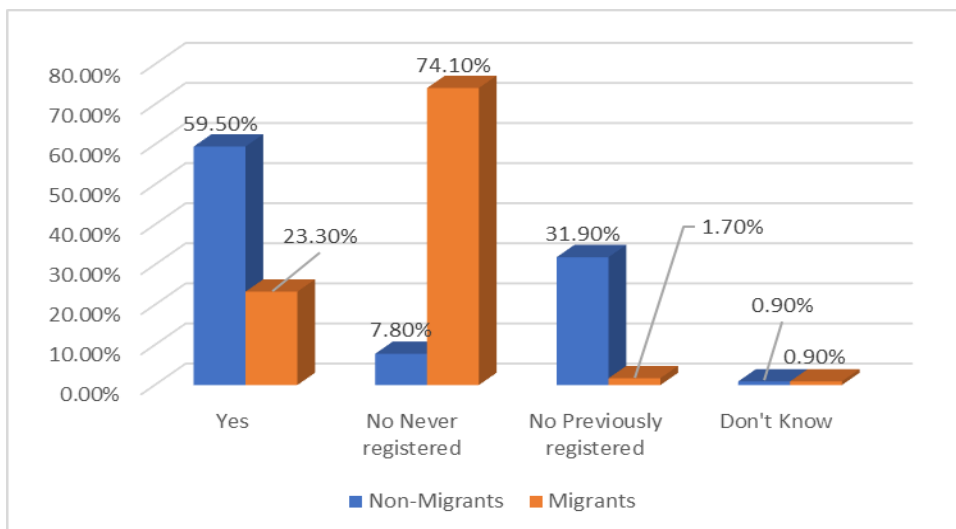
significant ( $P = 000$ ). The findings are consistent with Ku and Matani (2001) as their study discovered that, non-citizens (migrants) are less likely to have a usual source of health care, because of their low level of health insurance cover.

**Figure 6.1: Health Insurance Status of Respondent**



Source: Survey Nov-Dec 2018

**Figure 6.2: Health insurance status among migrants and non-migrant**



Source: Survey Nov-Dec 2018 ( $P = 000$ )

Nonetheless, the qualitative interview revealed that lack of knowledge of the processes of acquiring health insurance in Ghana and unwillingness to carry around too many cards and papers explained why some migrants have not been on any health insurance scheme in Ghana. Mr Sue, Borla and Donkor explain why they are not on any health insurance scheme in Ghana.

*“I have not registered with any health insurance in Ghana because, I go to the Chinese hospital. I don’t think I will register because, Ghanaians like paper and card too much. Everything card, paper. In China, everything is on my phone, insurance, bank account and everything. I do not have to carry paper and card”.* **(Mr. Sue, Male, aged 45, Chinese businessman)**

*“I am not on any health insurance because, I did not know I could register with the NHIS. Moreover, whenever I am coming from home after vacation, I come with my essential drugs, like para and others. When I run out of my essential drugs, and I have a headache I ask my roommate or buy from the drug store”.* **(Borla, Female, aged 24, Nigerian student)**

*“I am not on the health insurance because when I first did, I never used it. Is because I don’t usually feel sick, I am strong. I take pain killer when I have body pains after work”.* **(Donkor, Male age 31, Ghanaian trader).**

From the explanations of Mr Sue and Borla who are both migrants, they respectively depend on Chinese hospital and the pharmacy or drug stores to maintain health, which do not necessarily require the use of a health insurance. Deducing from their explanations, the availability of alternative health care (Chinese hospital) and ability to purchase drugs from pharmacy and drug stores without prescription may also be underlining reasons why some migrants may not want to register with a health insurance scheme in Ghana.

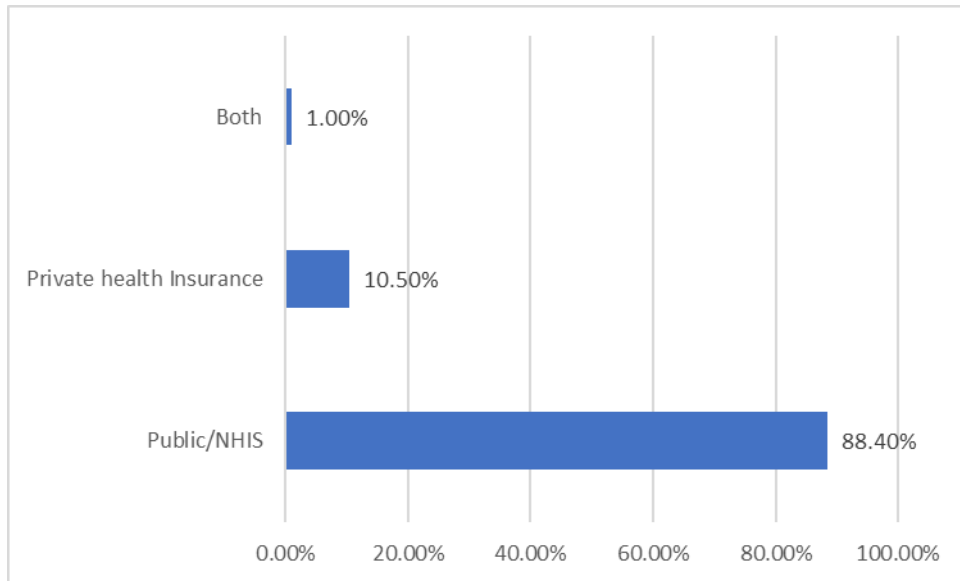
### **6.2.1: Health insurance type among migrants and non-migrants**

The respondents that were currently registered with a health insurance scheme as at the time of the interview were asked the type of insurance scheme they belong to. As the analysis shows, in Figure 6.3 88.5% of the respondents with health insurance cover are registered with the public or the National Health Insurance Scheme (NHIS). This means that the National Health Insurance Scheme in Ghana is the largest provider of health insurance coverage for the respondents that are currently registered with a health insurance. A little more than a tenth (10.4%) of the respondents are on private health insurance. While one percent of the respondents belong to both public and private health insurance.

In addition, the results show that a greater percentage of the non-migrants (97.1%) compared to the migrants (66.7%) are on the public/NHIS (Figure 6.4). The result of the analysis further showed that one-third (33.3%) of the migrants registered with a health insurance, are registered with a private health insurance scheme. This finding was explained in the analysis of the unstructured expert's interview, which revealed that foreign students (migrants) are purposefully enrolled on a private health insurance scheme, while Ghanaian students have a component of their fees as a health insurance cover. Below is how the Expert interviewed explained it.

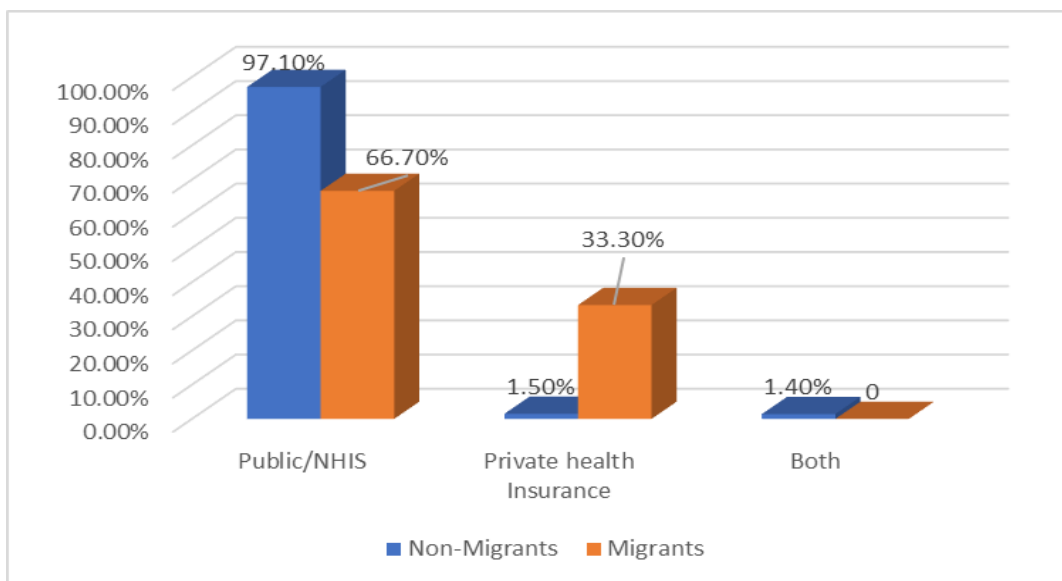
*“Yeah, what they do most is, the students, I think they are to enrol on a private Health Insurance. Before then they pay to the university, but I don't know, the whole policy changed.... The Ghanaian students pay a component of their fees basically for medical service. That is... another form of health insurance”* **(In Charge of Hospital Records, University of Ghana Hospital)**

**Figure 6.3: Health insurance type of respondents**



Source: Survey Nov-Dec 2018

**Figure 6.4: Health insurance type among migrant and non-migrants**



Source: Survey Nov-Dec 2018 (P=000)

### **6.2.2 Health coverage by affiliation among migrants and non-migrants**

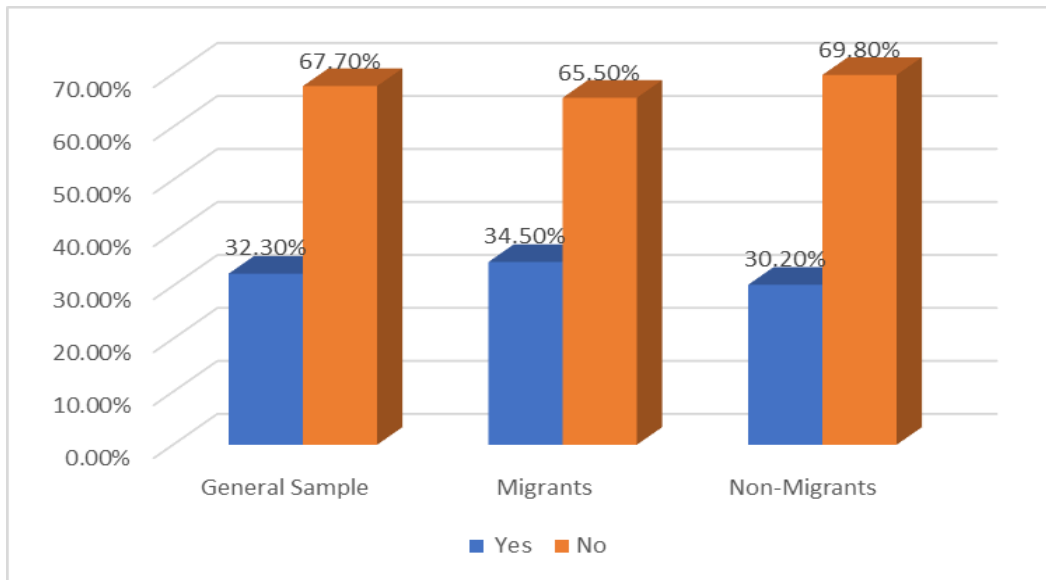
Two other questions were used in measuring access to health care. The questions are: (i) Are you affiliated to a workplace/ institution with a health facility that you are entitled to access by virtue of your affiliation without paying directly? And (ii) Are you affiliated to an institution or workplace that gives you health coverage? A new variable (Health affiliation) was created from these two questions. The individual has health coverage by affiliation, if he or she answers 'Yes' to any of the two questions above. And the individual is said to have no health coverage by affiliation, if he or she answers 'No' to both questions.

The import of these two questions was to capture individuals that may not necessarily be registered with a health insurance scheme in Ghana, but are able to access health care with minimum or no financial burden by virtue of the health coverage being provided for them at their workplaces. And also, to capture those that have health coverage because they themselves or their immediate family member or relative is affiliated with an institution that provides health coverage for them. For instance, the spouse or child of an employee of the Volta Aluminium Company (VALCO) can access health care services at the VALCO Hospital without necessarily paying cash which is also another form of health insurance. The same applies to employees of the University of Ghana and many other institutions in Ghana.

The results of the analysis revealed that about one-third (32.3%) of the respondents have health coverage by virtue of their affiliation to a workplace or institution (Figure 6.5). It further shows that 34.5 per cent and 30.2 per cent of the migrants and non-migrants respectively, have health coverage by virtue of their affiliation to a workplace or institution (Figure 6.5). However, the chi-square test results show that the differences in

the results with regard to migration status is not statistically significant ( $P > 0.05$ ). This can be explained by the percentage recorded in the two categories which are similar.

**Figure 6.5: Health coverage by virtue of affiliation to a workplace/institution**



Source: Survey Nov-Dec 2018 (Chi-Square;  $P=0.483$ )

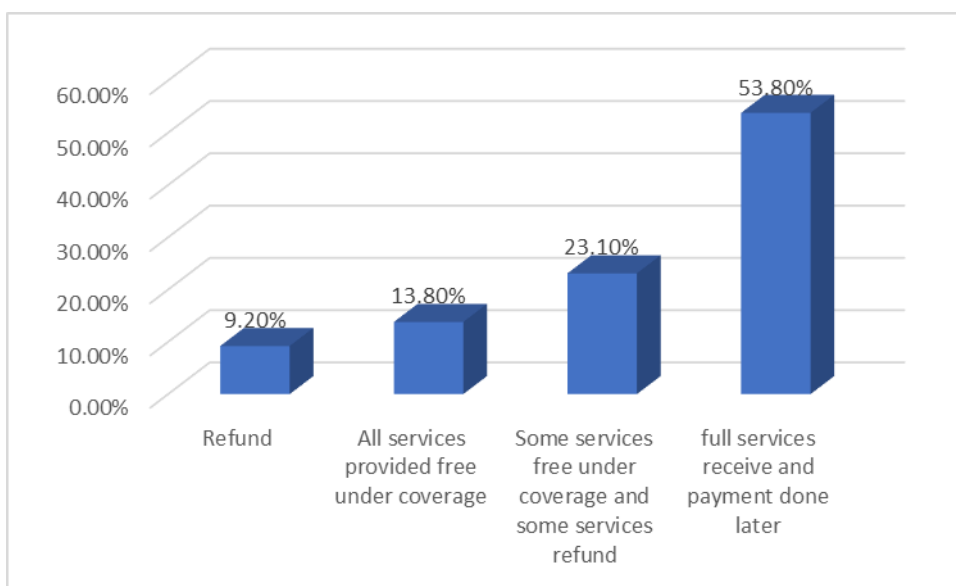
### 6.2.3: Administration of health coverage by affiliation

Respondents that had health coverage by virtue of their affiliation to a workplace or institution(s) were further asked how the health coverage is administered. The results (Figure 6.6) show that approximately 14 percent have all services provided free under the coverage. A little over one out of five (23%) have some services provided free under the coverage while some are paid for or refunded. Approximately 54 per cent receive full service with payment done later. Below is how Borla reinforced this point during the qualitative interview:

*“When I was admitted at the Valley View Hospital, I did not pay anything, but the bill was later added to what I owed the school. So that semester, my balance went up so much”.* (Borla, female aged 24, Nigerian student)

Borla’s explanation showed that, because of her affiliation to the Valley View University as a student, she is able to access health care in the Valley View Hospital without paying cash immediately. Health coverage for her may not be the same as it is for migrant students of the University of Ghana but she will not have to worry about immediately paying money for accessing or using health care, provided she will obtain it from the Valley View Hospital.

**Figure 6.6: Respondents’ Health coverage administration**



Source: Survey Nov-Dec 2018

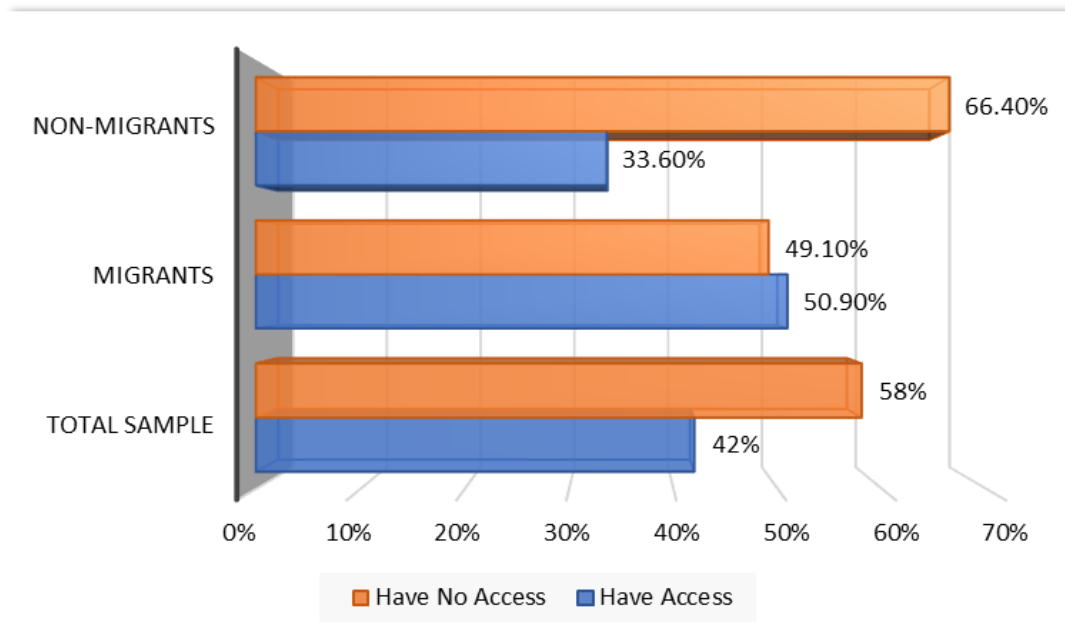
### 6.3 Access to health care among migrants and non-migrants

This section presents the analysed results of the respondents’ access to health care. Access to health care as explained in section 4.5 was measured using the three questions. A new variable called access to health care was created out of those three questions. A person is said to have access to health care when he or she answered ‘Yes’ to either (i) Are you affiliated to a workplace/ institution with a health facility that you are entitled to access by virtue of your affiliation without paying directly? Or Yes to (ii) Are you affiliated to an

institution or workplace that gives you a health coverage? ‘And Or’ answered ‘currently registered’ to the question ‘Are you currently registered with any health insurance?’

The results in Figure 6.7 show that more than half (58%) of the respondents have access to health care. This means that 58% of the respondents are either affiliated with a workplace or institution that gives them health coverage or are registered with a health insurance scheme in Ghana. The results (Figure 6.7) also show that 42% of the respondent have no access to health care in Ghana. The same results also showed that a higher percentage (50.9%) of the migrants compared to non-migrants (33.6%) have no access to health care. This finding is consistent with other studies such as Zinhidula et al (2015) and Wassink (2018). According to Zinhidula (2015) access to health care remains a challenge to their study participants. Their study found that the migrants have limited access to health care and also, there is the existence of a health coverage gap between migrants and non-migrants.

**Figure 6.7: Respondents’ Access to Health care**



Source: Survey Nov-Dec 2018

#### **6.4 Relationship between socio-demographic (Predisposing and enabling), need and migration characteristics and Access to health care.**

The relationship between selected socio-demographic characteristics, need factors, migration characteristics and access to health care are explained in this section. Chi-square test statistic was used to test the association at 95% confidence level (alpha level of 0.05).

The first part of the section presents the relationship between selected socio-demographic characteristics, need factors and access to health care. The second part examines the relationship between the migrants' characteristics and access to health care.

##### **6.4.1 Relationship between socio-demographic (predisposing factors) and access to health care.**

Displayed in Table 6.1 are the results of the examination of the relationship between the selected predisposing, enabling, and health need factors and access to health care. The results, as can be seen from Table 6.1 show that level of education is the only predisposing factor that has a statistically significant relationship with access to health care. The other predisposing factors or variables (age, sex, marital status and average monthly income) in the study have no statistically significant association with access to health care at 95 percent confidence level.

Level of education is statistically significantly associated with access to health care ( $P < 0.05$ ). About 73.5 per cent of the respondents with a post-secondary diploma have access to health care, about 66 per cent of those with bachelor also have access to health care while only 16.7 per cent of those with primary education have access to health care (see Table 6.1)

Though the analysis (Table 6.1) showed no statistically significant association between access to health care and the other predisposing factors such as age, sex and marital status,

it is revealed by the results of the analysis that more males (59.1%) than females (53.4%) have access to health care. Also, approximately two-third (66%) of the respondents aged 28-37 have access to health care. Also half of the respondents aged 48-67 have access to health care. The implication of the findings in relation to gender is that more of the male respondents than the female respondents are either registered with a health insurance scheme in Ghana or are affiliated to an institution or workplace that gives them health coverage. Closely related to this study is that of Antwi, Zhao and Koranteng (2014). However, the finding of Antwi, Zhao and Koranteng (2014) is different from what is found in this study. Antwi, Zhao and Koranteng (2014) found that there exist age, gender and educational inequalities in claims of the Ghana national health insurance. According to Antwi, Zhao and Koranteng (2014), younger men prefer to go to the hospital for treatment compared to older men. But among the women, it is those with basic education that choose to use hospital with their health insurance than those with higher education.

The finding in this study also contradicts what was found by Zhang et al (2018) as their study found that a significant relationship exists between age, sex and access to health care. According to Zhang et al (2018), the percentage of people with access to health care increased with age and the association was stronger among older women (above 75 years).

As part of the conceptual and theoretical framework of the study, marital status was observed as an independent or predisposing variable that can influence the study respondents' access to health care. This is because the study expected that, married individuals will be more proactive with the registration of a health insurance compared to the individuals that are not married. Also, married individuals may have health coverage from facilities that provide health coverage for their partners. Notwithstanding, this study found no statistically significant association between marital status and access to health care. But, the results of the analysis in Table 6.1 show that, a greater percentage (62.3%)

of the respondents that are married, have access to health care compared to the never married (56.3%) and the respondents that are out of marriage (50%).

This implies that, though the study did not find a statistically significant relationship between access to health care and marital status, more of the married individuals in the study either have a health insurance cover or affiliated to an institution or workplace that provides health coverage for them.

#### **6.4.2 Relationship between enabling factors and access to health care.**

The study also examined the relationship between the three enabling factors in the conceptual framework and access to health care. The study, based on the conceptual and theoretical framework adopted, predicted that the average monthly income, occupation and employment status have an influence on an individual's access to health care.

The chi-square test and the crosstabulation analysis of the relationship between the three variables show that, occupation is the only enabling factor that has a statistically significant relationship with access to health care (Table 6.1). The results of the analysis indicate that, close to seven out of ten (68.6%) of the respondents that engaged in sales or trade have no access to health care. Also, far more than half (57.1%) of the respondents with no education have no access to health care. However the analysed results show that, almost eight out of every ten (78.3%) of the respondents who are in managerial work have access to health care (Table 6.1). Not only that, more than half (55.7%) of the students in the study, have access to health care. This finding is consistent with the study of Boal et al (2018 ) as they found that occupation has a statistically significant relationship with health insurance coverage. Correspondingly, according to their study workers engaged in farming, fishing and forestry have lower health insurance coverage.

The results of the analysis show no statistically significant relationship between employment status and access to health. But, it is surprising to find in the results that a greater percentage (62.1%) of the respondents with no employment have access to health care compared to those engaged in part time employment (60.5%) and full time (61%). A plausible explanation for this finding, could be that, the unemployed because of lack of a regular source of income, will ensure themselves against any health contingencies. Another plausible explanation could be that, because a greater percentage (26.3%) of the respondents are students, they may not be employed, but may have an affiliation to health facilities by virtue of their status as students.

#### **6.4.3 Relationship between health need factor and access to health care**

This section of the study analysed the relationship between health need factors and access to health care. The health need factors considered in the study are (a) Living with a chronic illness, (b) having an injury or illness in the twelve months before the interview and (c) perceived health status of the respondent.

As the analysis shown in Table 6.1 indicates that, having an injury or illness in the twelve months before the interview and the perceived health status of the respondent are statistically significantly related to access to health care (Table 6.1).

From the analysis (Table 6.1), more than seven out of ten (77.3%) of the respondents that had an illness in the twelve months before the interview have access to health care. Also, more than nine out of ten (93.3%) of the respondents that had an injury in the twelve months before the interview have access to health care. However, less than half (45.9%) of the respondents that had neither injury nor illness in the twelve months preceding the interview have access to health care.

This finding is consistent with what has been revealed in the qualitative data analysis. The qualitative data analysis revealed that the study participants in most cases will only access health care when they encounter a serious health problem or had an emergency situation.

This is how Folarke, a participant explained her view on accessing health care:

*“I will say I only go when I am very, very ill or is like emergency case. But any small...I don't just stand up and go to the hospital because of any small illness. Because sometimes when you go the way they will treat you”.* **(Forlake, female aged 25, Nigerian student)**

The analysis (Table 6.1) also shows that, there exists a statistically significant association between the perceived health status of the respondents and access to health care ( $P=0.00$ ). As revealed in Table 6.1, far more than half (61.3%) of the respondents that rated or perceived their health status as very good have no access to health care. This result reflects Donkor's (pseudonym) point from the qualitative interview, stated in the earlier section of the chapter:

*“I am not registered with the health insurance because when I first did, I never used it. Is because I don't usually feel sick, I am strong. I take pain killers when I have body pains after work”.* **(Donkor, Male age 31, Ghanaian trader).**

What this implies is that, respondents that perceive their health status as very good will not be enthusiastic about or will be reluctant to register with any health insurance, since they cannot envisage themselves to be having any health-related problem in the near future.

**Table 6.1: Relationship between socio-demographic, need factors and access to health care**

<b>Characteristics/Factors</b>	<b>Access to Health Care</b>		<b>P-Value</b>	<b>Total N=232</b>
	<b>Have No Access</b>	<b>Have Access</b>		
	%	%		
<b>Sex</b>			0.675	
Male	40.9	59.1		115
Female	43.6	53.4		117
<b>Age category</b>			0.115	
18-27	42.1	57.9		121
28-37	34	66		50
38-47	44.8	55.2		29
48-57	50	50		16
58-67	36.4	63.6		11
68+	100	0		5
<b>Level of Education</b>			0.000**	
No education	50	50		2
Primary	83.3	16.7		6
Middle/JSS/JHS	60	40		20
Voca/Tech/Comm	75	25		12
SHS/SSS	68	32		25
Post Sec Diploma	23.5	73.5		34
Bachelor	34.4	65.6		90
Postgraduate	34.9	65.1		43
<b>Marital Status</b>			0.601	
Never Married	43.7	56.3		151
Married	37.7	62.3		69
Out of Marriage	50	50		12
<b>Average monthly Income</b>			0.095	
No income	57.1	42.9		42
<GHc 300	39.3	60.7		28
Ghc 300-499	46.9	53.1		49
Ghc500-799	36.4	63.6		22
Ghc 800-999	50	50		14
Ghc 1000-299	26.8	73.2		56
Ghc 3000+	47.6	52.4		21

**Table 6.1 continued**

Characteristics/Factors	Access to Health Care		P- Value	Total N=232
	Have No Access	Have Access		
<b>Occupation</b>	%	%	0.003	
No occupation	57.1	42.9		14
Professional/Technical	33.3	66.7		33
Managerial	21.7	78.3		23
Clerical	33.3	66.7		6
Sales/Trading	68.6	31.4		35
Agriculture-self	100	0.00		1
Household and Domestic	100	0.00		2
Service	29.7	70.3		37
Skilled manual	50	50		12
Student	43.3	55.7		61
Other	12.5	87.5		8
<b>Employment Status</b>			0.999	
Employed, part time	39.5	60.5		
Employed, full time	39	61		
Not employed	37.9	62.1		
<b>Living with a chronic illness</b>			0.253	
Yes	34.8	65.2		46
No	44.1	55.9		186
<b>Had an injury/illness</b>			0.00	
No illness/injury	54.1	45.9		146
Illness	22.7	77.3		66
Injury	6.7	93.3		16
Both illness and injury	60.	40.0		5
<b>Perceived Health status</b>			0.00	
Very good	61.9	38.1		84
Good	32.7	67.3		88
Moderate	67.3	32.7		49
Fair	62.5	37.5		8
Poos	66.7	33.3		3

Source: Survey Nov-Dec 2018

#### **6.4.4 Relationship between respondents' migration characteristics and access to health care**

This section of the chapter presents a further analysis of the relationship between the migration characteristics of the respondents and access to health care. The sample size for migration status and origin of respondent is 232 just as it is for analysing the relationship between predisposing, enabling, need factors and access to health care. But the sample size of the other variables presented in this section is 116. This is because the sample size of the migrants used in the study is 116 and questions on duration of stay were not answered by the non-migrants in the study. Only migrants answered questions about whether they will permanently return or stay in Ghana and whether they have relatives or friends in Ghana and also the type of migrants they were (documented or undocumented or students).

From the results (Table 6.2), migration status, the origin of the respondent, type of migrant and having a family/close relative in Ghana as a migrant are the factors that are statistically significantly associated with access to health care. The other factors show no statistically significant relationship with access to health care at, at alpha level of 0.05.

The results of the analyses (Table 6.2) further show that the migration status of the respondent which is statistically significantly associated with access to health care ( $P=0.008$ ) has about two-thirds (66.4%) of the non-migrants having access to health care. Meanwhile, less than half (49.1%) of the migrants have access to health care. The origin of the respondent also has a statistically significant association with access to health care ( $P=0.025$ ). The result showed that more than half (52.2%) of other West-Africans have access to health care. Also, about 54.2 per cent of non-Africans have access to health care, with only 36 per cent of other-Africans having access to health care.

In addition, the results of the analysis (Table 6.2) also show that the type of migrant has a statistically significant relationship with access to health care ( $P=0.006$ ). By the definition of access to health care used in this study, none of the refugee respondents in the study have access to health care. This could be as a result of the fact that the refugees in the study were only three constituting 2.6% of the study respondents. However, this finding corroborates that of Chuah et al (2018) which found out that, poor access to health care, exists among refugees in Malaysia. Chuah et al (2018) explained that, the existence of poor access to health care among refugees in Malaysia is perceived to have damaging consequences on both the health status of the refugees and the host community.

Meanwhile, the results show that, more than half, 57.7 per cent and 60.3 per cent of documented expatriates and documented students respectively, have access to health care. About one-third (31.3%) of 'other documented migrants' (spouses of migrants and non-migrants, businessmen and others) have access to health care. However, only 15.4 per cent of the undocumented migrants have access to health care. A plausible explanation for this finding is that the undocumented migrants may not have the necessary documentation to register for health insurance or work in an institution that can provide health coverage for them. The finding is consistent with the conceptual framework (section 3.3.0) implying that, a migrant's access to health care is a factor that is dependent on whether the migrant is documented or not. This is also consistent with the review conducted by Biswas et al (2012). Biswas et al (2012) found that, undocumented migrants have restricted access to health care in Denmark and Sweden (See section 3.1.4)

Having a family relative in Ghana is also statistically significantly associated with access to health care ( $P=0.042$ ). Approximately 60 per cent of the migrants with no family relation in Ghana have access to health care while 40.9 per cent of the migrant respondents with family relation have access to health care (see Table 6.2). This finding points to an

inverse relationship between a migrant having a relative in Ghana and access to health care. Though the conceptual framework of the study showed that having a relative in Ghana can influence access to health care, it was expected that a greater percentage of those with a family relation in Ghana should have access to health care compared to those with no family relation in Ghana. The conceptual framework expected that migrants' family relation in Ghana may provide the migrants with the necessary assistance regarding the processes and procedures of acquiring a health insurance cover in Ghana. This is because a lack of awareness of these procedures was found to be one of the reasons some migrants are not registered on any health insurance scheme in Ghana. But the findings in this study (crosstabulation and chi-square test analysis) show the opposite, as a greater percentage (60%) of those with no family relations in Ghana have access to health care (Table 6.2). What is also unclear with this finding which further studies can help to clarify, is the question on whether the migrants with family members/relations in Ghana depend on those family members or the family members depend on them. The reason is that, someone may have a family member in Ghana but may not depend on those family members for anything. It could also be that the migrant may have a family member(s) that could be a minor or actually a dependent on the migrant. Another question that can also be clarified with further studies is whether the migrants with family members in the study, came to Ghana before their family members or the family members came before them or they came together. Depending on the direction of this clarification a better explanation could be fixed for why a higher percentage (60%) of migrants with no family members or relatives in Ghana have access to health care compared with those with family relations in Ghana (Table 6.2)

Though a migrants' duration of stay in Ghana has no statistically significant association with access to health care, the analysis (Table 6.2) revealed that a greater percentage

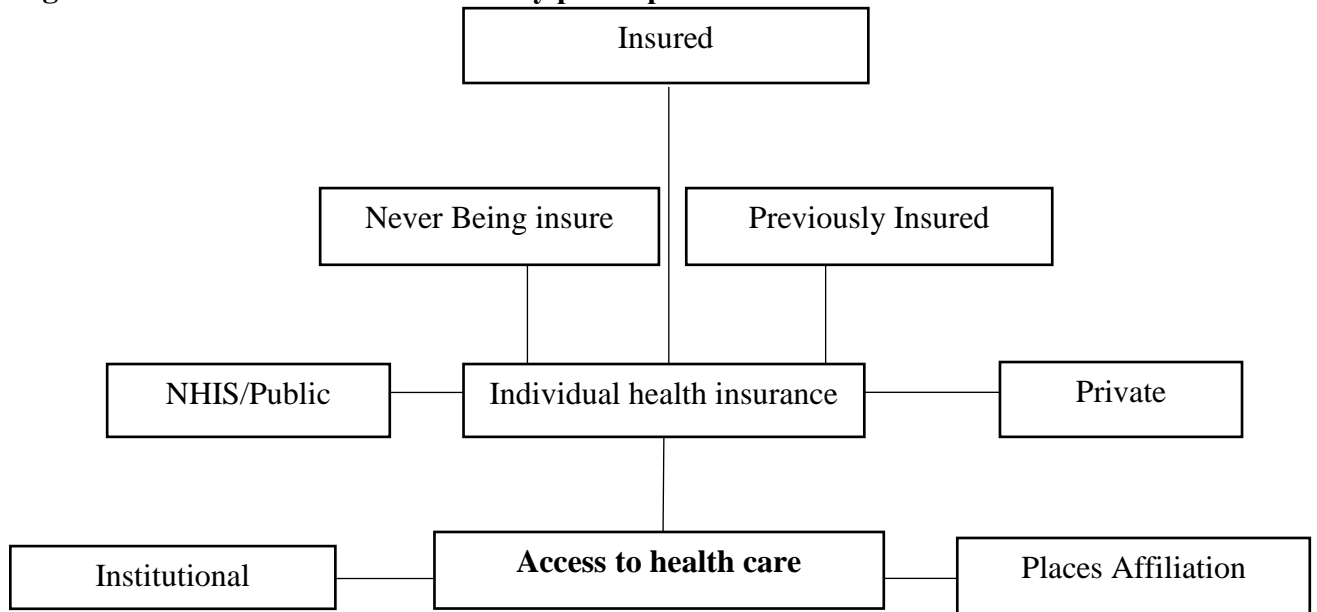
(60%) of migrants that have lived in Ghana for 20 years or over have access to health care. Also, about 54.4% of migrants who have lived in Ghana between one and ten years have access to health care while just a little more than a third (36.3%) of the migrants who have spent less than a year in Ghana have access to health care. What this means is that, the percentage of migrants with access to health care reduces with a reduction in duration of stay. A plausible explanation could be that, migrants with a shorter duration of stay in Ghana may not be conversant with the health systems in Ghana and for that reason may not be able to decide on their health insurance status. It could also be that, migrants with shorter duration of stay in Ghana are yet to negotiate their decision on how long they are going to stay in Ghana, for that reason may not have the drive to register for a health insurance in Ghana. It could also be that, the “Healthy Migrants’ Effect” is at play. Since the “Healthy Migrants’ Effect” explains that, migrants usually arrive in their host societies healthier and stronger than their native peers of the host society. This healthy nature of the newly arrived migrants may make them adamant to register for any health insurance in the host society.

**Table 6.2: Relationship between respondents' migration characteristics and access to health care**

<b>Respondents' Migration Profile</b>	<b>Access to Health Care</b>		<b>P-Value</b>	<b>Total N=232</b>
	<b>Have No Access</b>	<b>Have Access</b>		
	<b>%</b>	<b>%</b>		
<b>Migration Status</b>			0.008**	
Migrant	50.9	49.1		116
Non-migrant	33.6	66.4		116
<b>Origin of Respondent</b>			0.025**	
Ghanaian	33.6	66.4		116
Other West-Africans	47.8	52.2		67
Other-Africans	64	36		25
Non-African	45.8	54.2		24
<b>Duration of Stay</b>			0.398	
< 1 year	63.6	36.4		22
1-10 years	45.6	54.4		79
11-20years	62.5	37.5		8
20+	40	60		5
<b>Type of Migrant</b>			0.006**	
Refugee	100	0		3
Documented Expatriate	42.3	57.7		26
Documented Student	39.7	60.3		58
Other Documented	68.6	31.3		16
Undocumented	84.6	15.4		13
<b>Have A Close Relative in Ghana</b>			0.042**	
Yes	59.1	40.9		66
No	40	60		50
<b>Have Close friends in Ghana</b>			0.898	
<b>Yes</b>	50.5	49.5		91
<b>No</b>	52	48		25

Source: Survey Nov-Dec 2018 \*\* (P&lt; 0.05)

**Figure 6.8: Thematic network of study participants' access to health care**



Source: Field Interviews Nov-Dec 2018

### 6.5 Summary

In all, this chapter examined the respondents' health insurance status and access to health care. The chapter also examined the relationship between the respondents' socio-demographic characteristics and access to health care as well as the relationship between respondents' migration characteristics and access to health care.

The findings indicate that almost 3 out of every 4 (74.1 per cent) of the migrants compared to 2 out of every 25 Ghanaians (7.8%) have never registered with a health insurance scheme in Ghana. A higher percentage of the migrants (50.9%) compared to non-migrants (33.6%) have no access to health care.

Level of education, occupation, having an illness or injury in the 12-month period prior to the interview and the respondents' perception or the rating of his or her health status are the socio-demographic variables that are statistically significantly associated with access to health care (at an alpha level of 0.05). Migration status, the origin of the respondent, type of migrant and having a family/close relative in Ghana as a migrant are also the migration characteristics that are statistically significantly associated with access to health care at alpha = 0.05.

## CHAPTER SEVEN

### DETERMINANTS OF ACCESS TO HEALTH CARE AMONG MIGRANTS AND NON-MIGRANTS IN GHANA

#### 7.1 Introduction

This chapter examines the influence of migration status, selected socio-demographic variables and health need factors on access to health care. The socio-demographic variables examined include age, sex, level of education, marital status and average monthly income. The health need factors included in the equation are the perceived health status of the respondent and having an illness or injury in the 12 months prior to the interview.

A binary logistic regression was used in examining the influence of these variables on access to health care. The study carried out three models of binary regression, first examining the independent influence of migration status on access to health care. Socio-demographic variables such as age, sex, level of education, marital status and average monthly income were introduced in the second model. Thereafter health care need factors were introduced in the third model. Access to health care has two responds categories (have access and have no access), using have access as the reference category. The chapter is subsequently divided per the number of models run.

#### 7.2 Migration Status and access to health care among migrants and non-migrants

This section is on the independent influence of migration status on access to health care among migrant and non-migrant from Model 1 of the binary logistic regression model. The results are presented as Model 1 in Table 7.1. The Nagelkerke R-square indicates that migration status explains about 4.1 percent of the variation in access to health care. The

results also showed a statistically significant relationship ( $P < 0.05$ ) between migration status and access to health care. The results (Table 7.1) show that migrants are 51.1% less likely to have access to health care compared to non-migrants.

The finding is consistent with other works conducted outside Ghana (Ku and Matani 2001; Luque et al 2018; Ledous 2018 and Gonzales et al 2019). Notwithstanding, the finding is in contrast with works conducted on internal migrants in Ghana, as Lattof et al (2018) found that far more than half (58.2%) of migrant respondents reported having access to health care because they were currently insured.

The analysis of the qualitative data revealed that lack of knowledge of the processes of acquiring health insurance explained why some migrants have no access to health care. Below is what an Ivorian student had to say about why she is not covered health-wise

*“I am here to study English and go back... my institution has no health facility. I don't know if foreigners could also register for the Ghanaian national health insurance” (Lola, female age 19, Ivorian student).*

According to Mr Sue, one of the participants in the qualitative interview, he is not willing to register for any insurance in Ghana because he will not like to carry a card around. He noted:

*“Ghanaians like paper and card too much. Everything card, paper. In China, everything is on my phone, insurance, bank account and everything. I don't have to carry paper and card”. (Mr sue, Male, aged 45, Chinese business man)*

### **7.3 Migration status, socio demographic variables and access to health care among migrants and non-migrants**

This section of the chapter presents the results of the second model. The aim of the second model was to ascertain the influence of migration status and some selected socio-

demographic variables on access to health care. Age, sex, level of education, marital status and average monthly income of the respondents are the variables introduced in the second model. In this section, the respondents aged 58 years and above were put together. This is because less than three per cent of the respondents were aged 68+ in the previous categorization used in Chapter five (Table 5.1). The study putted 'no education', 'primary' and 'JHS' educational status together as 'basic/ no education'. The respondents with SHS and Technical/Vocational education were also coded together as SHS/Vocational. This was necessary because only 0.9 per cent (2) of the respondents had no education and less than 3% had primary education (Table 5.2).

After the introduction of these variables, the Nagelkerke R-square increased to 0.312 which indicates that 31.2% of the variations in access to health care is explained by migration status and the selected socio-demographic variables in this section. The result (Table 7.1) showed a statistically significant relationship ( $P=0.000$ ) between migration status and access to health care even after the introduction of the socio-demographic variables. According to the results migrants are 79 per cent less likely to have access to health care compared to non-migrants.

The results also showed that level of education is statistically significantly related ( $P=0.000$ ) to access to health care. From the results (Table 7.1), respondents with SHS/vocational education are 90.7% more likely to have access to health care compared to those with Basic education (primary and JHS). The results in Table 7.1 further show that respondents with a post-secondary diploma are 11.965 times as likely as those with basic education to have access to health care. The respondents with bachelor education are 11.034 times as likely as those with basic education to have access to health care. While respondents with a post-graduate education are 16.171 times as likely as those with basic education to have access to health care. The results in Table 7.1 showed that the higher the level of

education, the higher the likelihood of having access to health care. This finding is consistent with Reibling and Wendt (2010). Though Reibling and Wendt (2010) did not use health insurance or health coverage as a measure of access to health care, their study found that higher levels of education show a higher probability of specialist visits than their counterparts with lower levels of education.

Nonetheless, this finding, is in contrast with what was found by Mohammadbeigi et al. (2015). Mohammadbeigi et al (2015) examined the education-related inequality in access to and utilisation of oral health care in Iran. Mohammadbeigi et al (2015) found out that differences in the findings of these two studies could be because Mohammadbeigi et al (2015) studied respondents in relation to a particular illness (oral health). This study did not study respondents with reference to one particular illness, but rather examined the respondents' access to general health care using health insurance and health coverage as a measure which provides the ability to have access to health care with no or minimum financial risk. Another plausible explanation could be, because of the differences in relation to the study area, as this study is in Africa while that of Mohammedbeigi et al (2015) was conducted in Asia.

Average monthly income also has a statistically significant relationship ( $P=0.011$ ) with access to health care. The respondents who earn less than 300 Ghana Cedis are 4.995 times as likely as those with no income to have access to health care. Also, respondents that earn 1000-2999 Ghana Cedis are 4.623 times as likely as those that earn no income to have access to health care (Table 7.1).

Age, sex and marital status have no significant relationship with having access to health care. However, from the analysis, respondents aged 58+ are 72% less likely to have access to health care compared to those aged 18-27. Also, respondents aged 48-57 are 80.5% less

likely to have access to health care compared to those aged 18-27. The result also showed that respondents that are married/ living together are 2.293 times as likely as those that are never married to have access to health care. In contrast, the respondents out of marriage are 35.2% less likely to have access to health care compared to those that are never married.

#### **7.4 Migration status, socio-demographic characteristics, health need factors and access to health care.**

Health need factors such as having an illness in the 12 months prior to the interview and respondents perceived health status of him or herself were introduced to the equation in Model 3. The response for having an injury was re-coded at this stage for the purpose of simplifying the analysis. Having an illness or injury or both was coded together as yes had injury/ illness while having neither injury nor illness was also coded as no.

The results, indicate that the Nagelkerke R-square, after health need variables have been introduced, increased to 0.46, meaning 46% of the variations in access to health care were explained by migration, socio-demographic and health need factors (Table 7.1).

Also, migration status continues to have a statistically significant-relationship ( $P=0.001$ ) with access to health care even after the introduction of health care need factors. The analysis indicates that migrants are 73.8 per cent less likely to have access to health care compared to non-migrants (Table 7.1).

The results in Model 3, show that level of education continued to have a statistically significant relationship with access to health care ( $P=0.000$ ). It can be seen from Table 7.1 that, respondents with SHS/Vocational education are 1.054 times as likely as those with basic education to have access to health care. The respondents with post-secondary education are 8.568 times as likely as respondents with basic education to have access to

health care. The analysis also shows that the respondents with post - graduate level of education are 9.524 times as likely as those with basic education to have access to health care.

The results of the analysis further show that, the newly added variables (had an illness or injury in the 12 months before the interview and perceived health status) both have a statistically-significant relationship with access to health care ( $P < 0.05$ ). The respondents that perceive their health status as 'good' are 6.467 times as likely as those that perceive their health status as 'very good' to have access to health care (Table 7.1). The respondents who perceive themselves to have a moderate health status are 4.015 times as likely as those that perceive themselves as having 'very good' health status to have access to health care. The respondents that perceive themselves as having 'poor or fair' health status is 11.6 percent more likely to have access to health care compared to those who perceive themselves as having very good health status. Also, the respondents who have had an illness or injury in the 12 months prior to the interview are 3.239 times as likely as those that had no injury or illness in the 12 months prior to the interview to have access to health care.

This finding is consistent with the Andersen's model (1968) and what Wandera et al (2015) discovered in their study of determinants of access to health care among older persons in Uganda. Wandera et al (2015) found that health need factors and enabling factors were the most important determinants of access to health care.

However, average monthly income no longer had a statistically significant relationship with access to health care after the introduction of health care need factors ( $P > 0.05$ ). But a close observation of the results (Table 7.1) showed that, the respondents that are earning less than 300 Ghana Cedis are 64.8% more likely to have access to health care compared

to those who earn no income (see Table 7.1). The results of the analysis (Table 7.1) also indicate that, the respondents earning 300-499 Ghana cedis are 72.5 per cent more likely to have access to health care compared to those that earn no income. Also, respondents that earn between 1000 and 2999 Ghana Cedis are about 200 per cent more likely to have access to health care compared to those that earn no income.

**Table 7.1 Determinants of Access to health care among migrants and non-migrants**

Variables	Model 1			Model 2			Model 3		
	Exp ( $\beta$ )	S.E	95% C.I.	Exp ( $\beta$ )	S.E	95% C.I.)	Exp ( $\beta$ )	S.E	95% C.I.
<b>Migration Status</b>									
Non-Migrants (RC)	1.000			1.000			1.000		
Migrants	0.489***	0.27	0.288-0.31	0.210***	0.374	0.101-0.438	0.262***	0.409	0.118-0.585
<b>Age</b>									
18-27 (RC)	1.000			1.000			1.000		
28-37				0.835	0.493	0.318-2.193	0.716	0.554	0.242--2.121
38-47				0.356	0.676	0.095-1.337	0.288	0.783	0.062-1.336
48-57				0.195**	0.775	0.047-0.890	0.179**	0.843	0.034-0.936
58+				0.28	0.806	0.058-1.361	0.092***	0.907	0.016-0.545
<b>Sex</b>									
Male (RC)	1.000			1.000			1.000		
Female				0.955	0.326	0.504-1.810	0.81	0.369	0.393-1.670
<b>Education</b>									
Basic educ (RC)	1.000			1.000			1.000		
SHS/Vocational				1.907	0.647	0.537-6.775	1.054	0.721	0.256-4.332
Post Sec Diploma				11.965***	0.672	3.205-44.674	8.568***	0.768	1.901-38.616
Bachelor				11.034***	0.618	3.283-37.079	9.223***	0.69	2.384-35.667
Postgraduate education				16.171***	0.7	4.101-63.766	9.524***	0.779	2.070-43.803
N		232			232			232	
Nagelkerke R-Square		0.041			0.312			0.46	
Source: Survey Nov- Dec 2018      RC - Reference Category      ** - P < 0.05      *** - P < 0.001									

**Table continue**

Variables	Model 1			Model 2			Model 3		
	Exp (β)	S.E	95% C.I.	Exp (β)	S.E	95% C.I.	Exp (β)	S.E	95% C.I.
<b>Marital Status</b>									
Never Married (RC)	1.000			1.000			1.000		
Married/living together				2.293	.508	0.847-6.211	3.033*	.578	0.977-9.412
Out of marriage				.648	.856	0.121-3.470	.770	.892	0.134-4.424
<b>Average Monthly Income</b>									
No income (RC)	1.000			1.000			1.000		
Less than GHC 300				4.995**	.629	1.455-17.145	1.648	.719	0.403-6.743
GHC 300 - GHC 499				2.272	.514	0.829-6.222	1.725	.594	0.538-5.529
GHC 500 - GHC 799				2.062	.690	0.534-7.967	1.119	.764	0.250-5.006
GHC 800 - GHC 999				1.357	.743	0.3165-5.816	.939	.818	0.189-4.669
GHC 1000 - GHC 2999				4.623***	.557	1.551-13.780	3.001	.644	0.849-10.606
GHC 3000 +				2.442	.658	0.673-8.863	1.456	.730	0.348-6.093
N		232			232			232	
Nagelkerke		0.041			0.312			0.46	
Source Survey Nov-Dec 2018			RC - Reference Category		** - P < 0.05			*** - P < 0.001	

**Table Continue**

Variables	Model 1			Model 2			Model 3		
	Exp ( $\beta$ )	S.E	95% C.I.	Exp ( $\beta$ )	S.E	95% C.I.)	Exp ( $\beta$ )	S.E	95% C.I.
<b>Perceived Health Status</b>									
Very Good (RC)	1			1			1		
Good							6.467***	.455	2.650-15.779
Moderate							4.015***	.489	1.539-10.474
Fair or Poor							1.116	.999	0.157-7.903
<b>Do you have any illness and injury</b>									
No (RC)	1			1			1		
Yes							3.239***	.412	1.445-7.261
Constant	1.974***	0.197		0.229**	.729		0.126**	.844	
N			232			232			232
Nagelkerke			0.041			0.312			0.46
RC - Reference Category	** - P < 0.05			*** - P < 0.001					

## 7.5 Summary

This chapter examined the determinants of access to health care among migrants and non-migrants. The first part examined the independent influence of migration status on access to health care. This section of the analysis revealed that about 4.1 per cent of the variations in access to health care is explained by migration status. Migrants are 51.1 per cent less likely to have access to health care compared to non-migrants.

The second section of the chapter examined the influence of migration and socio-demographic factors on access to health care. The results of the analysis revealed that about 31.2 per cent of the variations in access to health care is explained by migration status and socio-demographic variables. The results also showed that, migrants are 79 per cent less likely to have access to health care compared to non-migrants in the second model. Also, the respondents with post-secondary diploma are 11.965 times as likely as those with basic education to have access to health care. The respondents who earn between 300 to 499 Ghana Cedis are 2.272 times as likely as those with no income to have access to health care.

The last section of the chapter examined the influence of migration, socio-demographic variables and health care needs on access to health care. The results indicate that, about 46 per cent of the variations in access to health care is explained by migration, socio-demographic and health care need factors. The results also indicate that, the respondents who perceived themselves as having 'poor or fair' health status are 11.6 per cent more likely to have access to health care compared to those that perceived themselves as having access to health care. Also, the respondents that have had an illness or injury in the 12 months prior to the interview are 223.9 per cent more likely to have access to health care compared to those who had no injury or illness in the 12 months prior to the interview.

It is revealed in this chapter that; migration status has a statistically significant relationship with access to health care at all stages of the analysis. Level of education also had a statistically significant relationship with access to health care in all the stages at which it was introduced into the equation (Model 2 and 3). Average monthly income had a statistically significant relationship with access to health care in Model 2 but not in Model 3 after health care needs were introduced. All the health care need factors (had an illness or injury in the 12 months before the interview and perceive health status) that were introduced in model 3 are statistically significantly related to access to health care. Age, sex and marital status, have no statistically significant relationship with access to health care at all levels of analysis.

## **CHAPTER EIGHT**

### **MIGRANTS AND NON-MIGRANTS USE AND SATISFACTION OF HEALTH**

#### **CARE IN GHANA**

##### **8.1 Introduction**

This chapter evaluates the use of health care among migrants and non-migrants in Ghana and the level of satisfaction they derived from the use of the health care services in Ghana. The chapter is divided into three main sections (sections 8.2; 8.3 and 8.4). The first section (section 8.2) explores what respondents usually do when they feel sick or are taken ill, while the second section (section 8.3) is dedicated to the respondents' use of health care within the shortest period (4Weeks and the most recent period of health care use). Lastly, section 8.4 is devoted to the respondents' general assessment of Ghana's health care system delivery and level of satisfaction gained from using this system. Some excerpts from the qualitative data analysis are also presented in this chapter to explain, complement or supplement the quantitative data analysis results. Sections of the thematic network on access, use and satisfaction of health care in Ghana (Figure 8.6 and 8.10) are also present in the appropriate sections.

##### **8.2 Migrants and non-migrants use of health care in Ghana**

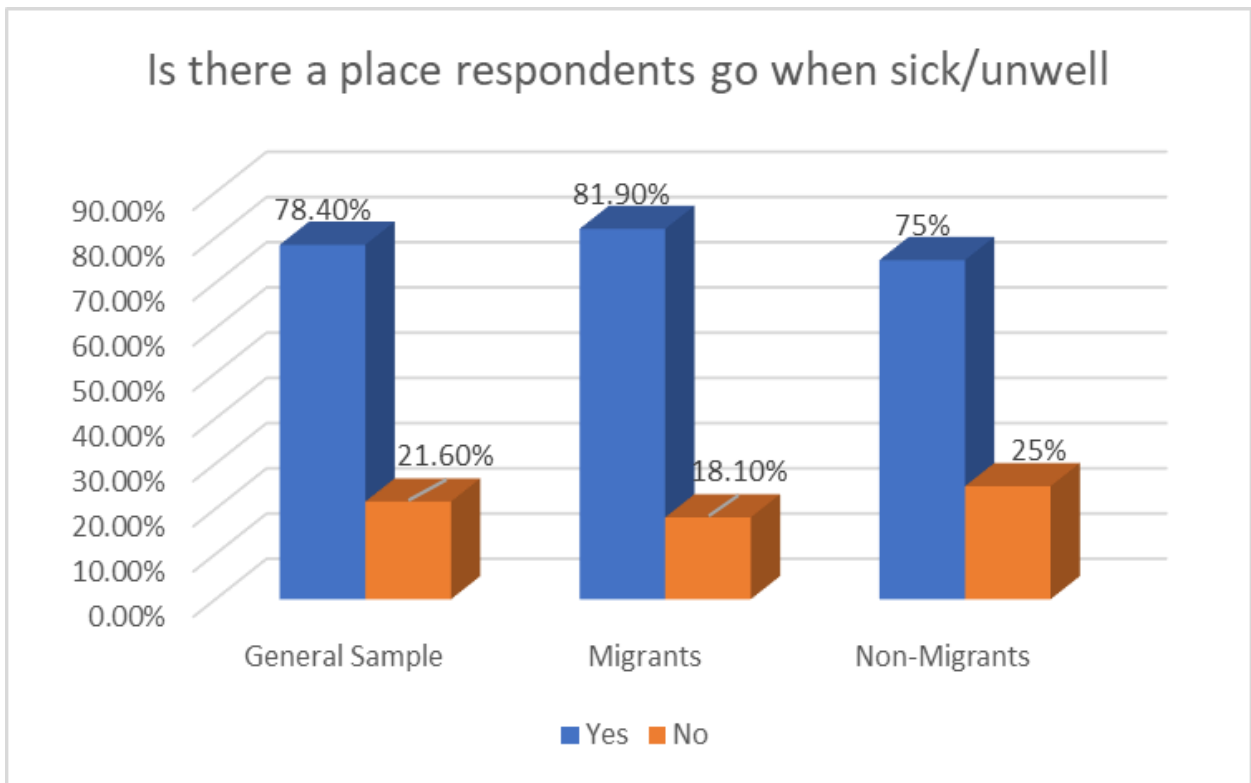
This section of the study explores the use of health care among the migrants and non-migrants. It is divided into three parts. The first part explores whether the respondents have a place they seek health, when they are sick by using a standard question ("Is there a place that you usually go when you are unwell/sick?") from the Ghana Living Standard Survey instrument developed by the Ghana Statistical Service. The second part focuses on a follow

up question to those respondents who answered 'yes' to the question above. The intent of the question is to explore the respondents' usual means of seeking health care. The last part of this section explores, what respondents' usually do when sick or unwell.

### **8.2.1 Migrants and non-migrants, having a place for health seeking.**

The analysis was carried out among the total sample used in the study and subsequently among migrants only and non-migrants only. The results of the analysis (Figure 8.1) revealed that the vast majority (78.4%) of the respondents among the total sample have a place they go when they are sick or unwell, while about 21.6 per cent said 'No' they go nowhere when they are sick or unwell. Also, approximately 82 per cent of the migrants only have a place they go to when they are sick or unwell and a quarter of the non-migrants (25%) have no place they go to when sick or unwell. In addition, three out of every four of the non-migrants have a place they go when they are sick or unwell. The chi-square test showed that the difference among migrants and non-migrants is not statistically significant ( $P > 0.201$ ). This is probably because the non-migrants were sampled from the communities where the migrants were found. This implies that they all use the same health facility(s) and system(s) of care.

**Figure 8.1: Respondents having a place for health seeking**



Source: Sourvey Nov-Dec 2018 (P = 0.201)

### 8.2.2 Migrants' and non-migrants' usual places for health use

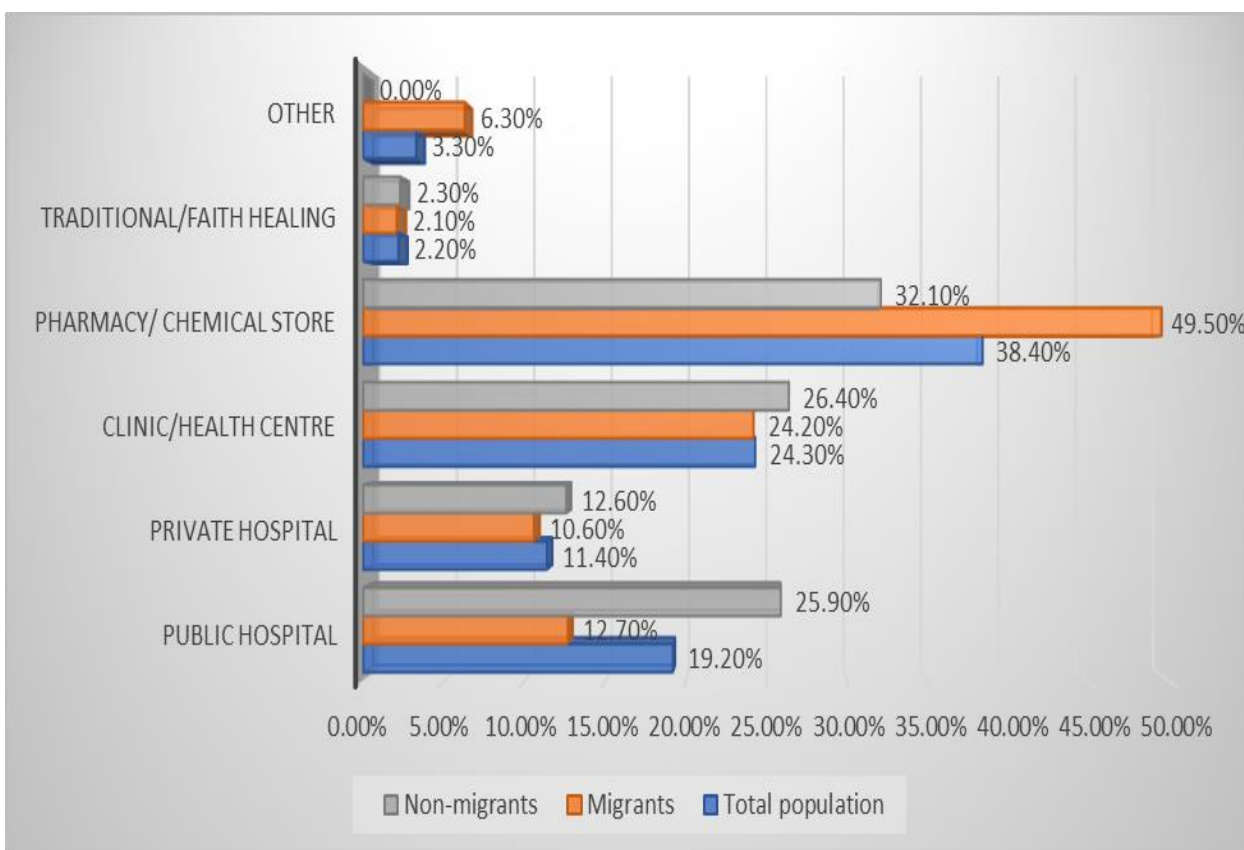
As can be seen from Figure 8.2 the greater percentage (38.4%) of the total sample that have a place they go when sick or unwell usually go to the pharmacy or the chemical store. Approximately 11 percent of the total sample does go to a clinic when sick or unwell. A little above one-fourth (25.3%) of the total sample go to private hospitals when sick or unwell while 19.2 per cent go to a public hospital when sick or unwell.

The finding is slightly similar to what Ansah et al (2016) found in their study. Ansah et al (2016) found that, the private drug retail sector is the first option for the majority of patients in Ghana. In this study too, the greater percentage of the respondents (38.9%) said they

usually go to the pharmacy or chemical store (which implies their first point of call) when they are not well.

However, a further analysis shows that, a higher percentage (49.5%) of the migrants compared to the non-migrants (32.1%) go to the pharmacy or chemical store when sick or unwell. A higher percentage (25.9%) of the non-migrants compared to the migrants (12.7%) however, go to public hospitals when they are sick or unwell (Figure 8.2). What this implies is that, migrants usually will avoid going to the hospital when sick or unwell and rather will prefer to go to the chemical store or the pharmacy.

**Figure 8.2: Migrants’ and non-migrants’ usual places for health use.**



Source: Survey Nov-Dec 2018

When respondents were asked during the in-depth- interview section how regularly do they use the hospital, these are some excerpts from their explanation:

*“I will say I only go when I am very, very ill or is like emergency case. But any small...I don't just stand up and go to the hospital because of any small illness. Because sometimes when you go the way they will treat you... If is something I know I will go and buy medicine from the pharmacy. I won't go!”* ( **Forlake, female aged 24, Nigerian student**)

*“I don't usually visit the hospital; I go when I have some Lab test to do. The last time, I went to the University's Hospital because I had toothache. It was unbearable and my face got swollen, so I have to go. When I got there, I was made to undergo some Lab tests”* (**Amala, Female aged 38, Nigerian student**)

*“I buy from the pharmacy shop here. When you go to the hospital, and you are not able to pay immediately, the bill is converted to dollars and added to the amount of fees you owe the school. So, me, I have my first aid and when I have a problem, I go to the pharmacy and explain to the guy at the pharmacy and he gives me medicine and it works”* (**Borla, female aged 24, Ivorian Student**)

*“When you go to the hospital, but the moment they hear your ascent or realise you are not a Ghanaian then they charge you a higher price, so, I don't go to the hospital any how”* (**Bruno, Male aged 3, Trader from Chad**)

This type of responses was common during the conversation with the interview participants. The participants' explanations imply that, they depend on the pharmacy for their day to day medications to maintain and keep themselves healthy. The migrants, normally avoid the hospital for individual reasons which include claims of price discrimination as in the case of Bruno, conversion of hospital bills into American dollars as in the case of Borla. Forlake and

Amala also will only go to the hospital when they have an emergency condition or an unavoidable situation.

Bruno and Borla's reasons for not using the hospital and depending on the pharmacy for their day to day medication sounds like a 'local surprise' from the analysis. However, that of Amala and Forlake's explanations were similar to what was found by Smith and Scheid (2014) when they applied the Andersen Model in their study of the Race Concordance Doctor patient relationships. Smith and Scheid (2014) found that, the blacks in their study have more emergency care visits as a result of their use of less primary health care in hospitals.

### **8.2.3 Practices of health care use among migrants and non-migrants**

It can be seen from Figure 8.3 that the higher percentage of the respondents (36.2% among the total sample; 42.2% of migrants and 30.2 % of migrants) use self-medication from the pharmacy when they are sick or unwell. The same results (Figure 8.3) revealed that 8.6 per cent of migrants and 10.3 per cent of non-migrants, which amount to 9.5 per cent of the total sample usually will do self-medication by using herbs. About 6 per cent of migrants and 7.8 per cent of non-migrants (6.9% of the total sample) usually will self-medicate using medication from friends or family relations.

The findings presented in Figure 8.3 are consistent with what other studies have revealed. For instance, a review conducted by Markkula et al (2018) revealed that about 50% of the articles they reviewed reported lower use of formal health care among migrants. The findings in Figure 8.3 are also in line with what has already been revealed in Figure 8.2 and consistent with the qualitative interview findings that the participants normally do self-medication and use the pharmacy when sick or unwell. The findings also revealed that they do not like to go

to the hospital because of how the hospital personnel respond to their illness when they go there. Below is a more detailed conversation with Forlake a Nigerian female student at the Valley View University expressing her use of health care services in Ghana:

**Interviewer:** *how regularly do you use the health care system in Ghana?*

**Participant:** *I will say I only go when I am very, very ill or is like emergency case. But any small...I don't just stand up and go to the hospital because of any small illness. Because sometimes when you go the way they will treat you.*

**Interviewer:** *how do they treat you when you go?*

**Participant:** *like the last time I went, I was complaining that I was having chest pain. And to them I don't know, maybe they felt it was normal, why am I coming to the hospital because of that? And they took it too lightly. So, for me, I stand to tell myself that for anything I don't just go to the hospital unless it is a very serious case.*

**Interviewer:** *So, what do you do when you are not feeling well if you told yourself that you don't go to the hospital, what do you do?*

**Participant:** *well, sometimes, I rest. Like I know the activities that make me not to feel well. Let's say I have been very stressed, I try to cut down on my activities. That is what I do. I just try to handle myself. I won't want to stress myself during that period, or some food and vegetables that will assist. Like maybe if I am having a cold, I know I will mix honey and onions so I won't go to hospital for that. If is something I know I will go and buy medicine from the pharmacy. I won't go!*

**Interviewer:** *you will buy medicine from the pharmacy without a doctor prescribing it for you?*

**Participant:** *Yes, because I am familiar with the symptoms and know what it is. I will go and get the medicine myself.*

**Interviewer:** *Is it something that you alone do or other students also normally buy medicine themselves?*

**Participant:** *other students before they come to school, their parents give them medicine for all sicknesses that they will possibly have. Let's say diarrhoea they will give them a medicine for that. And write the prescription and tell them, when you have "this", you take "that". Something like that. I*

*came with a few medicines, but because of the time frame, I have to throw it away. But normally that is what we do, sometimes too, you go to the pharmacy and buy.*

**(Researcher and Forlake a female aged 24, Nigerian student)**

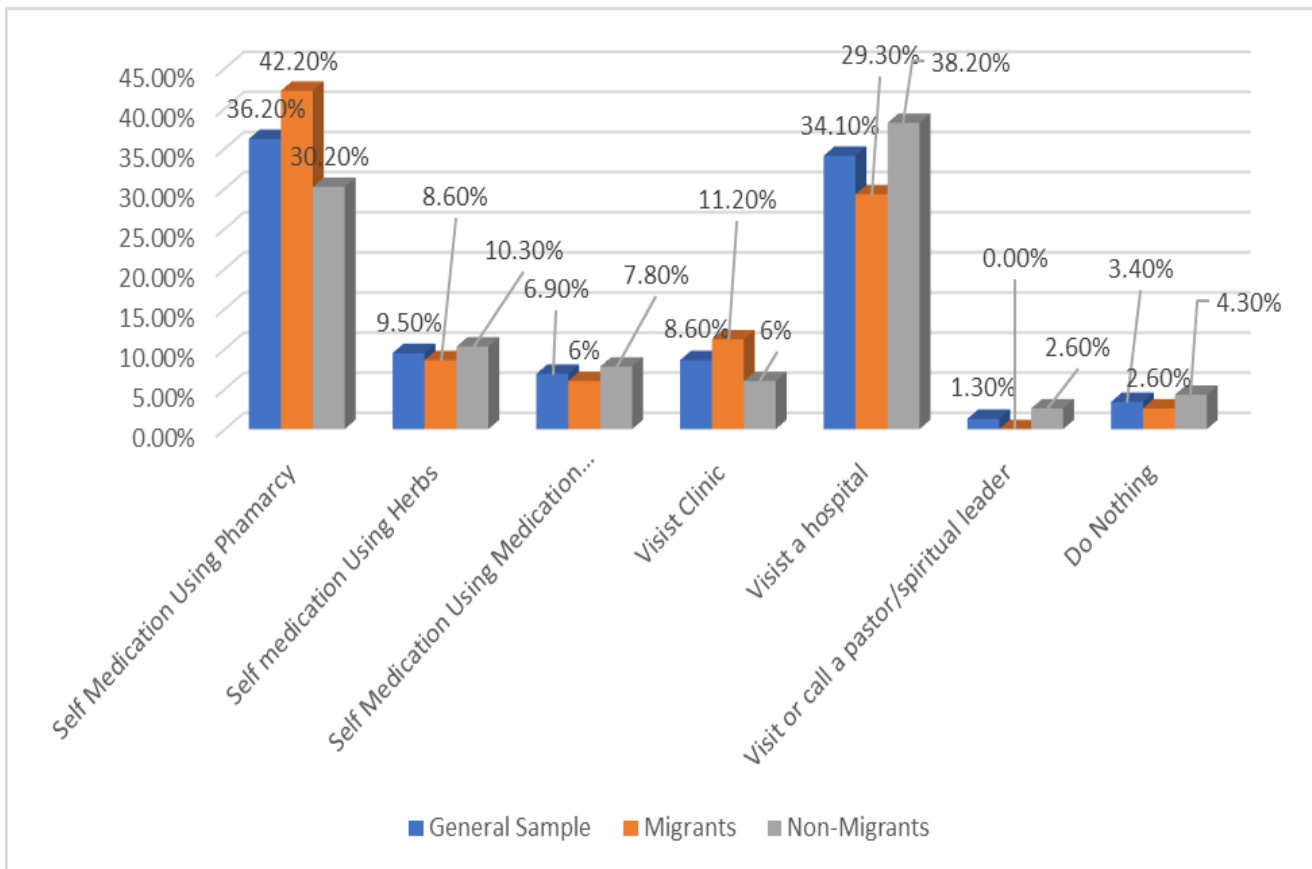
From the conversation self-medication is a usual practice of Forlake and other migrant students. She also avoids going to the hospital because of the attitude of health workers. She will go to the hospital only under emergency conditions. This in a way, can also affect the person's access to health care, as one can find it difficult to register for a health insurance which she knows she is not going to use. This is because, not many pharmacy shops accept health insurance for drug purchase, and even those that do accept health insurance, will not sell any drug without prescription from a doctor. This is the reason why individuals or migrants that practise self-medication will not be willing to register for a health insurance in the Ghana. Another reason for the avoidance of hospitals and the higher percentage (49.5%) of self-medication among migrants is because most of the pharmacy and chemical shops in Ghana do sell drugs to individuals without a prescription from a doctor.

Forlarke or the migrants are not the only participants that complained about the attitude of health workers in Ghana. Mr. Nomo also did complain about the attitude of health workers, which, for him make it difficult for him to visit the hospital. He explained

*“You see health care needs active workers. Especially, the first contact like the nurses. They need to be very active because they are there to save lives. When you go there, they look at you as if you have your personal problem and is not their problem. We have to beg them. Some people have to be given immediate attention. Somebody who is injured seriously, goes to the hospital and they will say, let's see your folder, let's do this and that. Meanwhile, the person is in pain and on the way to die. The processes would be dull and at the end, it ends up with people dying and, in some cases, worsen the situation. The situation worsens beyond control. So, you*

*see, the nurses who are the first contact need to be active” (Mr Nomo, aged 49-years, Ghanaian Civil servant)*

**Figure 8.3 Practices of health care use among migrants and non-migrants**



Source: Survey Nov-Dec 2018

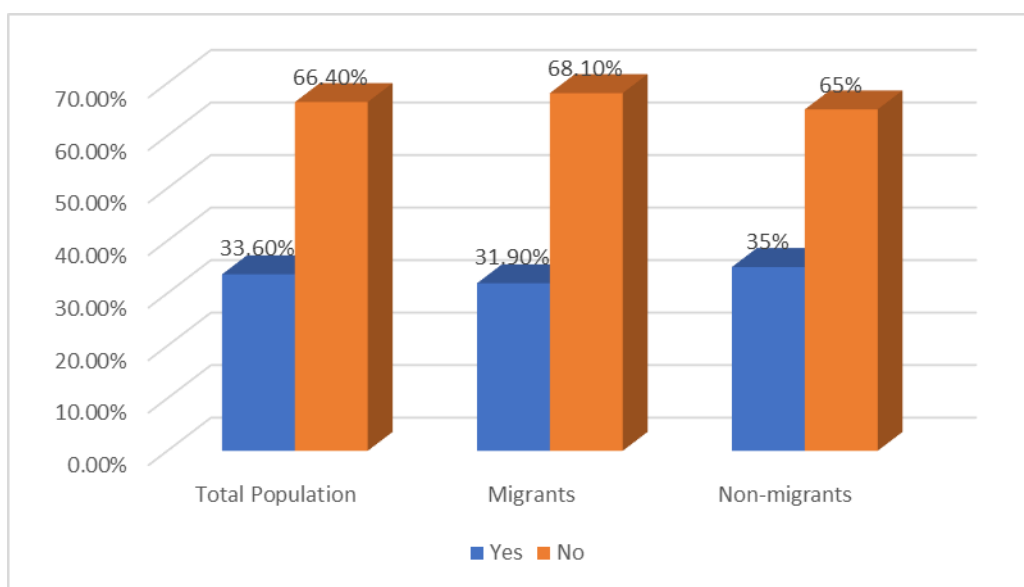
### 8.3 Consultation or purchase of a drug in the past 4 weeks.

The study also asked respondents both migrants and non-migrants if they had consulted a health practitioner or purchased a drug in the past four weeks. This question also was adopted from the Ghana Living Standard Survey instrument. The aim was to examine the use of health care among the migrants and non-migrants in the study.

The analysis as presented in Figure 8.4 shows that, 33.6 per cent, 31.9 per cent and 35 per cent of the total sample, migrants and non-migrants respectively, have consulted a health

practitioner or visited a health facility or consulted a traditional healer or purchased a drug in the 4 weeks prior to the interview. Also, about 66.4 per cent, 68.1 per cent and 65 per cent of respondents among the total sample, migrants and non-migrants in that order have not consulted a health practitioner or visited a health facility or consulted a traditional healer or purchased a drug in the 4 weeks prior to the interview.

**Figure 8.4: Consultation of a health care Practitioner or Purchase of a drug**



Source: Survey Nov-Dec 2018

Though far more than half of the migrants (68.1%) and non-migrants (65%) have not consulted a health practitioner or purchased a drug in the four weeks prior to the interview, it does not necessarily mean that, they were not using drugs or medications within the same period. This is because the qualitative data analysis revealed that, the study participants do anticipate their need for medication and do buy drugs or medication in advance. Below are some of the excerpts from the qualitative data analysis to explain this point:

*“Other students before they come to school, their parents give them medicine for all sicknesses that they will possibly have. Let’s say diarrhoea*

*they will give them a medicine for that. And write the prescription and tell them, when you have "this", you take "that". Something like that. I came with a few medicines, but because of the time frame, I have to throw it away. But normally that is what we do". (Forlake, female Aged 25, Nigerian student)*

*"I am not on any health insurance because, I did not know I could register with the NHIS. Moreover, whenever I am coming from home after vacation, I come with my essential drugs, like para and others. When I run out of my essential drugs, and I have a problem, I ask my roommate or buy from the drug store". (Borla, female aged 24, Nigerian student)*

*"I don't usually feel sick, I am strong. I take pain killer when I have body pains after work". When I have a fever I just have to put some neem leaves in hot water and cover myself with a cloth after sweating I will be fine. I don't feel sick!" (Donkor, Male age 31, Ghanaian trader).*

From these excerpts the migrants and non-migrants may not have consulted a health practitioner or purchase a drug in the past four weeks before the interview, but, may use a drug because some have anticipated their need for the drugs and bought them in advance as in the case of the students, explained by Forlake, or the borrowing of drugs or medicine from roommates from the narrations of Borla. For Donkor it is clear that he relies on herbs to keep himself healthy. So, a respondent like him, may not consult a health practitioner in the past four weeks, but may be using some herbs to maintain his health.

### **8.3.1 Migrants' and non-migrants' most recent visit to a health facility or purchase of a drug**

The study observed that the question about respondents' consultation with a health practitioner in the past 4 weeks, may have some limitations in capturing the respondents' use of health care. The question that was raised in the mind of the researcher was that, what if a respondent did not have any need for consulting a health practitioner in the past four weeks?

So, the study included a question on the respondents' most recent use or visit to a health facility or purchase of a drug.

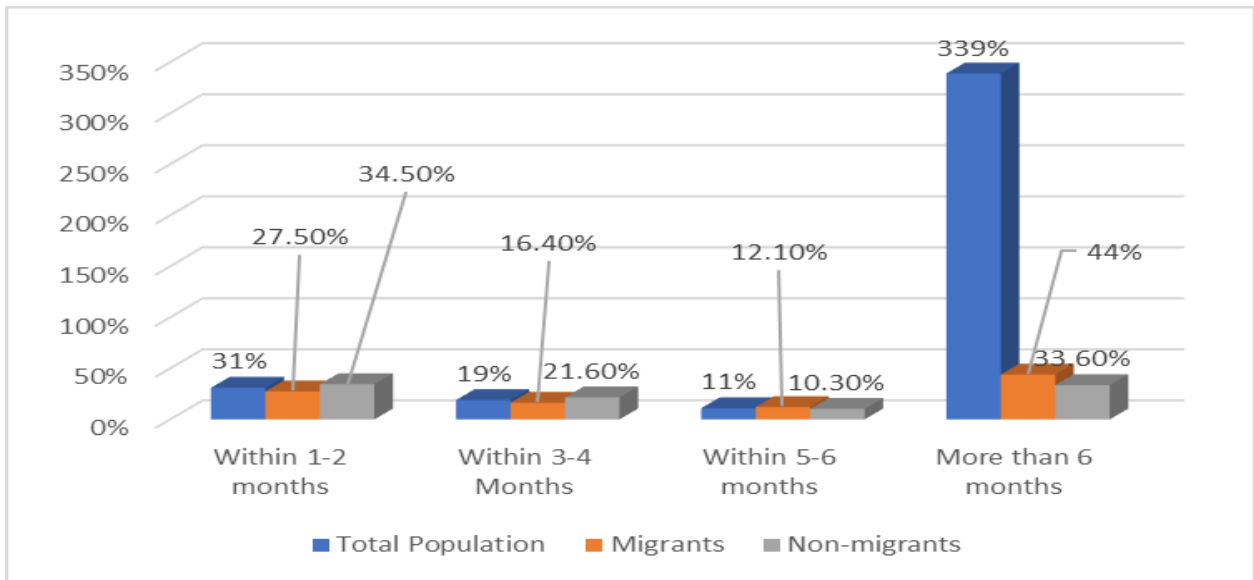
The results of the analysis , indicated that about 31 per cent of the total sample, 27 per cent of migrants and 34.5 per cent of non-migrants (Figure 8.5) have used a health care system in Ghana within the past 1- 2 months. Also, about 19 per cent of the total sample, 16.4 per cent of the migrants and 21.6 per cent of non-migrants have used a health care system in Ghana within the past 3-4 months before the interview. The results of the analysis further show that, 39 per cent, 44 per cent and 33.6 per cent of the total sample, migrants and non-migrants respectively (Figure 8.5), have used a health care system in Ghana for more than 6 months before the interview.

However, the qualitative data analysis revealed that, most of the migrants used or visited health facilities during the first years of their stay in Ghana.

*“When I first arrived in Ghana, because I did not want to have problems with my health, I always visit the hospital” (Lola, female age 19, Ivorian student).*

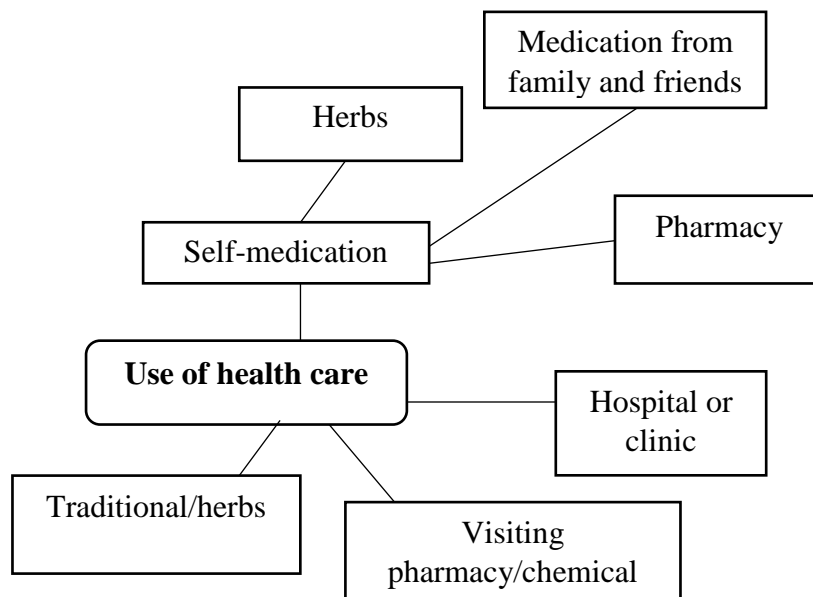
*“You know, when you are a student, you need to go through medical test, so when I first came, I have to do that, because is compulsory for every student to go through a medical test” (Borla, female aged 24, Nigerian student).*

**Figure 8.5 Respondents' most recent visit to a health facility or use of a health service or purchase of a drug**



Source: Survey Nov-Dec 2018

**Figure 8.6 Thematic network of study participants' Use of health care in Ghana**



Source: Field interview Nov-Dec 2018

## **8.4 Migrants' and non-migrants' evaluation and satisfaction of health care services in Ghana**

Presented in this section is the assessment of migrants and non-migrants of the health care system in Ghana. Three variables in the quantitative dataset were used in the analysis of the assessment of the health care systems in Ghana by the migrants and non-migrants. The variables include (i) assessment of the cost of formal health care in Ghana; (ii) general assessment of the formal health care in Ghana and (iii) satisfaction with the health care services in Ghana. Quotations from the qualitative interviews are also presented in this section to support the results from the quantitative data analysis.

### **8.4.1 Migrants and non-migrants' assessment of the cost of formal health care in Ghana**

As the analysis displayed in Figure 8.5 shows that, 6 per cent, 5.2 per cent and 6.95 of the total sample, migrants and non-migrants respectively, are of the view that the cost of formal health care services in Ghana is cheap. Also, 37.5 per cent, 37.9 per cent and 27.1 per cent of the total sample, migrants and non-migrants respectively, are of the view that the cost of formal health care services in Ghana is moderate. The analysis also revealed that about 32.8 per cent of the total sample and 31.9 per cent non-migrants are of the view that cost of formal health care in Ghana is very high/expensive, while more than one-third (33.6%) of the migrants think that cost of formal health care in Ghana is very high/expensive.

Though there is no much difference between the migrants and non-migrants in terms of their assessment or evaluation of the cost of formal health care in Ghana, some migrants express that, they are discriminated against when they are charged for health care use in Ghana.

One of the interviewees (Bruno;) in the qualitative study is of the view that, the cost of health care in Ghana is generally not expensive, but for the fact that he is a migrant, he is charged differently (higher than non-migrants). Below is what he has to say:

*“At least we are all blacks, but the moment they hear your ascent or realise you are not a Ghanaian then they charge you a higher price... we are all blacks, we are one”* **(Bruno; Male age 31 from Chad)**

The expert interview conducted with one of the hospitals belonging to an educational institution that also receives a significant number (about 2% from interview) of migrants confirmed that migrants pay twice the amount paid by the non-migrants. The study could not probe into the reason for the different charges for migrants and non-migrants. But below is part of the unstructured interview with the expert and how he expressed the different charges for health care use for migrants and non-migrants:

***Interviewer:** so, in terms of the payment, what about those who don't come with any insurance, have you ever encountered any difficulty in terms of payment?*

***Participant:** yes. They talk about the payment being too expensive. Of course! The., For our policy here, if you are a foreigner, you come and you want to make payment, you pay twice what the Ghanaian will pay* **(Records office; University of Ghana Hospital)**

Kafokafo also had her daughter admitted at the Valley View University Hospital for one night, a few days before the interview and this is how she expressed her assessment of the cost during the interview:

*“The cost is too high, I could afford, but the ordinary person, can such a person afford 500 Ghana Cedis for one-night admission? Is too high”* **(kafokafo; female aged 36, Togolese trader/business woman)**

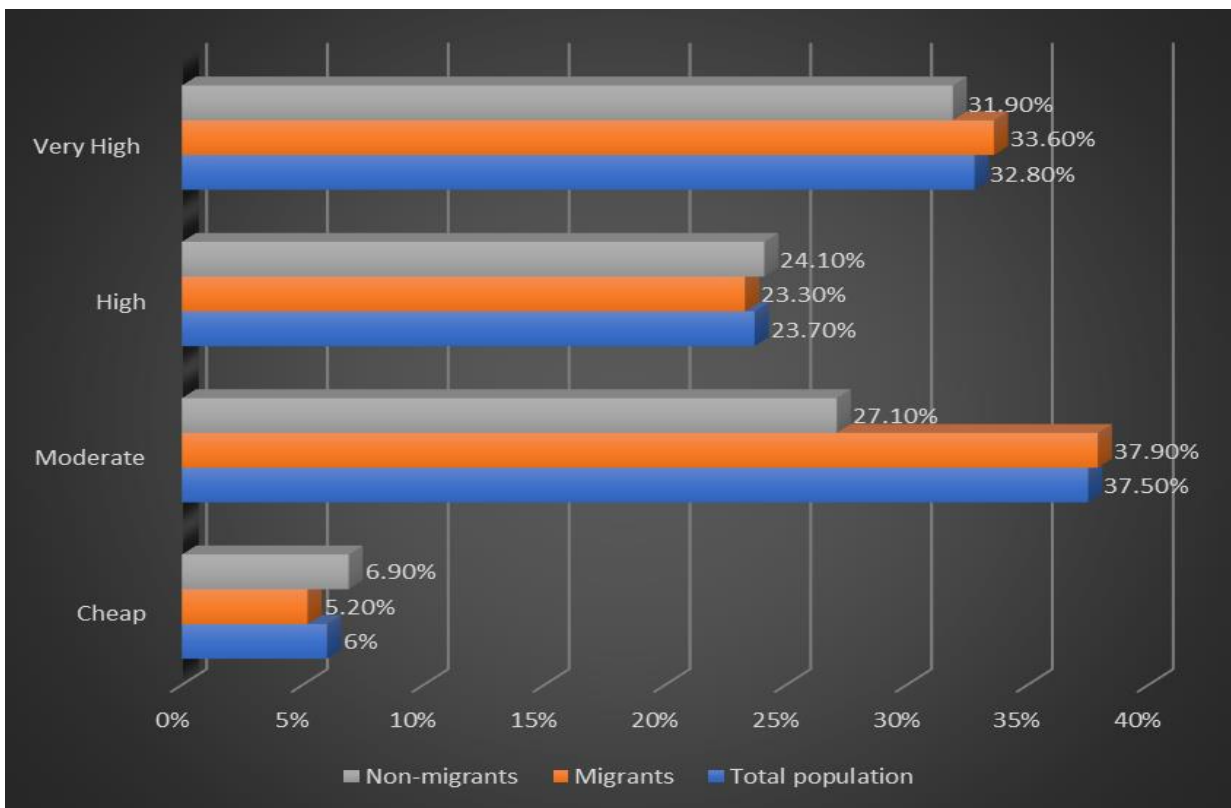
Mr Sue also explained that, the only time he used a Ghanaian health service was when he first arrived in Ghana and the cost to him was too high and he explained:

*“When I first arrived in Ghana, in 2006, I had a dog bite in the very week I arrived. I was taken to a hospital in East Legon. The nurses took good care of me, but I was charged two million, that is the old money (Old currency), now 200 Ghana Cedis. But it was a big money at that time, it was too high”*  
**(Mr Sue, Male aged 45, Chinese business man)**

From the expert interview and the conversation with Kafokafo, in spite of the ECOWAS protocols on free movement, residence and establishment, migrants’ (From West-Africa and other Places) basic right to services such health care is not guaranteed under the national regulation of health care delivery. Although the University of Ghana is a public institution, the hospital is considered a private facility rendering services to members of the University Community (students, lecturers and the other university workers). It can be inferred from the expert interview that foreigners (migrants) of the University community are charged twice as non-migrants. This can be said to be a form of price discrimination against migrants, which has the potential of hindering their access to health care. It is a known fact that foreign students of all public universities in Ghana pay higher tuition and residential facility user fees than their Ghanaian counterparts? Though arguable, it is understandable if foreigners are made to pay tuition and facility user fees which is subsidised by the Government of Ghana for its citizens. And also, because tertiary education is not a basic human right. But to charge someone different and a higher price for a basic right to health care because the person is not a native, can be termed as injustices against migrants. This can serve as an impediment to the realisation of the sustainable development goal three. This calls for further studies to

investigate the reasons for the discrimination in health care charges against migrants in Ghana.

**Figure 8.7: Migrants’ and non-migrants assessment of the cost of formal health care services**



Source: Sourvey Nov-Dec 2018

#### 8.4.2 Description of the formal health care in Ghana

The results of the analysis in Figure 8.6 show that, less than 5% of the total sample (3.4%, 2.6% and 4.3% of the total sample, migrants and non-migrants respectively) describe the formal health care in Ghana as ‘excellent’. The results of the analysis (Figure 8.6) also show that more than half (56%) of the total sample and a little above 3 out of 5 (61.2%) of migrants described the formal health care system in Ghana as good. However, exactly half (50%) of the non-migrants described the formal health care in Ghana as ‘good’. Also, about 12.1 per cent,

11.2 per cent and 12.9 per cent of the total sample, migrants and non-migrants respectively described the health care system in Ghana as ‘poor’

Little is known from existing literature about how migrants feel or evaluate the health care systems of their host nations. These findings will add to the existing literature, that though health care use in host societies generally do not favour migrants, more than 3 out of every 5 (61.2%) international migrants in this study describe the formal health care system in Ghana as ‘good’. This number actually exceeds the number of non-migrants (50%) in the study that describes the health care system in Ghana as ‘good’. What this actually means, is that the reality on the ground may not reflect what the sufferers of a particular ‘reality’ think of that ‘reality’. This is one of the core reasons that underpin the evolution of qualitative research methods.

In the qualitative interview, the migrants described the formal health care sector in Ghana based on their recent experiences. The experiences of Amala, Mr Sue and Kafokafo and what they make out of the formal health sector in Ghana are as follows:

*“I was at the Legon hospital and they were using electronics and before I got to the lab, the lab technician already had my information. **It was good.** For me, I see the positive side of things” (Amala; female aged 38; Nigerian student)*

*“The hospital I used when had the dog bit in 2006 was very good. The nurses treated me well, but they charge too much.” (Mr Sue, Male, aged 45, Chinese business man)*

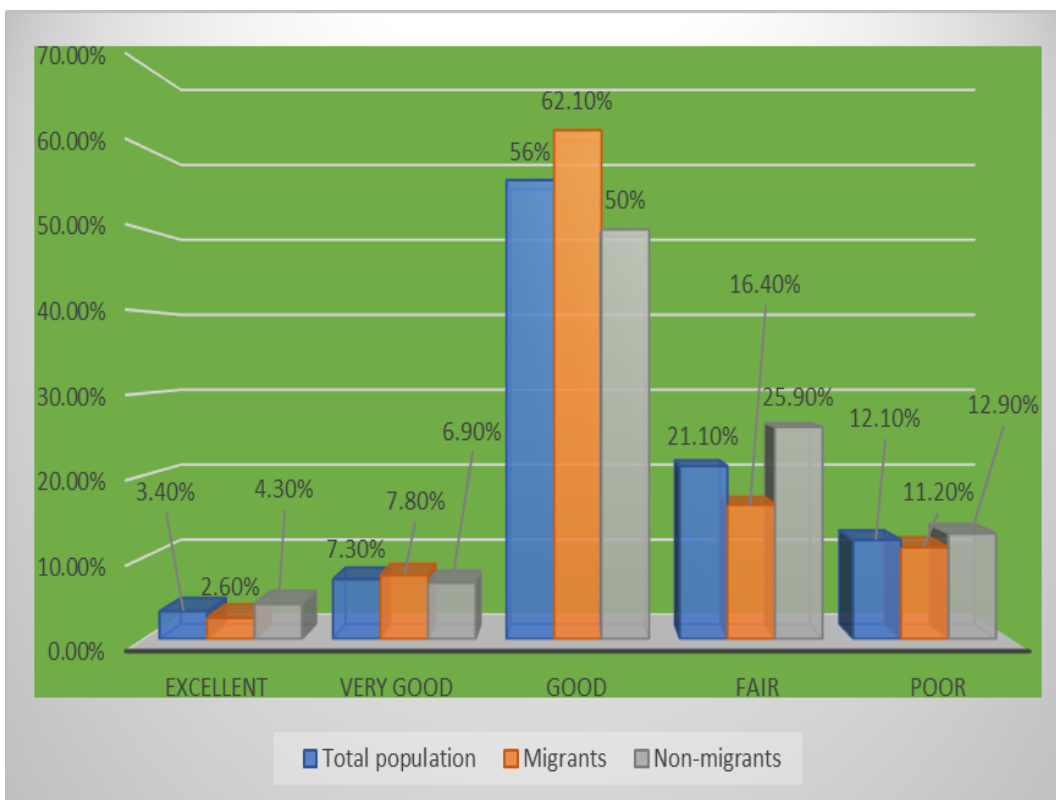
*“Last month I travelled to Togo, when I came back, I felt my daughter was not getting used to the environment. One midnight, the sickness became serious and she was rushed to the hospital and admitted. The guy that was*

*supposed to work on the Lab test, pricked my daughter's hand before looking for the thing that he will use to collect the blood sample. I felt like slapping him. The girl was crying and they were shouting and forcing her to keep quiet. When in other places outside Africa they will pamper the child... **The environment was bad, I sat in a broken chair throughout the night. I asked if that was the children's ward and they said it was. Is it not someone that will bring a child to the hospital? Where do you expect that person to sit or sleep while taking care of the child"?** (Kafokafo; female aged 36 Togolese business woman)*

Amala and Kafokafo both had different experiences from two different hospitals belonging to educational institutions, both of them based their evaluation on their experiences. Amala's evaluation was based on the use of technology in the hospital system to cut down on time spent in the hospital, while Kafokafo's evaluation is based on the unprofessional treatment given to her child and lack of facilities in the hospital. Her evaluation was also based on what she has experienced outside the African continent.

Mr Sue's evaluation was based on the treatment given him by the nurses and the hospital environment but he is of the view that the charges at the hospitals are too high for him to afford all the time.

**Figure 8.8: Migrants and non-migrants Description of the formal health care system**



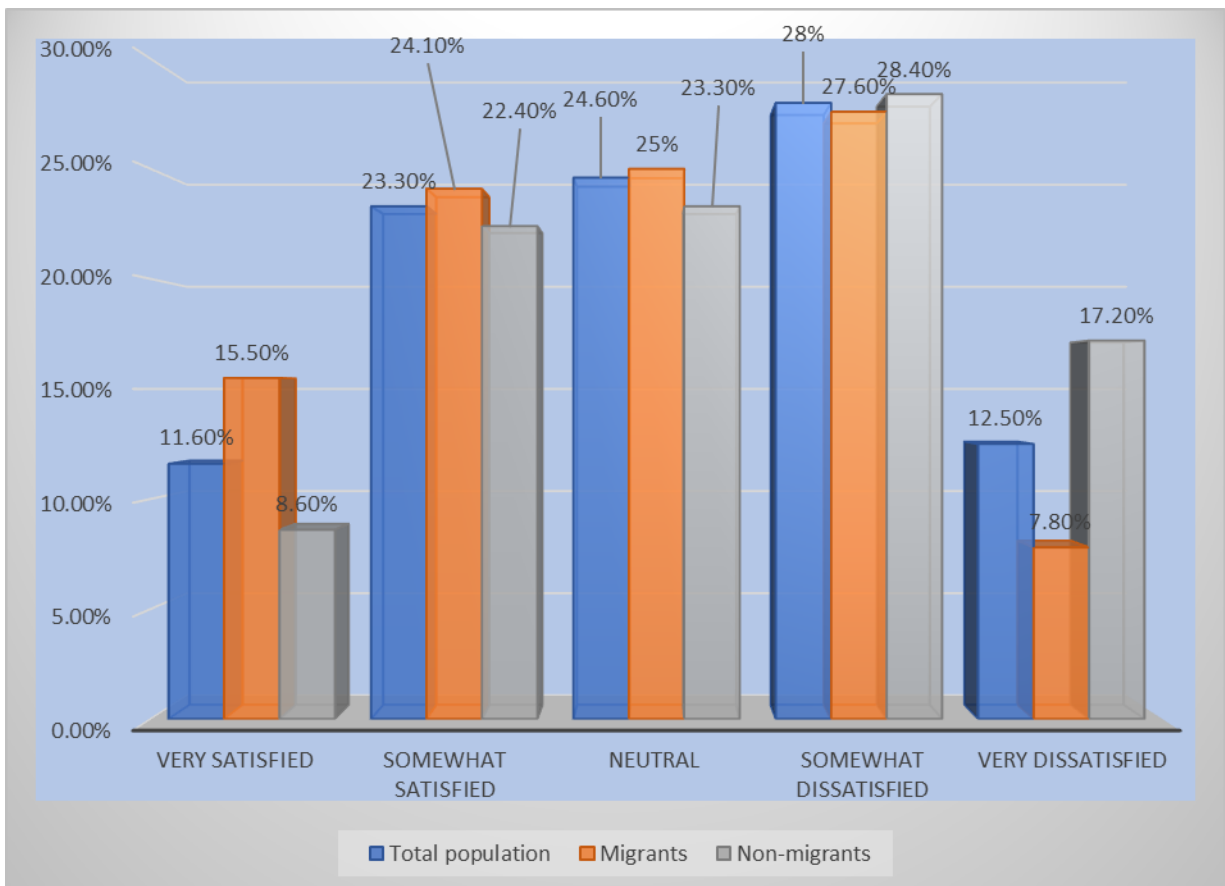
Source: Survey Nov-Dec 2018

#### **8.4.3: Migrants’ and non-migrants’ satisfaction of the formal health care system in Ghana**

The study also analysed the respondents’ satisfaction of the formal health care system in Ghana. The results (Figure 8.7) show that, 11.6 per cent, 15.5 per cent and 8.6 per cent of the total sample, migrants and non-migrants respectively, are ‘very satisfied’ with the formal health care system in Ghana while 12.5 per cent, 7.8 per cent and 17.2 per cent in similar order are very dissatisfied with the formal health care system in Ghana. About one out of four of (25%) the total sample are indifferent (neutral) with their satisfaction of the formal health care in Ghana. The finding in this section of the study is similar to the findings of Dias et al

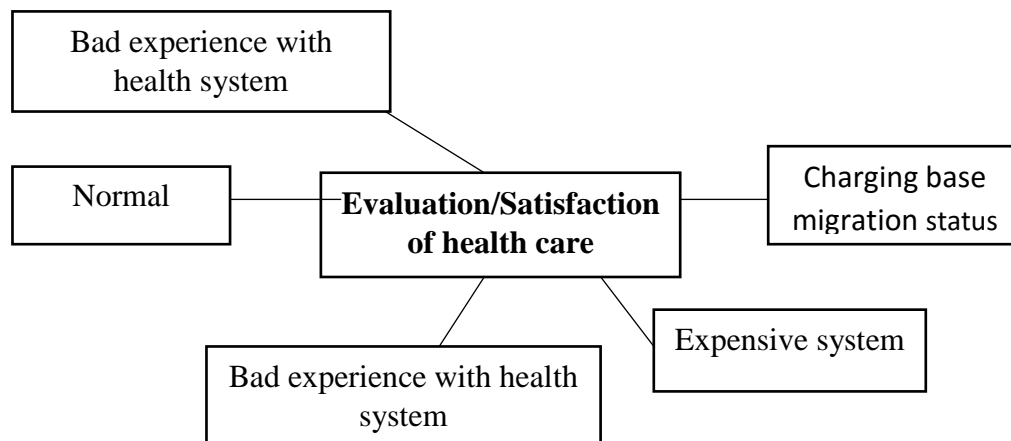
(2015), as they found that about 22% of the study respondents are unsatisfied with health care services. However, the satisfaction of the migrants in their study is statistically related to the length of stay of the migrants.

**Figure 8.9: migrants and non-migrants satisfaction of the formal health care system**



Source: Sourvey Nov-Dec 2018

**Figure 8.10 Thematic network of study participants' Evaluation/ Satisfaction of the health system in Ghana**



Source: Field interviews Nov-Dec 2018

### 8.5 Summary

The vast majority of the study respondents (78.4%) have a place they go to when they are ill. Approximately one-fourth (25%) of the non-migrants, say they go nowhere when sick or unwell, with more than 4/5 (81.9%) of the migrants having a place they go to when they are unwell.

The analysis presented in the chapter revealed that, 42 per cent and 31 per cent of migrants and non-migrants respectively uses the pharmacy when they are unwell. Less than one-fourth (24.2%) of the migrants and a little above one out of every four (26.4%) of the non-migrants use a private hospital. About 15 percent of the non-migrants use the district hospitals and less than 4 per cent of the migrants use district hospitals when sick or unwell. Also, about 1.6 per cent of the total sample use chemical stores when sick or unwell.

The findings in this chapter also revealed that the greater percentage of the study respondents use self-medication from the pharmacy (36.2%), herbs (9.5%) and medication from

friends/family. The qualitative interview reveals that, self-medication is a usual practice among migrant students. It also revealed that some of the respondents do not like going to the hospitals because they are familiar with the symptoms of their illnesses and also the health workers do not attach seriousness of their illness when they go. Claims of price discrimination is also one of the reasons why migrants do not like to use the hospital.

Also, about 66.4 per cent, 68.1 per cent and 65 per cent of respondents among the total sample, migrants and non-migrants in that order have not consulted a health practitioner or visited a health facility or consulted a traditional healer or purchased of a drug in the 4 weeks prior to the interview. Also based on their individual experiences, some of the respondents described the general health care system in Ghana as good or bad.

## CHAPTER NINE

### SUMMARY, RECOMMENDATION AND CONCLUSION

#### 9.1 Introduction

Migration and human mobility are common factors that drive issues on global health vulnerabilities (Beths 2011, Mott 2004, Appadurai 1996). Besides, this is one of the reasons behind the drafting of the Sustainable Development Goal three (SDG 3). The SDG 3 is not only important but also very crucial. This is for the reason that, having good health is vital to the growth of every society. It is mostly said that, 'health is wealth' and the same applies to societies and communities (Bloom and Canning 2000). But then and again, a population's ability to receive and sustain good health is subject to its ability to access and use the health care available to it.

The relationship between migration and health is multidimensional (Zimmerman et al 2011). However, the health of migrants and the health care conditions of destination areas are interrelated (Davies et al 2009; IOM 2001; Zimmermann 1998). In addition, some studies have shown that, migratory project or event can have a negative effect on the health of migrants (Nakash 2012; Virupaksha et al 2014), making migrants a vulnerable group irrespective of where their migratory project leads them.

Other studies (Haour-Knipe and Rector 1996) have also revealed that factors such as separation from family and partners, isolation and hopelessness that follows stigma and discrimination among other factors in the host communities intensify the vulnerability of migrants to contracting infectious diseases like HIV/AIDS. Women by their disadvantageous nature which makes them to migrate are forced to adopt unfriendly survival strategies in the

destination areas, which expose them to depraved health conditions in the host communities (Anarfi 2004 pp: 5). In the end, migrants are not only vulnerable to health risks, but also more disadvantaged regarding their access and use of health care (Cuadra 2012; Stanciole and Huber 2009).

Studies have shown that, two out of every five of the ever-increasing international migrants' stocks reside in developing countries. With empirical evidences showing that, a global south nation such as Ghana is also receiving a good number of migrants. For instance, in Ghana's 2010 population and housing census report, it was indicated that, there were close to 400,000 migrants living in Ghana (GSS 2014). About 60 per cent of this migrant population reside in the Greater Accra Region of the country.

In the light of these evidences, and the Sustainable Development Goal three, little is known about migrants' access and use of health care in Ghana. The aim of this study was to investigate the access and use of health care among migrants and non-migrants in Ghana. The more specific objectives of the study include:

- i. to examine health insurance coverage among migrants and non-migrants in Ghana,
- ii. to examine access to health care among migrants and non-migrants in Ghana,
- iii. to examine the factors that influence access to health care among migrants and non-migrants in Ghana,
- iv. to examine the use of health care among migrants and non-migrants in Ghana and
- v. to explore migrants' and non-migrants' satisfaction of the health care system in Ghana.

The study adapted the Andersen Model 1973 as its theoretical foundation. Based on this model and a review of current literature, the study designed a conceptual framework which guided the quantitative data analysis of the study.

A mixed research methods approach was used in this study. The study combines the use of quantitative data collection and analysis with qualitative research methods of analysis in the examination and exploration of matters related to access and use of health care among migrants and non-migrants in Ghana. Overall, 116 migrants residing in the Greater Accra Region and 116 non-migrants from the same residential areas as the migrants were sampled for the quantitative data of the study. In addition to the quantitative survey data, ten semi-structured interviews and one unstructured expert in-depth interviews were conducted for the qualitative data analysis.

Because migrants are a unique segment of any population, the findings from the study will contribute to the global debate on migration and access to health care. The findings, will also provide an in-depth understanding of the differences that exist among migrants and non-migrants in relation to their access and use in Ghana. In addition, the findings will also provide an essential base for policy on access and use of health care in Ghana. Likewise, the findings will contribute to the crosscutting issues on 'health' in Ghana's Migration Policy Document. Furthermore, the findings will provide a basis for the evaluation of the Sustainable Development Goal three (SDG 3) in Ghana.

The summary of key findings, theoretical implication of findings, policy recommendation, recommendation for future studies and the conclusion of the study are likewise presented in this chapter.

## **9.2 Summary of key findings**

### **9.2.1 Socio-Demographic (Predisposing, Enabling) and health need Characteristics**

The mean age of the migrants in the study is 32 years, which is less than the mean age of international migrants (39 years) according to the United Nation's 2017 report. This indicated that, the migrants in the study are relatively young. The findings indicate that, age is not statistically significantly related to migration status nor access to health care. Notwithstanding, a trend in the results of the analysis shows that as the age of the migrants increases, the proportion of the migrants in the various age groups decreases. The study also shows that, more than half (52.2%) of the migrants are within the ages 18-27 years. In addition, more than half of the non-migrants are females while more than half of the migrants' in the study are males.

About two-thirds of the migrants have either bachelor or post-graduate degree while 65 percent of the respondents (migrants and non-migrants) are never married. About 68% and 62.1% of the migrants and non-migrants respectively have never married. 12.1 per cent of respondents earn less than 300 Ghana Cedis, 9.1% earns 3000 and above Ghana Cedis.

The percentage (40.5%) of the migrants in the study are students while the greater percentage (20.7%) of the non-migrants are engaged in the service rendering type of occupation. A greater percentage (86.1%) of the non-migrants compared to the migrants (46.7%) are engaged in full time job. Likewise, one out of every four (25%) migrants are not employed, while one out of every five (20.7%) earns no income.

Approximately, one-fourth (25.9%) of the non-migrants are living with chronic non-communicable diseases while six out of every ten of the migrants had an illness or injury in the twelve months prior to the interview.

### **9.2.2 Migration Characteristics**

More than half of the migrants (58%) are from the West African Sub Region. A little over two out of five (21.6%) of the migrants are from other African countries, while 20.7 per cent of the migrants are from non- African regions. Approximately, 67 per cent of the migrants have spent between one to ten years in Ghana. The findings indicate that, 24 percent of the migrants are documented migrants, 50 percent are documented students while 13.8 per cent are undocumented migrants. More than half of the respondents (56.9%) have close or family relations in Ghana. About eight out of every ten (78.4%) of the migrants also have close friends in Ghana. Less than 50 per cent of the migrants have the intention to permanently return to their home countries, while about one out of every four (25.9%) of the migrants are not sure of such decision as at the time of the interview. Notwithstanding, approximately, 16 per cent of the migrants have the intention to permanently stay in Ghana. For some of the migrants, the subject of staying permanently in Ghana or returning permanently to one's home country is not a straightforward decision because of the love they have in both their home country and Ghana and also because Ghana is not their main destination point, but just a means to an end.

### **9.2.3 Health insurance and health coverage**

The findings of the study indicate that, health insurance coverage is low among the migrant population in Ghana compared to the non-migrant population and the differences are statistically significant. This study further revealed that, about seven out of every ten migrants in Ghana compared to two out of every twenty-five of the non-migrants in Ghana have never registered with a health insurance scheme in Ghana. Also, about 16 out of 50 non-migrants

and 1 out of 50 migrants have previously been registered with a health insurance scheme in Ghana.

In-depth analysis of the data revealed that, lack of knowledge of health insurance registration processes and unattractive packaging (too much dependence on cards and paper) and claims of price discrimination accounted for the lack of interest of migrants in registering with a health insurance scheme in Ghana.

#### **9.2.4 Types of health insurance**

Among the different type of health insurance Schemes existing in Ghana, the NHIS is found to be the largest provider of health insurance cover among the study respondents. The private health insurance schemes provided insurance cover for about 10 per cent of the study respondents, while one percent of the study respondents have both private and public health insurance covers. However, a greater percentage of the non-migrants (97.1%) compared to the migrants (66.7%) are covered under the public health insurance scheme.

The study further revealed that, one out of every three migrants with a health insurance cover is registered with a private health insurance system. Also, foreign students residing in Ghana, are purposely registered with a private health insurance different from Ghanaian students.

#### **9.2.5 Health coverage by affiliation**

The study showed that, 34.5 per cent and 30.2 per cent migrants and non-migrants respectively, have health coverage by virtue of their or a family/relation's affiliation to a work place or institution. The study further showed that, 14% of the migrants and non-migrants that have health coverage by virtue of their affiliation get all services provided for free, while the majority (53%) receive full services with payment done later.

### **9.2.6 Access and use of health care**

Access to health care is low among migrants compared to the non-migrants. The study showed that, a higher percentage of the migrants (50.9%) compared to the non-migrants (33.6%) have no access to health care.

The findings of the study further show that, migration status and level of education have a statistically-significant relationship with access to health care. Also, factors such as respondents' perception or the rating of his or her health status, origin of the migrant, type of migrant, and having a family relation in Ghana are also statistically significantly related with access to health care. Also, at the multivariate level, migration status, level of education and health care need factors are the determinants of access to health care.

Average monthly income was also found to be statistically significantly related to access to health care when health care need factors are excluded from the equation of the binary regression analysis. However, average monthly income no longer had a statistically significant relationship with access to health care after the introduction of health care need factors into the equation of the binary logistic regression model. Other socio-demographic factors such as age, sex and marital status have no statistically significant relationship with access to health care.

This study showed that, a greater percentage of (42.2%) of migrants compared to non-migrants practise self-medication using the pharmacy. And also, a greater percentage of the non-migrants (10.3%) compared to the migrants (8.6%) do self-medication, depending on herbs. About six per cent and 7.8 per cent of migrants and non-migrants respectively do self-medicate using medications from family and friends.

### **9.2.7 Evaluation and satisfaction of health care in Ghana**

According to the migrants, there exists price discrimination in health care charges among migrants and native-Ghanaians (non-migrants). The study further showed that, 33.6 per cent of the migrants and 31.9 per cent of the non-migrants are of the view that, cost of formal health care in Ghana is very high. Notwithstanding, about 66 per cent of the migrants compared to 50 per cent of non-migrants rated the formal health care system in Ghana as ‘good’.

### **9.2.8 Theoretical implication of findings**

The Andersen’s model (1973) has been the main theory underpinning this study. The theory suggests that, socio-demographic variables such as age, sex, marital status, level of education among others, are factors that predispose an individual to the access and use of health care. However, this study shows that, using health insurance and health coverage as a means of access to health care, level of education is the only socio-demographic variable that is a determinate of access to health care among both migrants and non-migrants in Ghana. The other socio-demographic variables such as age, sex, marital status are not predictors of access to health care among migrants and non-migrants.

The model also suggests that, enabling factors such as income is also a key determinate of access to health care. Nonetheless, this study showed that, average monthly income was the only predicting factor of access to health care in the absence of health care need factors (having an illness or injury). After the introduction of health care need factors, average monthly income was no longer a determinant of access to health care among the study respondents.

The study also shows that, it is not only the migration status of the individual that has a statistically significant relationship with access to health care but also, the type of migrant, the origin of the migrants and having a family relation in Ghana are also factors that have a statistically significant relationship with access to health care. However, the relationship between having a family relation in Ghana and access to health care is an inverse relationship.

What this means is that, not having a clear definition of what one means by access to health care, and not having a clearly defined study population as migrants and non-migrants may not yield an exact result as predicted by the Andersen's Model (1968-1973). The gap, as observed by the study in the Andersen's Model (1973) is that, the model, did not have a clear definition of what it means by 'access or use of health care'. This in a way, resulted in the many studies that applied the model curving their own definition of access and use of health care consequently some using the two words (access and use) interchangeably. But this study, with a clear definition of access and use of health care applied the Andersen's model and showed that, in a specific context of a definition and sampled population the model may not yield the necessary result as it predicted by the model. Thus, the Andersen's model should be revised to provide a clear definition of what it means by 'access to' or use of health care. Until this is done individuals will apply the model to their "subjective" definition of access and use of health care which may continue to result in, not necessarily the exact result as predicted by the model.

### **9.3 Recommendations**

#### **9.3.1 Policy recommendation**

In 2015, Ghana launched a national migration policy. Section 8.2 of the policy addressed issues on migration and health as a crosscutting issue. The policy stated that, migrants are

exposed to health risks and as a result, potential migrants trying to get into Ghana are required to undergo immunization. The policy also addressed the health risks associated with irregular migration and proposed that a framework is needed to reduce the health risks attached to migration. However, the policy is bereft of addressing issues relating to migrants' access to and use of health care in Ghana.

Also, based on the findings in this study that access to health care is low among migrants compared to non-migrants, as part of this study's recommendations, it is suggested that;

- i. The migration policy of Ghana should be reviewed, and migrants' access and use of health care, during their time of stay in Ghana incorporated into it. The policy must address how immigrants in Ghana can access health care when they need it and the charges that must be imposed on them when they use health care. The policy must address the issue, whether migrants are supposed to pay the same amount, in Ghana Cedis as non-migrants for receiving a health care service in Ghana? This and many other issues on migrants' access and use of health care must be addressed.
- ii. Ghana's Ministry of Interior and the Ghana Immigration Service should also include and examine migrants' means of accessing and use of health care before issuing and renewing of residence permits. As part of the requirements for entering and residing in Ghana, as an immigrant should be that, migrants must exhibit their means of health insurance in Ghana or must provide evidence that they have the means to afford health care services in Ghana before they are allowed to enter or reside in Ghana.
- iii. The Ghana mission in other countries should also include or intensify issues on health insurance status before giving out of Visa to potential immigrants into Ghana. These

recommendations will boost the immigrants' access to health care while in Ghana and also provide additional revenue for the Ministry of Health to address the health challenges in Ghana.

Also, based on the findings that, the unattractive bureaucratic procedures (overdependence on multiple cards and papers) of the health insurance in Ghana is one of the cardinal reasons that hinder most migrants from registering for the health insurance in Ghana, the study recommends that, health insurance companies and institutions must migrate from the system of cards and paper to a comprehensive electronic system for both registration, renewal and verification of health insurance status.

The study also recommends that, the Ghana Health Service, the Ministry of Health, the Food and Drugs Authority and the law enforcement agencies must regulate and stop pharmaceutical companies from making indiscriminate, unsubstantiated advertisements and curtail the sale of medicines without prescription. This is based on the finding that self-medication using the pharmacy is a practice among migrants and non-migrants in Ghana.

### **9.3.2 Recommendation for future studies**

The study also recommends that, a further study should be conducted to investigate the differences in health care charges between migrants and non-migrants in health facilities. To investigate the claim of some migrants, that, they are charged a higher price for the use of health care than their Ghanaian counterparts. This is because in the quest for achieving a universal health coverage, it will be an unfair treatment to charge migrants in a developing country (Ghana) a higher cost compared to natives especially under the ECOWAS treaty which encourages free entry, residence and establishment.

#### **9.4 Conclusion**

This study sets out to investigate the access and use of health care among international migrants and non-migrants in Ghana. Lack of knowledge of health insurance registration processes and unattractive packaging of health insurance products in Ghana, and claims of price discrimination for health care use account for the low registration for insurance schemes (both public and private) among the migrants. Also, the public health insurance scheme or NHIS is the largest provider of health insurance cover for the respondents in the study. However, more of the migrants compared to non-migrants have health coverage by virtue of their affiliation to a work place or institution.

Access to health care is low among migrants (49.1%) compared to non-migrants (66.4%).

The respondents' level of education is the only predisposing factor that has a statistically significant relationship with access to health care at 95 percent confidence level. Other predisposing factors such as age, sex and marital status are not statistically significantly related to access to health care at the 95 percent confidence level.

Enabling factors such as employment status and average monthly income are also not statistically significantly related to access to health care at  $\text{Alpha} = 0.05$ . However, the occupation variable is statistically significantly related to access to health care at  $\text{Alpha} = 0.05$ . Health care need factors such as having an injury or illness in the twelve months before the study and perceived health status are also statistically significantly related to access to health care at  $\text{Alpha} = 0.05$ .

The origin of a migrant, type of migrant and having a close/family relative in Ghana are also the migration characteristics of the migrants that have a statistically significant relationship

with access to health care at  $\text{Alpha} = 0.05$ . Other migration characteristics such as having a friend in Ghana and the migrant's duration of stay in Ghana are not statistically significantly related to access to health care at the bivariate level of analysis at  $\text{Alpha} = 0.05$

At the multi-variate level of analyses, migration status, perceived health status, having an injury or illness in the twelve months preceding the survey and level of education are the determinants of access to health care. Other variables such as type of migrants, origin of the migrant and having a family relative in Ghana were found to have a statistically significant relationship with access to health care.

Self-medication using the pharmacy, herbs and medication from friends, are health use practices among the study respondents but more among the migrant population.

The study observes that without a clear definition of 'access' and use of health care, the application of the Andersen's model may not yield the necessary result as predicted by the model. This therefore implies that the model should be revised and a specific definition of access to health care incorporated into it. This will help users of the model to stick to one definition of access and use of health care and also help get a proper ground for evaluating the efficacy of the application of the Model

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**APPENDICES**

**Appendix A: Characteristics of in-depth interview participants**

<b>Participant Number</b>	<b>Pseudonym names</b>	<b>Sex</b>	<b>Age in Years</b>	<b>Occupation</b>	<b>Home Country</b>
1	Robert	Male	24	Student	Ivory Coast
2	Kafokafo	Female	36	Trader	Togo
3	Borla	Female	24	Student	Nigeria
4	Mr Sue	Male	45	Trader/Business Man	China
5	Donkor	Male	31	Trader	Ghana
6	Lola	Female	19	Student	Ivory Coast
7	Bruno	Male	31	Trader	Chard
8	Amala	Female	38	Student	Nigeria
9	Forlake	Female	24	Student	Nigeria
10	Nomo	Male	49	Civil servant	Ghanaian

**Appendix B: Coding Frame on Access, use and satisfaction of health care among migrants and non-migrants in Ghana**

<b>Codes</b>	<b>Definition</b>	<b>Theme</b>	<b>Description of Theme</b>
Insured	The individual is currently or as at the time of the interview registered or covered by an insurance scheme in Ghana. It also means that the individual can access health care with minimum financial risk of not necessarily as at the time of accessing health care pay direct cash.	Access to health care	I have health insurance
Never insured	The individual has never been on any insurance scheme in Ghana	"	I have not registered with any health insurance in Ghana because, I go to the Chinese hospital. I don't think I will register because, Ghanaians like paper and card too much. Everything card, paper. In China, everything is on my phone, insurance, bank account and everything. I do not have to carry paper and card".
Previously insured	The individual has ever been on an insurance scheme in Ghana but is currently not	"	I am not on the health insurance because when I first did I never used it
NHIS/Public	Type of scheme	"	I have the National Health Insurance
Private	Type of scheme	"	Well, my workplace has insured us with Metropolitan health insurance
Work place Affiliation	The individual has health coverage because the workplace has a health facility	"	My work brought me to Ghana, so they have health insurance for me
Institutional	The individual has health coverage	"	The school gives us health coverage, you

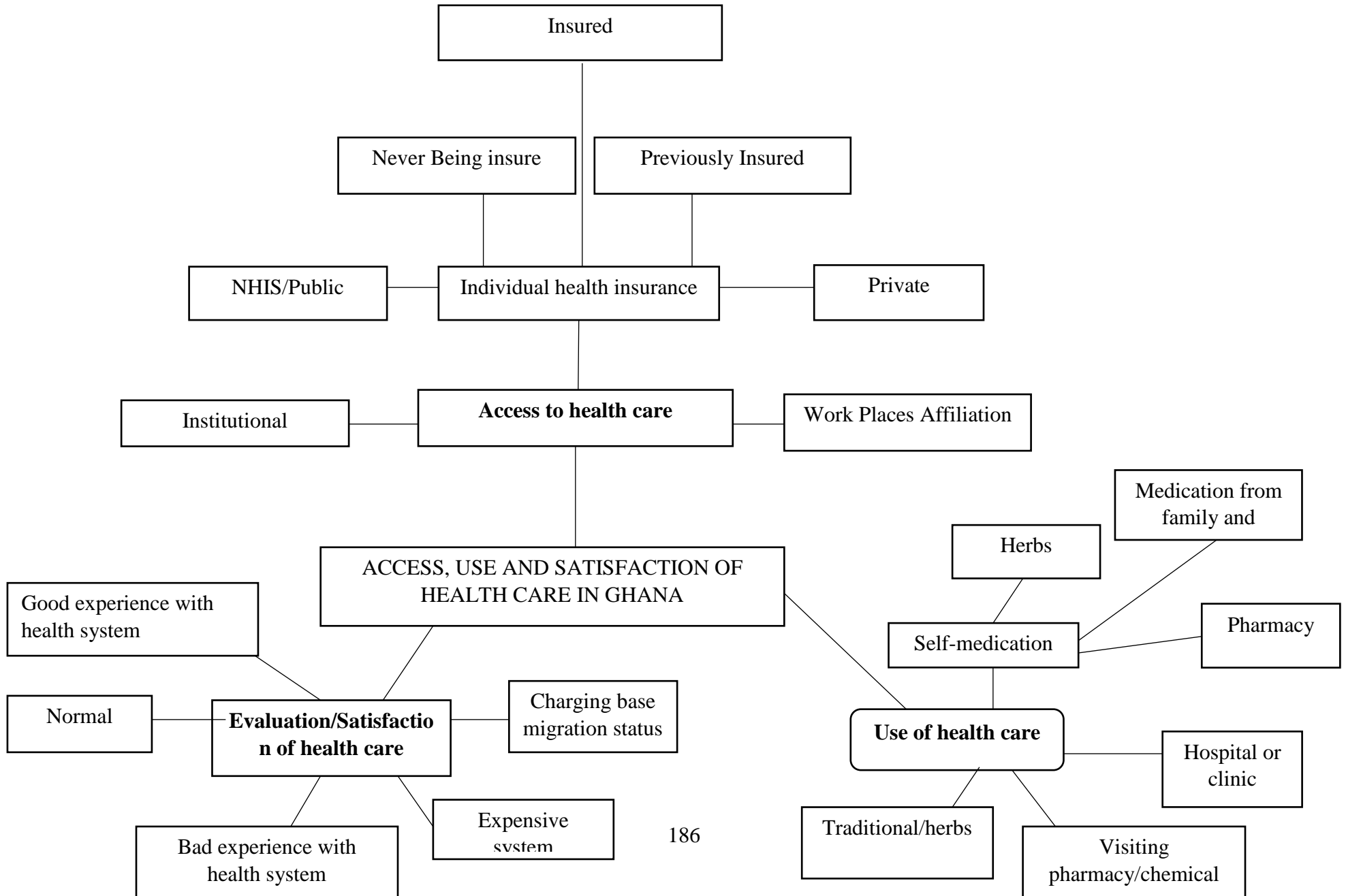
Affiliation	because he or she is directly or indirectly affiliated with an institution that provides the coverage		can go even if you don't have Money it will be added to your fees
Bad experience	Participants' negative experience with health care system	Satisfaction and evaluation	The environment was bad I sat in a broken chair throughout the night
Good experience	Participants' positive experience with health care system	"	Before I got to the Lab, the Lab technician already had my information, it was good.
Normal	Participants' indifference view of the health care system	"	The charges are normal
Charging by migration status	The claim of price discrimination in health care charges based on migration status	"	At least we are all blacks, but the moment they hear your ascent or realised you are not a Ghanaian then they charge you a higher price... we are all blacks, we are one
Expensive system	Participants' evaluation of the cost of health care	"	The cost of care in Ghana is expensive
Self-medication	Participants' use of health care when ill	Use of health care	I take pain killers when I have body pains
- Pharmacy	Means of self-medication	"	I won't go to hospital for that. If is something I know I will go and buy medicine from the pharmacy
-Traditional herbs	"	"	I use herbal I do not want to depend on these orthodox medicines, some of them are even fake. Some of them have expired and they are still using it.
-Medication from family/friends	"	"	When I run out of my essential drugs, and I have a headache I ask my roommate

Visit hospital/clinic	Participants' use of health care when ill	"	I try to go to the hospital when the condition is serious
No knowledge of procedures			I don't know if foreigners could also register for the Ghanaian national health insurance"
Return	Being certain with the decision to return to home country		I will be going back after I finish my program
Not to return	Being certain with the decision not to return to home country		I will like to stay in Ghana, if I get a job here
Transit	To not directly return to home country, but move to another country from Ghana		I will not return permanently to my country, but will also not like to stay in Ghana. My aim is to go to the United States, I am only here to learn English
Indecisive	Not certain with the decision to return	I love Ghana, I will like to stay because my husband is a Ghanaian but we will visit my home town from time to time	

**Appendix C Basic themes for access, use and satisfaction of health care among migrants and non-migrants in Ghana**

Themes and codes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	Total
Insured								*		*	2
Never insured	*		*	*							3
Previously insured		*			*						2
NHIS/Public		*			*					*	3
Private								*			1
Work place Affiliation											
Institutional Affiliation			*					*	*		3
Bad experience		*	*						*	*	4
Good experience			*	*	*			*			4
Normal	*			*		*	*		*		4
Price Discrimination	*						*	*	*		3
Expensive system	*		*	*	*	*	*			*	6
Self-medication											
- Pharmacy	*	*	*		*	*	*		*		7
-Traditional herbs					*						1
-Medication from family/friends			*						*		2
Visit hospital/clinic	*	*				*	*	*		*	6
No knowledge of procedures	*					*					2

**Appendix D: Thematic network showing important basic and organizing themes of access, use and health care satisfaction among migrants and non-migrants in Ghana**



**Appendix E: Sample transcript**

**Expert interview: With University of Ghana Hospital (Records Section)**

**Date: 26/07/2018**

**Duration: 0:14:25.9**

**I: Interviewer**

**P: participant**

**===: incomplete statement**

**....: Unclear/ anonymity**

I: the study is on access to health care and I am looking at migrants and non-migrants. so, before we start, I don't know if you can introduce yourself?

P: I am ....

I: How long you have been working hear?

P: I have been working hear for the past 18 years

I: wow! then you have a lot of information for me. Yes, so from the administrator, I was talking about migrants but he made it clear that only foreign student s normally come hear but I told him that, they are also included in the study. so apart from the foreign students do you receive any other type of migrants like refugees or foreigners...

P: Not refugees but they are foreigners in the country, like one happens to be a Ghanaian and he or she is married to a non-Ghanaian. they are not in the majority. Very few

I: So, you receive those type of migrants in addition to the foreign students too

P: Yes

I: So, when it come to the foreign students, is basically because is the university hospital

P: Yes

I: so, with the foreign students and the non- foreign students or the Ghanaian students, which group of people normally use the services hear.

P: No, the non-Migrants

I: Do they use it more than the Ghanaians students:

P: come again

I: do they use the facility more than the Ghanaian students? comparing them with the students that are Ghanaians, which of them use the facility

P: Ghanaians use more than the non-Ghanaians, Yes. I will like to compare some of the months but generally, Ghanaians more.

I: Are there specific months that, sometimes you receive more migrants

P: Most of them come to do this sandwich program so when they come you see more of them coming

I: which is around which month

P: somewhere June, July when the regular students are on vacation to the end of August

I: so, on the average, how many people do you receive as new cases.

P: New cases?

I: Yes

P: I don't understand because, he comes here with malaria, last year and maybe three months later I come again with a different illness

I: someone coming for the first time

P: so, you are talking about somebody coming for the first time?

I: Yes

P: So, looking at the whole year, the whole year for the first time we get close to between 9000...

I: so, with this number, if you can tell me, it could be accurate or you can guess what percentage do you think happen to be migrants

P: about 2%

I: 2%?

P: Yea

I: okay, alright, thank you. and then in terms of payment, have had any experience with migrants when it comes to payments or maybe, they have to get drugs. I know with the university, been a student, how do you call it, you can enjoy the service

P: Yea, what they do is, most of them. the students, the foreign students, they, I think they are to enrol on a private insurance. Before then they pay to the university but I don't know, the whole policy change.

I: Different from what the Ghanaian student have

P: Yes. Ghanaian students pay a component of their fees basically for medical service. that is what is like another form of insurance.

I: so, the foreign students have a separate insurance, which is private

Interruption from other staff

I: So, this is different from what the foreign students have. And that private insurance, are they able to use it hear in the university of Ghana, hospital?

P: oh yes. some of them, we have the metropolitan. Is accepted. not all of them but some is accepted. but the one that they cannot what they do, is they pay for and then get a refund.

I: so, is it the university that decides which insurance?

P: No. that one, I have no idea as to. you know they have a department for that. so, I have known idea. they do that for them

I: Which is the international programs office?

P: International programs office! So that one I don't know if they do that for them or they have to do it right from their own country before they come

I: so, you said on the average, 2% of the people are migrants?

P: yes 2%, yea

I: so, in term of the payment, what about those who don't come with any insurance, have you ever encountered any difficulty in terms of payment?

P: yes. they talk about the payment ...that is too expensive. of course! The., for our policy hear, if you are a foreigner, you come and you want to make payment, you pay twice what the Ghanaian

I: In terms of the hospital system?

P: Yes

I: wow

P: you pay twice

I: Okay, so, when it come to the kind of illness, are there specific illnesses, that you know that, this one, is mostly is the non-Ghanaians that come with this particular illness?

P: with my stay here, I mean, the sort of illness that I have seen foreigners complain of malaria, flue basically this are the two things. Or maybe so injury through accident mean yes, basically this are what I have seen. But when you talk about hypertension, diabetes, no, no

I: so, they don't normally come with chronic diseases, they come with infectious diseases

P: Yes. they come with UTI

I: So, when it comes to emergency and non-emergency cases. which group of people comes more with emergency cases. the migrants or non-migrants?

P: the non-migrants

I: the non-migrants. okay, alright. this is unstructured interview. If you have any other thing you can add to it, like in terms of foreign students their access to the university hospital. How they access the hospital, how they use it, any difficulty you have with them

P: Yes! you see, the sort of system that they have there, especially those, how do I even describe them? the whites. Not the Africans but the, maybe the Americans and the Europeans, their system is different. So, when they come and meet the crowd here, the queuing, the stuff, they are a little bit frustrated and... in a way. because they think when they come they are supposed to be given immediate attention right. but it does not work like that for those of us hear. Laugh! we do this, and because you are a foreigner, you are supposed to be give special treatment. For you to be seen ignoring our other people who have been here before you came. But! they don't see it like, they think that because they are foreigners, they are supposed to be seen

I: is it because they are foreigners or because they are foreigners form special places. you made mentioned that the Africans

P: No, the African regions, me I don't see them complaining too much

I: And have you had any confrontation with maybe one of them getting frustrated and then====(11:41)

P: Oh yea!

I: can you please==== (11:43)

P: I think one of them, before she came. And then she presented herself as a student, where is your ID card? I think she left her ID card and you know before we can treat you, you have to show evidence. I mean it became an issue between her and the personnel providing the service.

for her to call someone to bring it was also an issue. she seems not to know the system. the phone that she was using does not have the persons number to call and treatment was delaying. you know the she started crying (Laughter)

I: so how did you help her

P: we treated her

I: I can see you have to attend to someone. if you have any other thing to add

P: for now, I don't think

I: Thank you very much

## Appendix F: Study Questionnaire

### University of Ghana



### Centre for Migration Studies

Questionnaire for gathering data on migrants' and non-migrants' access and use of healthcare in Ghana

#### Introduction

Dear Sir/ Madam, I am Alberta Teye, a PhD candidate from the University of Ghana (Centre for Migration studies). I'm conducting a research on migrants' and non-migrant's accessibility and utilization of health care in Ghana.

The purpose of this research is to understand "migrants' and non-migrants' accessibility and utilization of health care in Ghana" and other issues relevant to the study objective. I will be grateful if you could assist by providing answers to these questions in other to address the study objectives.

Thank You

**Location of interview**.....

**Interviewee ID/Code**.....

### Section 1: Socio- Demographic Information

101) Age: .....

102) Sex 1) Male 2) Female

103) Level of education: 1) No education 2) Primary 3) Middle/JSS/ JHS  
4) Voc/Tech/Commercial 5) senior secondary/ senior high

- 6) Post Sec Diploma      7) Bachelor Degree      8) Post graduate  
9) other (Please specify) .....

104) What is your marital status?      1) Never married      2) Married      3) living together/consensual/informal      4) separated      5) divorced      6) widowed

105) Religion      1) No religion      2) Catholic      3) Protestant      4) Pentecost/Charismatics  
5) other Christian      6) Islam      7) Traditionalist/ spiritualist  
4) other (specify).....

106) What is your average monthly income 0) No income 1) < GHC 300 2) GHC 300 - 499  
3) GHC 500 -799 4) GHC 800 -999 5) 1000 – 2999 6) GHC 3000+

107) Employment status      1) Employed, Part time      2) Employed full time  
3) Not Employed Students      4) Not employed, non-student

108) Occupation      1) No occupation      2) professional/technical      3) Managerial      4) clerical  
5) Sales/Trading      6) Agriculture-self      7) Agriculture      8) Household and Domestic  
9) Service      10) Skilled manual      11) other (Specify)

109) How would you classify your economic situation?      1) AccepTable      2) unaccepTable

## Section 2 Migration Status information

201) In which country where you born?.....

202) What is your Nationality?

- 1) Ghanaian            2) West African (Please specify)  
3) other African (Please specify)  
4) Non-African (Please specify)            5) Dual Citizen ( Please specify)

202a) Migration status of respondent    1) refugee   2) Documented, expatriate to Ghana  
2) Documented student   4) Undocumented   5) Other Specify   5) N/A

202b) How long have you been in Ghana?.....

202c) Do you have any relative in Ghana? 1) Yes   2) No

202c.i) Do you have any close friend in Ghana? 1) Yes    2) No

202d) At the moment do you have any intention of permanently returning to your home country?

- 1) Yes            2) No            3) Not Sure

Why.....

202d.i) At the moment do you have any intention of permanently staying in Ghana?

- 1) Yes            2) No            3) Not sure

Why.....

**Note: Skype to Q203**

202f) If Ghanaian **in question 13**, which region where you born?

- 1) Ashanti region    2) Eastern region    3) Volta region
- 4) central region    5) Western region    6) Brong Ahafo region
- 7) Northern region    8) Upper East    9) Upper West
- 10) Greater Accra Region

202g) In which region did you spend most of your first 15 years of life?

- 1) Ashanti region    2) Eastern region    3) Volta region
- 4) central region    5) Western region    6) Brong Ahafo region
- 7) Northern region    8) Upper East    9) Upper West
- 10) Greater Accra Region

202h) How long have you been in the Greater Accra region.....

### **Section 3 Health coverage and Access to health**

301) Are you affiliated to a workplace/ institution with a health facility that you are entitled to access by virtue of your affiliation without paying directly?

- 1) Yes    2) No

302) Are you affiliated to an institution or work place that gives you a health coverage?

- 1) Yes    2) No    If No Skype to

303) How is the coverage administer?

- 1) Refund    2) All services provided free under coverage
- 3) some services free under coverage    and some through refund
- 4) Full services received and payment done later

304)    Are you currently registered on a health insurance?

- 1) Yes Currently registered    2) No, never registered    3) No, previously registered



402) Have you used your health insurance card within the last 12 months?

- 1) Yes      2) No      3) N/A

403) What do you usually do when you are unwell/sick?

- 1) Self-medication using the Pharmacy      2) self-medication using herbs  
3) self-medication using medication from a friend/ family member      4) Visit a clinic  
5) Visit a hospital      6) visit a herbalist or traditional healer      7) Visit or call a pastor/  
spiritual leader

404) Is there a place that you usually go when you are unwell/sick?

- 1) Yes      2) there is more than one place      3) there is no place

405) What kind of place do you usually go to most often?

- 1) Teaching hospital      2) regional Hospital      3) District hospital  
4) Other Public hospital      5) Poly clinic      6) Health Centre  
7) CHPS      8) MCH Clinic      9) Maternity Home  
10) Private Hospital      11) Clinic      12) Chemical Store  
13) Medical practitioner home      14) Patient's home      15) Mission hospital/ clinic  
16) Pharmacy      17) Homeopathy      18) Traditional healer's Home  
19) Herbalist/ Spiritualist      20) Prayer Camp      21) other (Specify).....  
22) N/A

406) In the last 4 weeks, have you consulted a health practitioner, visited a health facility or consulted a traditional healer or purchased drugs?

- 1) Yes      2) No      3) N/A

407) When was your most recent visit to a health facility or use a health service or purchased a drug?      1) Between 1-2 months ago      2) 2-3 months ago      3) 3-6 months ago      4) Over 6 months ago

**Section 5: Respondents' Health Condition**

501) Have you had any illness/ injury, that kept you away from your usual daily activities in the past 12 months?

- 1) Neither                      2) Illness              3) injury  
4) Both illness and injury                      5) Don't know

502) In the past six months, have you been taking any medication regularly prescribed by a doctor/ nurse for any long-term illness?

- 1) Yes              2) No              3) Don't Know

503) How would you rate your health status today?

- 1) Very Good      2) Good              3) Moderate  
4) Bad              5) Very Bad              6) Don't Know

504) Have you ever been hospitalised or admitted in any hospital in Ghana?

- 1) Yes              2) No

505) Comparing your current health status with when you first arrived in Ghana, how would you describe your health?

- 1) Currently healthier than then      2) Healthier then than now      3) Same now as then  
(4) Don't know                      5) N/A

506) Generally, comparing with your age cohort in your home country who have not migrated, how would you describe your current health status?

- 1) I have better health status compared to them      2) they have better health then my current health status              3) My health status is not different from theirs  
(4) Don't Know                      5) N/A

507) Generally, if you are to compare your current health status with your age cohorts who are Ghanaians living in Ghana, how will you describe your health?

- 1) I have better health status compared to theirs      2) they have better health than my current health status      3) My health status is not different from theirs  
(4) Don't Know      5) N/A

### Section 6: Evaluation of the health care in Ghana

601) What do you like most about the formal health care system in Ghana?

- 1) Method of delivery      2) Payment system      3) attitude of health workers      4) Number of health workers  
5) facilities      6) Logistics  
7) None      8) Don't know

602) What don't you like most about the formal health care system in Ghana?

- 1) Method of delivery      2) Payment system      3) attitude of health workers      4) Number of health workers  
5) facilities      6) Logistics  
7) waiting time      8) None      8) Don't know

603) What in your opinion are the barriers to accessing formal health care in Ghana?

- 1) Distance and Transportation      2) cost      3) facility  
4) Waiting Time      5) Logistic      6) Language  
7) Attitude of health workers

604) How would you rate the cost of formal health care in Ghana?

- 1) Very cheap      2) cheap      3) Normal      4) Moderate      5) Expensive  
6) Very expensive

605) How satisfied are you with the General formal health care in Ghana?

- 1) Completely satisfied      2) Very satisfied      3) Satisfied      4) Somehow not Satisfied  
5) Not satisfied      6) completely not Satisfied

606) How satisfied are you with the health service in the specific health facility you used the last time?

- 1) Completely satisfied    2) Very satisfied    3) Satisfied    4) Somehow not Satisfied  
5) Not satisfied                    6) completely not Satisfied

607) In General, how would you describe the formal health care in Ghana?

- 1) Excellent    2) Better    3) Good  
4) Bad    5) Very Bad    6) Poor

608) Comparing the formal health care in Ghana with the formal health care in your home country, how would you describe the health care in Ghana?

- 1) Excellent    2) Better    3) Good    4) Bad    5) Very Bad    6) Poor    7) N/A

609) Can you please explain your answer?

.....  
.....

**Section 7 Supplementary questions**

701) Can you read a phrase/sentence in English or French?

702) Can you write a phrase/ sentence in English or French?

- 1) Yes English    2) Yes French    3) Yes Both English and French  
4) None    5) Don't Know

703) In what Ghanaian language can you read a sentence?

- 1) None    2) Twi/Fanti/ Akyem/ Akuapim    3) Ewe    4) Ga-Dangbe  
5) Dagbani    6) Frafra/Grusi/Gruma    7) Nzema    8) Wali/Dagari    other (Specify)

704) In what Ghanaian language can you write a sentence?

- 1) None    2) Twi/Fanti/ Akyem/ Akuapim    3) Ewe    4) Ga-Dangbe

5) Dagbani 6) Frafra/Grusi/Gruma 7) Nzema 8) Wali/Dagari other (Specify)

705) Please do you have any  
comment.....

.....

## Appendix G: Semi-Structured Interview Guide

**University of Ghana**



**Centre for Migration Studies**

Semi-structured interview guide for gathering data on migrant workers in the meet industry in Ghana.

Introduction

Hi, I am a PhD candidate from the University of Ghana (Centre for Migration studies). I'm conducting a research on migrants' and non-migrants' accessibility and utilization of health care in Ghana.

The main focus of this interview is to get narrative on how migrant and non-migrants in Ghana access health care and their formal and informal coping strategies in times of health crises. And also, to explore how their work duties interfere with their access to health care and how their health also interferes with their work.

### **Section A: socio-Demographic characteristics**

1. Could you please tell me about yourself?

Probe: Name, Age, Marital status, Migration status, level of education etc.

Probe: country of origin, duration of stay in Ghana, reason for migrating and intention to return (in the case of migrants).

**Probe:** if ever migrated in the case of non-migrants

### **Section B: health information**

2. Please do you have a health insurance cover?

Probe Answer

3. Can you please tell me about the last time you had a major injury or illness that made you stay away from work or your usual activities?

Probe: date, type of injury/illness, duration, how it happened

Probe: if the service of a health facility was used,

4. Can you tell me about your experience with the formal health care system, the last time you were on admission or hospitalized?

Probe: Challenges, coping, satisfaction,

5. How did you manage work load that accrued as a result of the illness/ injury crises?

Probe: official work load, domestic activities and others

6. How would you rate your health status today? Would you say is good or bad

Probe Answer: why?

7. Comparing your current health status with when you first arrived in Ghana, how would you describe your health?

Probe Answer: Why?

8. Generally, comparing with your age cohort in your home country who have not migrated, how would you describe your current health status?

Probe Answer: Why?

9. Generally, if you are to compare your current health status with your age cohorts who are Ghanaians living in Ghana, how will you describe your health?

Prove answer: Why?

### **Section C: experience of the healthcare system in Ghana**

10. When was the last time you accessed a healthcare facility in Ghana?

Probe: reason for accessing the system

11. Have you used other health care system (traditional, faith based, Chinese, homeopathy) apart from the formal health care system in Ghana.

Probe for: period; purpose; experience etc.

12. Can you tell me of your experience with a health care system in Ghana, the last time you use one?

Probe: satisfaction

### **Section D: Evaluation of Health care in Ghana**

13. What is your view about health care in Ghana?

14. What is exceptional about health care in Ghana?

Probe: Method of delivery; attitude of health workers; logistics

15. What is your view about the cost of formal health care in Ghana
16. Are you satisfied with healthcare in Ghana? Probe reason
17. If you are to compare the health care in Ghana with that of your home country what would you say? (in the case of migrants)

**Appendix H: Ethical Clearance**

This study was reviewed by the University of Ghana Ethics committee for Humanities (ECH) on 16/07/2018. The proposal for this study accompanied with the structure questionnaire for the quantitative data collection and the interview quid used for the in-depth interview were submitted for ethical review and approval. The study was reviewed by the Ethics committee for the Humanities and clearance given with the reference number “ECH 191/17-18.

All Ethical protocols, including voluntary participation, informed consent, confidentiality and respondent and data protection were strictly adhered to at all staged of the thesis both on field and off field.

**Appendix I: Inform consent form**

**PROTOCOL CONSENT FORM**

Title of Study	<b>Migrants’ and non-migrants’ access and use of healthcare in Ghana.</b>
Principal Investigator	Alberta Teye
Certified Protocol Number	

**General Information about Research**

I am a PhD Candidate at the Centre for Migration Studies of University of Ghana, Legon-Accra. I am conducting a research on “Migrants’ and non-migrants’ access and use of health care in Ghana”. The aim of the research is to examine the access and use of health care in Ghana in relation to migration status. The study also aims at exploring the perceived access to health care barriers and the experiences of participants with the formal health care system in Ghana during health crises (hospitalization/ hospital admission)

**Benefits/Risks of the study**

Your participation in this study may not bring you material benefits, but the findings will contribute to policy formulation by providing insight on the population’s (migrants and non-migrants) satisfaction of the health care system in Ghana as well as the barrier to access to health care.

**Confidentiality**

Any information provided for this study would be treated with utmost confidentiality. Only the researcher and supervisors can have access to the information provided and under no circumstance will your identification be revealed to a third party or a comment attributed to you without due process. The information you provide will be used only for academic purposes.

**Compensation**

The study has not made provision to compensate your participation in this study either in cash or material, however, transportation cost will be paid to a participant who has to travel to meet the research team.

**Withdrawal from the Study**

Your participation in this study is very important for its success, but with no compulsion, and you can withdraw at any point of the exercise without a penalty. Under no circumstance will you be adversely affected if you decide to participate and later withdraw your decision to participate.

### Contact for Additional Information

If you need further information or clarification on this research or in case of research-related injury Please contact my supervisor and Director of the Centre for Migration Studies, University of Ghana, Professor Joseph Teye on: 0245733233 or Email: teyejoseph@yahoo.co.uk

Thesis Supervisor:

Dr. Delali Badasu of the Centre for Migration Studies, University of Ghana on: 0269782129 or Email: delalibadasu@yahoo.com

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at [ech@isser.edu.gh](mailto:ech@isser.edu.gh) / [ech@ug.edu.gh](mailto:ech@ug.edu.gh) or 00233- 303-933-866.

### Section C- PARTICIPANTS AGREEMENT

**"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."**

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Name of Participants

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Signature or mark of participants      Date