UNIVERSITY OF GHANA

MIGRATION AND HEALTH AMONG FEMALE PORTERS (*KAYAYEI)* IN ACCRA, GHANA

BY

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DECLARATION

I declare that except for the references to works which have been duly cited, this thesis is the result of my original research conducted under the supervision of Professor Joseph Awetori Yaro, Dr. Delali Badasu and Dr. Joseph Teye and that it has neither in whole nor in part been presented for another degree elsewhere.

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DEDICATION

I dedicate this work to the memory of my late parents Mma Awabu Abdullai and the late Alhaji Ziblim Yahaya. May their souls rest in the bosom of the Lord.

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After five years of hard work, I realize now that obtaining a PHD degree is not just a one person effort. I would like to publicly acknowledge the contributions and sacrifices from many people who have played a crucial role in the completion of this study.

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ABSTRACT

The thesis aimed at contributing to the emerging body of knowledge about migration and health linkages, with a focus on migrant female porters *(Kayayei*) in Accra, Ghana. Several studies that have so far given attention to female porters have focused mainly on their livelihoods, with only cursory remarks made on the health of these migrants. Also, some existing studies have largely examined the health of migrants without reference to the entire migration process. Employing both quantitative and qualitative methods of data collection, this study has provided both empirical depth and theoretical clarification on the migration dynamics of female porters, their health seeking behaviours, and the multiple factors that hinder their access to health.

Migration is seen by the female porters as a means to gain autonomy in their lives, a means of livelihood diversification. The migration process of female porters is enabled by social networks with varying levels of social capital which facilitates movement and settlement. Social networks provide safety nets for female porters as it increases their social asset base**.** The reasons for their migration are related to the declining importance of agriculture and the non-availability of jobs at their origin which can be blamed on the liberalization of the Ghanaian economy

The working and living arrangements and work environment of the female porters constitute the major sources of health risks. The nature of their work also exposes them to physical stress, particularly waist and neck pain, and accidents resulting normally in sprains and fractures. The poor living environment is the major cause of diseases such as malaria, typhoid and cholera. Sleeping in the open in front of shops exposes them to mosquitoes, while the lack of decent bathrooms, toilets or hygiene in general exposes them to skin infections and water related diseases. Sleeping in the open also exposes them to the harsh weather conditions and also to rapists. The poor working and living conditions also provide possibilities for illnesses contracted at the origin to thrive and become complicated.

The majority of the female porters sought health care in avenues other than health facilities. These avenues included drug peddlers, local herbalists and Chemists' shops. Those who used traditional medicines mostly brought them along from the origins in the north, particularly in cases where they were already ill before migrating. Generally, female porters visit health facilities when their conditions become serious. Migrants' age, levels of education and marital status were generally found to have a positive effect on health-seeking behaviour. Thus the combinations of individual and local dynamics of the *Kayayei* communities at their destination in Accra have a great influence on their well-being, which translates into influence on their health and health seeking behaviour.

An integrated approach aimed at addressing these complex and multidimensional problems requires national and local policies that are multidimensional in nature and seek to capture the different aspects of vulnerabilities that affect the health of female porters at their destination.

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AMA:	Accra Metropolitan Assembly
ANC:	Antenatal Care
CAMFED:	Campaign for Female Education
CBD:	Central Business District
CHAG:	Christian Health Association of Ghana
CMS:	Centre for Migration Studies
CPR:	Contraceptive Prevention Rate
DFID:	Department of International Development
DSW:	Department of Social Welfare
FGDs:	Focus Group Discussions
GDC:	Gonja Development Cooperation
GDHS:	Ghana Demographic and Health Survey
GDP:	Gross Domestic Product
GHS:	Ghana Health Service
GLSS:	Ghana Living Standard Survey
GMOH:	Ghana Ministry of Health
GNFPP:	Ghana National Family Planning Programme
GPRS:	Ghana Poverty Reduction Strategy
GSS:	Ghana Statistical Service
HIV/AIDS:	Highly Human Immune Virus-Acquired Immune Deficiency Syndrome
LESDEP:	Livelihood Empowerment and Social Development Programmes
MCH:	Maternal and Child Health

SDGS:	Sustainable Development Goals
MOWAC:	Ministry of Women and Children Affairs
NGO:	Non-Governmental Organisation
NHIS:	National Health Insurance Scheme
PAC:	Post Abortion Care
PHC:	Primary Health Care
PPAG:	Plan Parenthood Association of Ghana
RAINS:	Regional Advisory Information and Net Work System
PRA:	Participatory Rural Appraisal
RCHU:	Reproductive and Child Health Unit
RH:	Reproductive Health
SADA:	Savanna Accelerated Development Authority
SAP:	Structural Adjustment Programme
STDS:	Sexually Transmitted Diseases
STI:	Sexual Transmitted Infection
TBS:	Traditional Birth Attendant
TFR:	Total Fertility Rate
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
WDR:	Word Development Report
WHO:	World Health Organisation

CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Background to the Study

Migration is a key feature of human society. The phenomenon is one of the most significant drivers of societal change and well-being of different people. Today, it remains a key means by which people escape climatic, social, political, agricultural and economic threats and seek alternative life options elsewhere (Castles & Miller, 1993; Bakewell & Haas, 2007; Foresight, 2011). One of the key aspects of contemporary migration is the global rise in female migration. This has contributed immensely to the on-going rapid urbanization worldwide, with serious implications for the health of migrants and the receiving populations (Castles & Miller, 1993; Adepoju, 2010). However, female migration has received little attention in the contemporary analysis of the relationship between migration and health (Bakewell & Haas, 2007; IOM, 2014).

Even the few studies on the subject have largely focused on international migration to the neglect of internal migration, though the latter is more prominent. This study seeks to investigate the contemporary migration dynamics of north-south internal female migrants in Accra and their vulnerabilities to various health risks. The scale of global migration and the fact that migrants are often moving from parts of the world with distinct health geographies have critical implications for global and regional health (Patterson, 1981, Rodney, 1972; Castles & Miller, 1993).

Those implications are often obscured by complications of culture, language and perceptions of health and health protection by different people, thus making it difficult to

establish the linkages between migration and health (Carballo, 2005; Markwalder & Carballo 2005). Over the last century, migration has been on the increase and almost half of migrants are women (Castles & Miller, 1993). The feminisation of migration is one of the most striking aspects of contemporary population redistribution (Castles & Miller, 1993; Adepoju, 2010; IOM, 2014). Until the second part of the last century most female migrants followed their husbands or family. Most female migrants now move independently (Castles & Miller, 1993; Adepoju, 2010). Female migrants moving to cities are often among the most vulnerable in society, mainly because they are often low-skilled and concentrated in dense and in informal settlements with low levels of health care, water and other services (Foresight, 2011).

Female migrants often face serious barriers to good health including discrimination, language and cultural barriers and other economic and social difficulties (Van Landingham, 2003; Adepoju, 2010). Female migration, particularly within borders of countries, it is perceived, will continue to rise in the foreseeable future as the conditions that initiate the underlying determinants of rural-urban migration are not expected to change significantly (IOM, 2014). Thus an understanding of the health implications of this migration is not only of contemporary relevance but also useful for the foreseeable future. This is more crucial as it is the most economically active of the world female population that are largely involved in the migration process.

In Ghana, female migration has become a common response to unfavourable cultural and social issues and a survival strategy that enables households cope with the economic

difficulties and other unfavourable conditions (Van der Geest, 2011). Until recently, the pattern of north-south migration in Ghana has been male dominated, long term and long distance in nature, with mostly females joining husbands or moving to stay with relatives for economic and social reasons. However, this pattern has changed and today the dominant migration stream from north to south is of female youth, moving independently of their families, and mainly towards the cities of Accra and Kumasi (Iddrisu, 2001; Litchfield & Weddington, 2003; Whitehead & Hashim, 2007; GSS, 2012).

A striking feature of contemporary female migration is that unlike previously when it was frowned upon by families, today families consciously support females' migration by aiding the decision making process and funding the migration process due to the enormous benefits associated with remittances (Awumbilla, 2007). Migration and health share a complex bidirectional relationship (Soskolne & Shtarkshall, 2002; IOM, 2014). Migrants also contribute to the spread of certain communicable diseases within national populations, in particular from rural to urban areas (Wilson, 1995; Iddrisu, 2001; IOM, 2014). There is a general consensus among migration scholars that conditions both at origin and destination have an influence on the health of the migrants. But scholars such as Schenk (2007) further argue that conditions at the origin and destination can lead to deprivation, thereby leading to greater exposure to several vulnerabilities (Schenk, 2007). This study will focus on this perspective in addition to others in investigating the situation of the *Kayayei*.

According to the IOM (2014), information on migrants' health and on their access to health services is generally scarce. Most countries' health information systems fail to disaggregate data in a way that permits analysis of key health issues that are either found among migrants or resulting directly from migration. The IOM, however, indicates that existing qualitative studies have been very useful in many ways, particularly in pointing to migrants' different perceptions on health and their approach to seeking health care. However, there is the need to complement qualitative data with quantitative data to clearly show migrants' migration processes and their linkages to health, their perceptions of health and of approaches to health-seeking behaviour, especially among females (IOM, 2014).

1.2 Statement of the Research Problem

The rise in female migration is an emerging dynamic of contemporary migration within Ghana (Awumbila & Schandorf, 2008; IOM, 2014). Female migration from the northern parts of Ghana, comprising the Northern, Upper East and the Upper West regions of the country, to the economically rich regions in southern Ghana, particularly the Greater Accra and the Ashanti regions, is largely due to environmental, social and economic factors (Awumbila & Schandorf, 2008). Female migration is closely linked to the gap in development between north and south dating back to colonial times. The north has the highest concentration of the poor in Ghana (Bening, 1975; Codjoe, 2006; Ghana Statistical Service, 2007, 2012). More recently, liberalization and structural adjustment programmes, coupled with environmental deterioration and ethnic conflicts in the north, have widened these spatial disparities, (USAIS,2012).

The Economic Recovery Programme of the 1980s resulted in the peasantisation and feminization of poverty with greater effects on the north due to its economic dependence on agriculture (Yaro, 2004). The patterns of poverty have not changed as the north is still the poorest part of the country (GSS, 2012). For this and other reasons people are forced to migrate to the south to better their economic status and to improve upon their lives. Vast gender differentials in access to and control of resources in most societies in the developing countries contribute immensely to female migration (Murie, 2008). This seems to be the case in northern Ghana where most female porters migrate from. Females are generally not allowed to own and control landed property in spite of playing major roles in household production and reproduction.

Women play a major role in agriculture in the northern Ghana. The limited access to land has contributed to the continuous migration of young women and girls from the north to southern Ghana to earn their livelihood working as *Kayayei* (Awumbila & Schandorf, 2008). Most women in the northern part of the country who migrate to the urban areas have low or no skills and therefore seek employment in the informal sector as manual labourers (Awumbilla, 1997; Anarfi et al. 2003). Female migrants in major urban cities are confronted with difficult life circumstances and heightened stress in the migration and adjustment process, leading to diminished psychological and physical well-being (IOM, 2014). This is more so for girls as young as eight years old working as head porters (*Kayayei*) (Anarfi et al. 2003). Just like other migrants, they continue to experience various stressful circumstances even as they adapt to the new social environments and lifestyles.

The living and working conditions of these girls are so poor that they become vulnerable to various health risks. Health is a revealing indicator of wellbeing and adjustment and an important variable in migration research which must be given attention. This important dimension of female migration calls for further rigorous studies, a call which the current study aims at fulfilling. Previous researchers (Anarfi et al. 2003; Awumbila & Schandorf,, 2008,; Van der Geest, 2010; Jarawura 2014; IOM, 2008, 2012) have examined the various dimensions of migration in Ghana , but without an in-depth focus on the health dimension. Older studies such as those by Patterson (1981), Wilson (1995) and Iddrisu (2001) have given attention to the health of migrants by concentrating largely on the spread of communicable diseases. This study adopts a holistic approach that considers not only the migration-health relationship, but also the intertwining range of livelihood conditions within which female porters navigate.

The main explanation for migrants' health has been the conditions in the destination (Schenk, 2007). However, recent studies such as Schenk (2007) argue that conditions both at origin and destination have an influence on the health of migrants. Conditions at the origin and destination can lead to deprivation which will have an effect on the health of the migrants, thereby leading to greater exposure to several vulnerabilities (Schenk, 2007). Scapendock (2012) draws our attention to the need to consider the departure circumstances and the nature of the journey together with conditions at the destination as a holistic approach in understanding the migration process and health. To what extent do pre-existing conditions, the migration processes, and life in the destination interact to define migrant health?

The processes of migration and its associated dynamics may magnify or constitute an initial vulnerability to health risks, which are magnified by debilitating circumstances in the destination. An already impoverished and malnourished migrant who finds herself sleeping in the open in the destination without adequate sanitation will certainly have a higher exposure to health risks with little resistance. Framing the issues of migrant health in the light of pre-existing conditions, process conditions, and destination circumstances provides a coherent holistic understanding of the linkages between migration and health. The orientation, adaptation and process of integration into the host society can also influence the health of the migrant (Miller et al, 1993). The living and working environment of migrants in the destination and the nature of the health care systems and access to these services by the migrant induce good or poor health (Schenk, 2007).

Rafique, Massey and Rogaly (2006) stated that migrants in manual work experience physical exhaustion and harm, poor housing, unguaranteed wages, employers' malpractice and poor shelter conditions. Patterson (1981) describes the poor working conditions in mines in colonial Ghana and how these combine with the social environment to impose severe health problems including bronchitis, tuberculosis and other pulmonary diseases. The urban environment is similarly affected by hazardous factors as the female porters spend their nights in front of market stores, at bus terminals, in wooden sheds, and on pavements (Jarawura, 2014). In order to secure these hazardous spaces as dwelling places, some girls are forced to offer sex to the owners or are raped during the night, which exposes them to sexually transmitted diseases (Awumbila, 1997; Awumbila, et al. 2008).

The cramped living conditions also make them susceptible to contagious diseases such as whooping cough, cerebro-spinal meningitis (CSM), skin rashes and tuberculosis. Some *Kayayei* as young as eleven years old engage in commercial sexual activities as a secondary source of income, which results in some cases in unwanted pregnancies and contraction of sexually transmitted diseases (STDs) (ILO, 2002; IOM, 2005). Health seeking behaviour is the mediating variable when people are exposed to health risks. A range of factors including social networks, availability and access to health facilities, belief systems and language determine the health seeking behaviour of migrants (Adepoju, 2010, WHO, 2014). The social network of the migrants at the destination can have a great impact on the health of the migrant. The willingness of peers to contribute to pay the medical bills and the availability of the health facilities in the urban environment can improve the health of migrants in the host community (Awumbila & Schandorf, 2008).

Adepoju (2010) argues that the availability of personal resources, individual health problems, the educational levels of the migrants and risks associated with the occupation of the migrant are the major factors influencing the health of the migrant. Notwithstanding the importance of individual level factors, studies on health seeking behaviour seem to have over emphasised the relevance of the individual as an agent of decision making (IOM, 2005). But the factors influencing 'good health seeking behaviours' are not rooted solely in the individual, but also in the dynamic, collective, interactive elements (Schenk, 2007; IOM, 2014). This study therefore argues for a more serious examination of the local dynamics of communities and how they interact with

individual idiosyncratic factors in mediating the vulnerability of the migrant to health risks.

This thesis examines the relationship between migration and the health of the *Kayayei* by looking at the nature of their migration process, the conditions at the destination and the factors that influence their health seeking behaviour.

1.3 Objectives of the Study

1.3.1 The Broad Objective of the Study

The main objective of the study is to examine the relationship between migration and health of migrant female porters.

1.3.2 Specific Objectives

Specifically, the study examined the following research objectives:

1. To examine the socio-demographic characteristics of migrant female porters and to assess the migration processes and dynamics of their north-south migration.
2. To examine the working and living conditions of the migrant female porters and discuss the effects on their health.
3. To identify and analyse the health-seeking behaviour of the migrant female porters.
4. To propose practical strategies for mediating the migration processes and health of the migrant female porters.

1.4 Justification for the Study

Migration is increasingly playing a vital role in livelihood change in northern Ghana (Van der Geest, 2004; Awumbila & Ardayfio-Schandorf, 2008), but little empirical research has been carried out to examine the health of migrants. The migration of young girls and women to the cities in Ghana to work as porters is now drawing the attention of the government, nongovernmental organizations and all stakeholders in northern Ghana and at the destination areas. This phenomenon has drawn the attention of researchers and policy makers to investigate the causes of their migration, their employment conditions and health related issues of the migrants. This study therefore brings to the attention of parents of the female porters at their origin the health challenges the migrant female porters face at their destination in the city.

The study will contribute to knowledge about the continuous movements of young girls from the north to the south and highlight on the health and other challenges the *Kayayei* are confronted with at their destination. The study will also serve as a guide to the health implications of their migration and their migration processes for policy makers who are concerned about the migration of these young girls and women. Thus it will help in policy direction by serving as an eye opener to policy makers who will then know where to begin. It will also help government and the district assemblies in the north to have an idea about the living conditions of the young girls who migrate to the south to work as *Kayayei*. This in a way will help to redesign the policy on the Savannah Accelerated Development Authority (SADA) on *Kayayei* capacity. The study will also help in

redefining the theory of health behaviour of migrants. This is so because the theory focuses more on international migrants to the neglect of domestic or internal migrants.

1.5 Structure of the Thesis

The thesis is divided into seven chapters. Chapter 1 introduces the research problem and provides justification for the study. The chapter also presents the objectives of the study and the research questions. Chapter 2 reviews literature on migration and health dynamics, historical perspectives of migration in Ghana, migration processes and outcomes, determinants of migration, and health and conceptualising migration and health. Chapter 3 provides background information on the study areas: both the origin of the migrant female porters in the north and their destination in Accra. This includes the physical, demographic and socio- economic features and development indicators in both areas. The chapter also presents the methodologies employed for the study.

Chapter 4 outlines the migration processes and dynamics of the migrant female porters. It provides more rigorous analysis of the migration processes and dynamics of female porters. The chapter analyses the reasons for migration, decision to migrate and recruitment agents, as well as how the migrant female porters financed their trip to their current destination. The chapter concludes by analysing the social capital and social networks of migrant female porters.

Chapter 5 provides a more rigorous analysis on the living and working conditions of the migrant female porters and how it affects their health. It examines and analyses the living

and working environment of the female porters; the housing conditions as well as the sleeping arrangements; and the water and sanitation situation. Chapter six outlines the health seeking behaviours of the female porters at their destination. The chapter analyses the following: knowledge of existing health facilities, places where the porters sought health care, factors that influence migrant female porters' access to health care and how the migrant female porters finance their health care needs. Chapter seven summarises the main research findings and the conclusions drawn from them. It also outlines the recommendation for policy and for future research.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

Chapter two provides a review of literature on migration and health. The chapter begins with a general review and focuses on the relations between female migration and health.

2.1 Migration and Health

Migration simply means the moving away of individuals or family members from their resident households for varying periods of time. It can also be termed a flexible and dynamic phenomenon that encompasses territorial mobility of people and their absence from home for periods of days to several years (Susannah, 2006). Spatial movements of the human population are increasingly pronounced and more significant than ever (Castles & Miller, 1993). Historically, migration has enabled human populations in larger groups to resettle in more suitable environments, thereby navigating various spaces of risks and vulnerability. In recent history, migration has made it possible for the "new world" to become populated and economically viable (Castles & Miller, 1993). Today, socio-political and environmental dynamics of different countries, and persistent economic growth along the individual and collective complexities of societies, have increased migration of populations on individual and family basis within and across the geographical contours of nation states (Awumbila & Schandorf, 2008).

Migration has remained one of the main ways in which people escape climatic, social, political, agricultural and economic threats and seek alternative life options (Hugo, 1996; Hunter, 2005; Brown, 2008; Foresight, 2011). While its relevance to economic

development and demographic revitalization is still valid and in some cases more so than before, migration is becoming more controversial and surrounded by political and social attitudes that make it a more precarious process than it ever was. Migratory movements characterized by increased quantitative growth and qualitative differentiation along the lines of migratory patterns, nature of migrants, their quality and final destination, have facilitated differentiated development patterns, creating various spaces of vulnerabilities including health risks (De Haan, 2010). The increasing magnitude of migration and its current dynamics, including the rise in irregular and female migration, clearly suggests that migration can expose individuals and groups in many settings to health risks (De Haan, 2010).

Meanwhile, migrants generally remain excluded from the benefits of health and health care at their destinations (IOM, 2005). Migrants have largely been conceptualised as problematic in the context of policies, both nationally and internationally. However, research concerning migrant vulnerabilities has given little attention to the health implications of the phenomenon. The focus of this section of the thesis is on the health implications of migration in the context of public health as well as in relation to the health of the individual and the existing barriers of access to health services at their destination.

As migration is one of the major focuses of the 21st century, migration must also be recognized as a social determinant of health. Although mobility is not of itself detrimental to health, it is a social determinant of health. Circumstances in which

migration takes place, together with individual factors such as gender, sex, language, migration status and the culture of the people, have a significant impact on health-related vulnerabilities and access to health services (Casttles & Miller, 2003). The fact that people are often moving from parts of the world with very distinct health conditions and disease profiles inevitably carries with it implications for the health and healthcare of those who move, for receiving societies and even for those they leave behind.

The health implications of migration are often coloured by complications of culture, language, gender and how people from different parts of the world perceive health and health protection. The fact that much of contemporary migration is occurring in a socio-political context in which migration is becoming less appreciated by some receiving societies has implications for the health of those who move and for the receiving areas. The reluctance of many states to ratify the Convention on the Rights of Migrants and the on-going exclusion and discrimination of migrants in the laws suggests that many national and international policies have not yet been able to address the challenge of migrants in a way that takes into account the public health issues involved (Markwalder & Carballo, 2005; Adepoju, 2010).

The International Organisation for Migration (2005) argues that it is important to pay particular attention to rural-urban migration as it is the most prevalent form of spatial mobility in the world (IOM, 2005). Also, the destinations of rural-urban migrants provide unique conditions that enable the spread and contraction of diseases (IOM, 2005; Adepoju, 2010). Rising trends in both global urban populations and rural-urban migration

(IOM, 2005) make this proposition even more significant. This thesis therefore focuses on rural-urban migration. The next section reviews literature on rural-urban migration.

2.2 Migration in Ghana

This section is a broad overview of studies on Ghana's migration. The review covers three main areas, namely migration patterns, the determinants of migration, and the impact of migration. Although migration is very common in Ghana, it has not received deserved attention. Most studies have concentrated on economic analysis of the movements. This is apparently due to the fact that over the years, there has been a general lack of detailed migration data (Van der Geest, 2011). Some notable attempts have, nevertheless, been made to capture the main patterns and reasons for migration in Ghana. Whilst most of these studies are descriptive, they often present cross-tabulated survey statistics and other information that offers valuable insights into the reasons, extent and patterns of migration (see, for example, Caldwell, 1968, Gbortsu, 2010). Thus, for instance, according to the literature, the reasons for migrating include job search, schooling, marriage, and other family-related considerations, but little insight is offered into welfare issues (Caldwell, 1969; GSS, 2012).

2.3 Patterns of Migration in Ghana

Migration in Ghana in the early twentieth century was mainly in the form of rural-to-rural movements, as people migrated to work on cocoa farms and gold mines on a seasonal or semi-permanent basis (Brydon, 1992). Whereas permanent migration has assumed increased importance over the past four decades, data constraints have considerably

limited the available information on the magnitudes and patterns of temporary and seasonal migration. According to GSS (2010), 52% of Ghana's adult population are internal migrants, with the corresponding percentages for men and women being roughly the same (51.4 percent and 52.2 percent respectively). In view of the fact that these figures do not include temporary and seasonal migration, population mobility in Ghana is quite high. Regarding the occurrence of temporary and seasonal migration in Ghana, these are mainly associated with agricultural activity. More than four decades ago, Beals and Menezes (1970) observed that temporary migration is the major form of labour mobility in Ghana.

Whilst the increase in manufacturing and other non-farm activities may have contributed to an increase in permanent migration, there is no reason to doubt the importance of temporary migration, even if it is not the most dominant form of migration in Ghana at present. A significant component of temporary migration is seasonal migration, which often results from the different farming calendars between northern and southern Ghana. The slack season in the north is the busiest season in the south. Therefore migrants tend to move to the southern regions of Ghana to work on cocoa and coffee farms as a livelihood diversification strategy.

'Short-term movement from [savannah] to forest was thus a natural adaptation, particularly because the kinds of work required in the cocoa and coffee regions, harvest [labour] and the clearing of new plantations, lent themselves to seasonal or casual performance" (Berg, 2000, P.69). The concentration of economic development initiatives

in the urban areas of the south and the associated emergent employment opportunities have also attracted migrants from northern Ghana. Tutu (1995) identifies the dominant regions of destination as Greater Accra, Ashanti, and Western. These regions have received much attention from various governments in terms of economic and social development, thus attracting migrants from other parts of the country, particularly the impoverished north (Van der Geest, 2011). The high influx of migrants, particularly from rural areas into these three regions, has contributed to a high and rising urban population in the country.

In consonance with earlier predictions by the Ghana Statistical Service (GSS, 2010) and the World Urbanization prospects (2010) in the year 2010, the number of people living in urban Ghana had surpassed those living in rural areas by a small margin (GSS, 2010; World Urbanization Prospects, 2012). The increasing rural-urban migration trend from northern Ghana to the south indicates the growing importance of non-farm livelihood strategies (Ellis, 2000), as urban areas largely provide non-agricultural jobs, for example, in the construction and service industries. In most developing countries, especially in sub-Saharan Africa, a shift from subsistence to cash crop production or manufacturing has resulted in temporary or permanent exodus of men, and sometimes women, from rural communities to urban areas in search of wage employment opportunities (Deshingkar & Grimm, 2005).

Rural-urban migration is a major type of livelihood diversification that households and individuals undertake as a means of survival (Ellis, 2000; Morten, 2008). Beyond playing

the role of a source of livelihood to migrants, rural-urban migration results in pressure on various infrastructure and available job opportunities, which in turn has significant consequences for the wellbeing of the migrants and their host populations.

2.4 Patterns and Trends of Migration from Northern Ghana

In pre-colonial times there seems to have been little migration from present- day northern Ghana to the South. Cleveland (1991. P 92) describes human mobility in this era as ‘‘a tradition of local migration by many and long-distance migration by a minority of warriors and traders.’’ People migrated over shorter distances in search of fertile land and to escape conflict and slave raiders.

In the eighteenth and nineteenth centuries, large-scale voluntary migration was impeded by conflict and insecurity resulting from the wars between the Ashanti, the Gonja and the Dagomba and the related activities of slave raiders. The Northern Territories of the Gold Coast (now northern Ghana) were colonized by the British at the turn of the century. The first decades of colonial rule were a time of forced migration through labour recruitment. This period lasted about two decades, from 1906 to 1927 (Lentz, 2006). The colonial government recruited labourers for the mines and for railway and road construction in southern Ghana.

Voluntary migration started not long after the first forced migrants had returned from southern Ghana. Most of the early voluntary migrants were attracted by good labour opportunities in the booming cocoa sector. Therefore, it can be argued that population

growth declined in northern Ghana, while it increased in southern Ghana, due to increasing North-South migration. This is the case between the 1910 and 1960 censuses and in the last inter-censual period (1984–2000) (GSS, 2000).

The trend in annual population growth for northern Ghana, however, indicates that migration gradually increased during the course of the twentieth century. From the 1990s out-migration from northern Ghana gradually increased, although there was a gradual recovery in rainfall and economic growth. The inter-censual period of 1984–2000 indicates that migration propensities increased sharply. Similarly, that of 2000-2010 also shows a rising trend in north-south migration. The trend, however, shows a temporary decline in the 1970s and 1980s. The 1970–1984 inter-censual periods shows temporary decline in migration from north to south (Van der Geest, 2011). This period was a time of widespread economic crisis, political instability and high food prices in the South.

Evidence of North-South migration shows that the densely populated northeast is a principal source area of migrants, but the Upper West region has the highest out-migration rate: 26.9 per cent of the people born in that region were living in the South (GSS, 2010). The figure for the Upper East region is 22.2 per cent, and for the Northern Region it is 13.0 percent (GSS, 2010). The food crop producing middle belt, the cocoa frontier in the Southwest, and the cities of Kumasi and Accra are prime destination areas of migrants from the north.

2.5 Determinants of Migration in Ghana

The literature on migration in Ghana indicated that the determinants may be grouped into community/household characteristics and individual attributes. As is common in the general migration literature, many of the studies on migration in Ghana focus on rural-urban migration. As a result, the migration determinants identified are often mainly applicable to migration from rural to urban localities. The major community and household characteristics mentioned in the literature include distance from potential destination, the economic condition of the destination locality, the welfare status of the sending household or community, and the presence of kin or friends in the destination locality. The trend in family migration indicates that people are moving to cities on a permanent basis. Literature on determinants of rural-urban migration, with the exception of few studies, suggests that individual or household characteristics are the motivating factors for migration (Kirk-Greene, 2000); Oda (2005); Memon (2005). One of the key results of the study by Beals et al. (2010) is the negative impact of distance on migration rates.

Using data from the 1960 population census, Beals et al. (1967) found statistically significant evidence in support of distance as a strong deterrent to interregional migration in Ghana. In a study of rural-urban migration using survey data, Caldwell (1968) also found evidence in support of the negative effect of distance on migration. According to Caldwell, for all persons aged more than 20 years, there was a clear inverse association between the tendency to migrate to the towns and the distance from the nearest large locality. It is important to note that Caldwell found this result to be statistically

significant for both men and women. As suggested by Beals et al. (1967), the negative effect of distance might be correlated to information costs, as well as important cultural and social differences between localities. The 2010 population and housing census reported that about 60 percent of the migrants were in their youthful age and that the development in road infrastructure and the transport sector has made movement very easy in the country (GSS, 2010).

Migration studies in Ghana suggest that the welfare level in the sending community (or household) exerts an effect on migration. In their studies, Beals et al. (1967) found a negative effect of origin locality's income on migration. Notably, when urbanization was included in the migration equation, this effect (of origin locality's income) was stronger than that of the destination locality's income level. Caldwell (1968) found a higher propensity to migrate to the towns with better-off rural households. Whilst the results of Beals et al. (1967) and Caldwell (1968) appear to vary, it could be that they both are capturing different effects on migration. The result of the former is a reflection of the tendency for people to want to stay in an area where favourable economic conditions prevail. The latter's result shows that for any community characterized by unfavourable conditions, members of richer households are generally better able to embark on migration.

It is worth noting also that apart from the fact that the two studies used different datasets, Caldwell was only reporting an association, whereas Beals et al. (1967) carried out a regression analysis. These results nevertheless highlight the complex nature of migration

determinants and outcomes. The importance of networks in migration decisions has been acknowledged (Lucas, 1997), and for Ghana, this factor appears to be crucial in most migration decisions (Trauger, 2005). This is because the establishment of networks often results in the reduction of migration costs. On the basis of data from the Ghana 1991 Migration Survey, Tutu reports that for persons intending to migrate, 76 percent had friends or relatives residing in the destination locality.

In the context of rural-to-urban migration, Caldwell (1968) also found a very strong statistically significant association between the presence of rural household members in the destination locality and the likelihood of other members visiting (or migrating to) the town. As observed by Tutu (1995), the role of access to destination-based kinship and other networks in migration decisions is closely linked to the cost-reducing effect of such access. A dynamic element has further been associated with the role of destination-based networks of relatives and friends. In his study of rural-to-urban migration in Ghana, Caldwell (1969) observes that by increasing the population of rural residents' relatives and friends in urban centres, rural-to-urban migration can be self-reinforcing. This especially has to do with young people migrating southwards from the north. Certain characteristics, particularly the marital status and number of dependents of these young people, are crucial in the decision to migrate.

The evidence of Ghana's migration studies relating to the effects (on the tendency to migrate) of marital status and the number of dependents is, however, somewhat tentative. Tutu (1995) observes that the unmarried are more likely to migrate, but Caldwell's

(1968) evidence for this factor was not very strong. Again, in respect of the number of dependents, the former reports a negative effect on migratory movements, whilst the latter was very cautious on this. Caldwell, however, found a positive relationship between number of siblings and rural-to-urban migration. In the context of rural-to-urban migration, Caldwell further suggests there is often strong pressure on persons of low birth order (that is, older siblings) to stay at home, and – in the case of persons who have migrated – to return home. According to Caldwell, this tendency is due to the fact that the most senior siblings are often required by social norms to shoulder certain responsibilities, such as looking after aged or ailing parents and managing the family farm.

In their econometric investigation of interregional migration in Ghana, Beals et al. (1967) found a negative effect of education on migration. This result was contrary to what had been hypothesized, and the authors acknowledged that they "simply do not know what underlies the observed inconsistency". Caldwell (1968), on the other hand, found a statistically significant positive association between education and the propensity for rural-to-urban migration. According to the 1991 Migration Research Study, however, a higher percentage of migrants have no formal education, compared to non-migrants (Gbortsu, 1995). Data reported by Gbortsu further suggests that it is only with respect to university education that the proportion of migrants with education exceeds that of non-migrants. Clearly, the education-migration interplay appears to be complex.

This complexity may be attributed to the potential for considerable correlation between education, incomes, and migration. The incorporation of a correction for selectivity bias is a key aspect of a recent econometric migration study by Tsegai (2005). In investigating the determinants of the migration decision, Tsegai places particular prominence on the role of migration income. In view of the fact that migrants may be non-randomly selected from the population, the study employs Heckman's two-step procedure for selectivity correction.

A major result of the study is the evidence found for expected income gains in influencing migration decisions. Other factors found to influence the migration decision include previous migration experience of the household head and/or spouse, household size, education, social capital, ethnic networks, and having irrigated fields and off-farm activities. Since the study's geographical focus was much localized, its findings cannot be generalized for the entire country. Notwithstanding this limitation, the study's results, and more importantly the methodology, constitute a valuable addition to the Ghana migration literature. The literature reviewed in this sub-section suggests that studies on Ghana's migration determinants are dominated by the use of descriptive statistics. Whilst the usefulness of such methods can hardly be ignored, it is appropriate to emphasize that an increased use of alternative and more rigorous approaches to the analysis of migration data can be insightful and complementary.

2.6 Health

The World Health Oraganisation (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001). A review of the literature revealed that rather than proffering definitions of health, a significant number of studies attempted to provide a deeper understanding of the meaning of health (Aina, 2004; Kaddour, Hafez, & Zurayk, 2005; Labun & Emblen, 2007; Weerasinghe & Mitchell, 2007). Evidence suggests that there is no common view about the meaning of health (Aina, 2004; Kaddour et al., 2005; Labun & Emblen, 2007; Weerasinghe & Mitchell, 2007). It varies from individual to individual and this meaning may be influenced by a number of worldview factors (Aina, 2004; Bardin, 2002; Kheong, 2003; King, 2000).

Worldviews of health are described through a number of models: these include the biomedical model (Abiodun, 2005; Bardin, 2002; Kheong, 2003; Koch, Webb, & William, 1995), the behavioural model (Doyal, 1996; Ghaddar, Shamseddeen, & Elzein, 2009; Weissman, 1998; Weitz, 1996) and the socio-ecological model (Marshall & Altpeter, 2005; McCarthy, Ruiz, Gale, Karam, & Moore, 2004; Swanson & Wonjar, 2004). It can also be explained from a gendered perspective (Keskinoglu et al., 2007; K. M. King, 2000). For the purpose of this study, I will limit it to the biological, behavioural and the socio-ecological models.

2.7 Approaches to the Study of the Health of Migrants

2.7.1 The Biomedical Approach

The biomedical approach focuses on health as the absence of illness or disease (Ivanitz, 2000; Morgan, Calnan, & Manning, 1993; Tetrick, 2002). It offers a scientific explanation of health and takes into account the physical manifestation of illness (Ahmed, Kolker, & Coelho, 1979; Engel, 1977; Ivanitz, 2000). Based on the Cartesian dichotomy between mind and body (Lock & Scheper-Hughes, 1996), the body is perceived as part of a natural world, and diseases are presented entirely as physical entities occurring in specific locations of the body (Balog, 2005; Ivanitz, 2000). This model's primary emphasis is around the physiological disease process and the curing of diseases through scientific management of symptoms (B. O. Abiodun, 2005; Bardin, 2002; L. Bennett & Duke, 1995; Han & Ballis, 2007; Kheong, 2003). Thus, biomedical notions of health concentrate on disease and illness rather than health (Abiodun, 2005; Bardin, 2002; Bell, 2000; Hummelvoll & da Silva, 1994), with the focus being on the level of exposure to germs and conditions that expose people to infection (Cockerham, 1978; Marks & Worboys, 1997).

Kermode (2004) observed that within the biomedical model, health outcomes are measured by default - by apparent reductions in disease and illness. Through its scientific approach, it has been argued since the 1960s and 1970s that treatments are initiated for the unhealthy patients with a focus on disease and system pathology (Abiodun, 2005; Bardin, 2002; Bell, 2000; Hummelvoll & da Silva, 1994). This is a very narrow approach to health and precludes a broader and deeper understanding of health.

Even so, the biomedical approach constitutes the dominant model guiding health provision. The substantial decline in the death rate, which coincided with the spread of this approach in 19th century Europe and the specific etiology theory of disease, added credibility to the effectiveness of this model (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993). It was particularly recognised and distinguished from previous approaches in terms of its effectiveness in controlling disease and improving the health of people. It was documented that between 1851 and 1971 the crude death rate (CDR) in England and Wales declined from 22.7 per 1000 people to 12.5 per 1,000 people (McKeown, 1979). Seventy-six percent of this decline was due to a reduction in mortality from infectious diseases (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993).

The biomedical model not only gained recognition in the clinical knowledge of disease, but also its dominant role in the academic study of disease was noted in the literature (Ahmed, Kolker & Coelho, 1979; Tetrick, 2002). The successful establishment of the causal link between germs and disease was considered the most significant singular break-through in the history of medicine (Ahmed et al., 1979; Tetrick, 2002). Twaddle and Hessler (1977) considered this achievement as the greatest weapon in the battle against disease. The emphasis on immunisation and treatment was generally acclaimed as the beginning of an era of optimism in which it seemed possible to eradicate all illness of mankind (Ahmed et al., 1979; Engel, 1977; Morgan et al., 1993; Twaddle & Hessler, 1977).

Despite the recorded achievements and dominance of the biomedical model of health, its assumptions have been criticised for a number of reasons (Ember & Ember, 1985; Engel, 1977; Helman, 2000; Levin & Browner, 2005). First, this model has been increasingly criticised for not giving adequate consideration to socio-psychological dimensions of health and illness (Bardin, 2002; Bell, 2000; Helman, 2000; Kheong, 2003; Milford, Kleve, Lea, & Greenwood, 2006). Second, it is also criticised for its quick fix approach to treatment (Ahmed et al., 1979; Helman, 2000; Morgan et al., 1993). To be free from sickness does not connote health (Perry & Woods, 1995). Third, it is criticised for being gender biased (Rogers, 2004). More holistic studies have shown that influences such as behaviours, socio-cultural background, gender, and life experiences underlie the meaning of health.

2.7.2 The Behavioural Approach

The behavioural approach argues that lifestyle issues and behavioural factors influence people's health (Beech, 2000; Kaplan, 1985; Kelly & Maloney, 1992; Piko & Kopp, 2004; Stefansdottir & Vilhjalmsson, 2007; Wallace & Tennant, 1998). This approach emphasises that human behaviour is complex and must be understood to maintain and improve people's health (Stefansdottir & Vilhjalmsson, 2007; Wallace & Tennant, 1998). Proponents of this approach identified behaviours including smoking, drinking, and drug-abuse as destructive behaviours that are detrimental to health (Beech, 2000; M. P. Kelly & Maloney, 1992). As such, this approach contens that certain cognitive behavioural changes are crucial in maintaining health (Kaplan, 1985; Piko & Kopp, 2004; Stefansdottir & Vilhjalmsson, 2007).

The behavioural approach considers health as a group concern rather than that of individuals alone (Beech, 2000; Kelly & Maloney, 1992). There are empirical studies that suggest that people's health behaviour impacts on people around them (Boye et al., 2001; Myrin & Lagerstrom, 2006). Although the behavioural approach has enhanced the understanding of the concept of health by making reference to collective responsibility, it was criticised for undermining the experience of suffering that illness may bring on the affected individuals (Brady, Kunitz, & Nash, 1997). Family members and others closely involved with a patient may be sympathetic but may not fully comprehend the exact level of pain experienced by that person. The behavioural approach has also been criticised for its tendency to raise "scape goats" responsible for the society's predicament (Brady et al., 1997). Nevertheless, it has broadened our knowledge that behaviours may have a significant impact on health. This is of particular concern in sexually transmitted diseases like HIV/AIDS (Bardin, 2002; Bell, 2000).

2.7.3 The Socio-Ecological Approach

The socio-ecological approach emerged as a result of the recognition that health is a product of cultural and social conditions. Proponents of this perspective perceived health as a social construction or disability, whereby ill health is believed to be a result of poor social conditions (Marshall & Altpeter, 2005; McCarthy et al., 2004; Swanson & Wonjar, 2004). This social ecological model advocated proactive social and political intervention, instead of dealing with illness after its occurrence (Marshall & Altpeter, 2005; McCarthy et al., 2004; Swanson & Wonjar, 2004). Sociologists, who were the main advocates of this perspective, were especially interested in exploring how different societal groups

define health and illness and sought to understand how social forces moulded differences in people's health. Even though the socio-ecological approach contributes to the understanding of health, it does not take into account inherited medical conditions and other factors unrelated to social circumstance that may have a tremendous impact on health. This gives weight to the argument that a multifocal view of health may provide a deeper understanding of the concept (Bardin, 2002; Bell, 2000; Daly, 1995; Swanson & Wonjar, 2004).

2.8 Theories of Health Behavoiur

A number of theories and models have been developed in an attempt to understand health-seeking behaviour of migrants. The most popular of these are referred to as the cognitive theories.

2.8.1 Cognitive Theories of Health Behaviour

The cognitive theories and models, which explain health behaviour, emphasise individual cognition and reflection (Conner & Norman, 1996, p. 179). These theories are generally described as learning theories with the argument that learning a new and seemingly complicated pattern of behaviour like changing from a deskbound to an active lifestyle, or giving up smoking or drinking, usually demands a modification of some aspects of the previous lifestyle (*E*ndrawes, 2007; Munro, Lewin, Swart, & Volmink, 2007; Noar & Zimmerman, 2005). These entire learning theories centre around assumptions that before lifestyle changes occur, certain decision trails take place within the individual (Becker, 1974; Gebhardt & Maes, 2001; Rosenstock, 1974; Stroebe, 2000). There are assumptions

that attitudes and beliefs, in addition to the expectations of future actions and outcomes, are important aspects of the decision trail and crucial determinants of health related behaviour (Gebhardt & Maes, 2001; Stroebe, 2000). There are a number of cognitive theories, but only those considered relevant to this study are examined here. These are the health belief model, the theory of reasoned action or theory of planned behaviour, and the social cognitive theory.

2.8.2 Health Belief Model

The health belief model proposes that before a person adopts a health promoting behaviour, a rational assessment of the balance between the barriers and benefits of action is assessed (Becker et al., 1979; Blackwell, 1992). This model explains that the individual will consider the seriousness of a potential illness, the risk of contracting that illness, or the level of susceptibility to that illness (Armitage & Conner, 2000; Champion & Menon, 1997; Strecher & Rosenstock, 1997). The individual will also consider the difficulties or barriers in taking up the healthy action and then assess the benefit of adopting the healthy lifestyle (Armitage & Conner, 2000; Champion & Menon, 1997; Strecher & Rosenstock, 1997).

The health belief model is illustrated in the following literature adapted from the story of Mrs. Nuggett (Davidhizar, 1983; Roden, 2004): Mrs. Nuggett is contemplating giving up smoking (health enhancing action) following her doctor's advice regarding the increased risk of smokers developing lung cancer. Mrs. Nuggett will consider the seriousness of lung cancer (perceived severity) and her risk of contracting lung cancer - her father was a

smoker and he died of lung cancer (perceived susceptibility). The health belief model also suggests that Mrs. Nuggett will further consider the difficulty in stopping smoking: she works in a tobacco company, her husband is a smoker and most of her friends are smokers (perceived barriers). She will also consider what she will gain by stopping smoking: a healthy life (perceived benefits). Thus, according to the assumptions of the health belief model, if the perceived severity, the perceived susceptibility and perceived barriers are higher than the perceived benefits, Mrs. Nuggett will not stop smoking. However, if the perceived severity and susceptibility are high, but the perceived barriers are low and the perceived benefits are high, she is more likely to stop smoking.

This model has been extended to incorporate self-efficacy, which means an individual must also have a certain level of confidence in his or her ability to adopt the healthy behaviour (Rosenstock, Strecher, & Becker, 1988; Strecher & Rosenstock, 1997). It is also suggested that the individual, as in the case of Mrs. Nuggett, may need periodic prompting to avoid social outings with smokers, as these may compromise her resolve to stop smoking. The health belief model has been used in a number of studies to predict people's health behaviour (Sapp & Weng, 2007; Yarbrough & Braden, 2001) and in explaining health related actions (Yarbrough & Braden, 2001). It has been widely used to explore people's preventive health behaviours, risk behaviours and sick-role behaviours (Sapp & Weng, 2007; Sullivan, Pasch, Cornelius, & Cirigliano, 2004; Yarbrough & Braden, 2001).

This model has been used to study immigrant women, particularly in relation to their breast screening behaviours: Chinese American women in the USA (Lee-Lin et al., 2007); Filipino, Chinese and Asian-Indian women in the USA (Wu, West, Chen, & Hergert, 2006) and South Asian immigrant women in Canada (Ahmad, Cameron, & Stewart, 2004). The health belief model has been criticised for its inconsistency in predicting behaviours (McKenna & Horswill, 2006; Yarbrough & Braden, 2001). It was criticised for over-emphasising the individual decision making process without recognition of the societal factors that may be beyond an individual's control (Bandura, 2000; Munro et al., 2007). However, it is considered relevant for this study, as the *Kayayei* may need to adopt some health enhancing behaviour, and it is important to know their health behaviour pattern when developing health interventions for these women (Hanson, 2005).

2.8.3 Theory of Planned Behaviour

The theory of planned behaviour is a modified version of the theory of reasoned action developed by Ajzen and Fishbein (1980). The major assumption of this theory is that the highest determinant of behaviour is the person's intention to engage in the behaviour. This intention may pertain to the person's readiness or willingness to perform the given behaviour (Lautenschlager & Smith, 2007; Norman, Armitage, & Quigley, 2007).

The intention is the cognitive representation of a person's preparedness to perform a particular behaviour (Ajzen, 1988, 1991). This intention is in turn determined by the behavioural, normative and control beliefs that influence health behaviours. The

behavioural belief relates to a person's attitude towards the behaviour, which is reflected in an overall positive or negative evaluation of the behaviour. The normative belief, however, is concerned with the person's perception of social pressure from significant others to perform the behaviour, while the control belief is about the person's perception of control over performing the behaviour (Ajzen, 1991).

The proposition of this theory is that a person's intention can be predicted from his/her attitudes, the subjective norm of the significant others and perceived control over the behaviour (Ajzen, 1988, 1991; Lautenschlager & Smith, 2007; Norman et al., 2007). This theory has been criticised for playing down the role of social norms in determining people's intentions to engage in health-related behaviour (Godin & Kok, 1996). However, studies grounded in this model show that perceived normative expectations, particularly perceived expectations of significant others, affect health behaviour (Bissonnette & Contento, 2001; Fila & Smith, 2006). This is of relevance to this study as African culture may demand that West African women seek approval from their husbands before seeking health care (Ilika, Okonkwo, & Adogu, 2002).

2.8.4 Social Cognitive Theory

Social cognitive theory developed by Bandura in 1977 suggests that a number of environmental and personal factors affect an individual's ability to adopt health-promoting actions (Bandura, 2000; Munro et al., 2007). Central to the social cognitive theory is the concept of self-efficacy (Bandura, 1997). Similar to the health belief model, the social cognitive theory's notion of self-efficacy suggests that an individual must trust

his or her own ability to bring about a behavioural change. Other factors, such as positive expectations outweighing negative expectations and high value for the outcome of the behavioural change, are also considered as important for adopting a behaviour that is health enhancing (Bandura, 1997, 2000).

The proponents of social cognitive theory argue that self-efficacy is the most important ingredient for a person to change from health damaging behaviour to health promoting behaviour (Bandura, 1997, 2004). This theory emphasises that other factors such as the importance that people put on benefits of healthy behaviour only manifest out of a person's perception of his or her own capability. It further suggests that efforts at developing people's self-efficacy are important in interventions for behavioural change (Bandura, 1997, 2004). Self-efficacy can be enhanced through the provision of opportunity for skill development or training, or through modelling of expected health behaviour (Munro et al., 2007).

2.9 Determinants of Migrants' Health

This section discusses the various factors that influence the health of migrants. The determinants of health include social, economic, cultural and physical/geographical factors. These influence exposure and/ or access to health care systems and utilisation of services.

2.9.1. Social Determinants

Migrants go through several experiences that ultimately affect their health, particularly in settings where they face a combination of social, cultural, legal, economic, and behavioural and communication barriers during the migration process. Inequalities which exist in every society and between different societies mean that the freedom to lead flourishing lives and enjoy good health is unequally distributed amongst different population groups. Migrants frequently find themselves among those negatively affected by these imbalances. Individual biological, physical behavioural as well as social factors, intervention and access to social and health services determine the health of such an individual or group of people. Migrants are likely to experience specific challenges in relation to their health due to their being migrants. Social determinants of migrants' health relate to factors that influence the migration process, that is, reasons for migrating, mode of travelling, length of stay, educational background and skills, the sex of the migrant, social network, language, race, ethnic background and legal status (De-Haan, 2010).

These determinants of migrants' health are complex and interrelated. Migrants can come from different backgrounds and situations and once they migrate their status often changes dramatically. Different categories of migrants may have different experiences. Determinants of migrants' health are shaped by their experiences and situation in the place of origin, transit and destination. Migration itself adds a particular dimension to social determinants of health, given that being a migrant can make a person more vulnerable to negative influences to his or her health. Many of the factors that drive

migration also contribute to the health inequalities between and within countries. Being a migrant exposes the individual to certain risks and disadvantages in a society as compared with individuals in the host communities in the same social strata.

In addition to being particularly vulnerable to certain health risks, migrants often experience certain challenges and barriers to accessing health and social services, especially if they are undocumented with regards to international migration. This in itself is a social determinant of the health of migrants. Social determinants of health are recognized as the conditions in which people are born, grow up, live, work and age (Commission on Social Determinants of Health, 2008). These conditions are shaped by political, social and economic forces. There are various layers of determinants influencing a person's health.

These are biological factors such as age and sex, life style factors, social and community influences, living and working conditions and the general socio- economic, cultural and environmental conditions. All these factors have particular implications for migrants and migration can also exacerbate the impact of such factors. Migration can therefore be regarded as an additional layer to the previous ones. Migration health thus addresses the state of physical, mental and social well-being of migrants and mobile populations. However, the structural inequalities experienced by migrants have a significant impact on their overall health and well–being. Migration health thus goes beyond the traditional management of diseases among mobile populations and is intrinsically linked with the broader social determinants of health.

There are different categories of migrants, including seasonal migrants, economic migrants, students, asylum seekers and displaced persons, documented and undocumented. These groups of migrants face different health challenges and have different levels of access to health care services and other social services. These challenges interact with social and economic inequalities. Lower socio-economic position and irregular status increase and exacerbate those challenges. Certain categories of migrants with legal documents and better socio-economic status may experience particular challenges and limits to accessing services due to language and cultural differences as well as institutional and structural obstacles. A study of the health of the *Kayayei* in Ghana by Ghanaian Denis Community Programme (GDCP) in 2004 revealed that the majority of the *Kayayei* found it difficult to access health services at their destination because they could not speak English and Akan, which are the most commonly spoken languages in Ghana.

High levels of teenage pregnancy and abortion complications have drawn national attention to youth reproductive health in Ghana. Teenage pregnancy and complications of unsafe abortion are the leading causes of maternal mortality among young Ghanaian women and are of critical concern to Ghanaian policy makers (Reproductive and Child Health Unit, 2001). By age 17, more than 80 percent of young women are sexually active and 30 percent of all births are by women aged 15 to 24 (Fayorsey, 2005). As argued by Awusabo-Asare et al.2005), lack of information and taboos concerning sexuality leave young women ignorant of almost everything about their sexual and reproductive health.

Social networks constitute one component of social capital which comprises sets of interpersonal ties that connect migrants, former migrants, and non-migrants to one another through relations of kinship, friendship and shared communities of origin. (Palloni et al. 2001, Garip, 2012) indicates that migrant social capital (resource of information or assistance) generates migration from rural areas in Thailand. Zhao (2003) identified social networks as a source of dependence among migrants. Individuals often develop social networks in their rural villages, for jobs, housing, financial assistance and social support both during and after migration. These social networks function in a number of ways. The function of social networks in migration starts from the rural settings by facilitating the process. Similarly, Aguilera (2003) and Bashi (2007) found that social networks facilitate locating jobs and access to credit for entrepreneurship for migrants. It also facilitate migrants' access to health through the support they get from their peers.

Aside of economic considerations, research over the past two decades shows the centrality of social networks to the process of migration. As social beings, humans are inevitably enmeshed in interpersonal webs of strong ties to close friends and relatives and weak ties to more distant relatives, casual acquaintances, and friends of friends. By drawing on the social ties, an individual can mobilize the social capital to gain valuable information, moral support, and material assistance that may reduce, often quite substantially, the costs and risks of migration. As a result, people with migrant friends and relatives display a much higher likelihood of emigration compared to those who do

not have any. The stronger the social connections are, the more and better the person's migratory experience and the higher the odds of eventual outmigration.

The social networks are reconstructed at the destination of the migrants. Qingwen (2011) found that the value of social networks on immigrants' "life satisfaction" appears to be dependent on particular network characteristics and the specific migrant group in question. There is often a tendency for studies to focus specifically on the act of seeking health care as defined officially in a particular context. Although data are also gathered on self-care, visits to more traditional healers and the use of unofficial medical channels such as buying drugs from the drug peddler, as often used by the *Kayayei* in Accra, are seen largely as practices which should be prevented, with the emphasis on encouraging people to opt first for the official channel (Ahamed et al., 2001). The health impacts of migration on migrants are a result of multiple factors: social, economic, political and cultural. Schenk's (2007) structural model on the relationship between migration and health provides a possibility to structure and categorize these different factors. The next section discusses this model.

2.9.2 Economic Determinants

Economic factors relate to both exposure and health care accessibility. Migrants often engage in jobs that demand high energy output and also expose them to physical and physiological risk (Adepoju, 2010). Meanwhile, migrants are also often less paid and exploited in other ways at the work place. Females particularly are sometimes susceptible to rape or forced to offer sex to their superiors or people who help them along the way in

exchange for assurances of continuous assistance (Adepoju, 2010). Low skilled migrants are usually among the most poor in society largely due to their engagement in less paid jobs and their exploitation by the owners of capital. This hampers their ability to access health care when ill (Awumbila & Schandorf, 2008).

Globally, economic issues affect much of the population, irrespective of age, gender and race. The situation is no different in Ghana where about 30% of the population lives below the poverty line (Smith, 2011). Few and sub-standard economic resources have a significant impact in the arena of health care, especially in situations where fees are charged for services and payment is required before care is received. It has been observed that in most developing countries, as much as 80% of families' income is spent on health care (Berman & Larsen 2010). Studies conducted in Burkina Faso reveal that economic ability to access health is a major factor affecting health care seeking behaviour in general and reproductive health of women in particular. In Ghana, for example, the majority of women have limited control over family property and household financial resources and limited access to credit from financial institutions (Nukunya, 2004).

Women's financial dependence on their husbands affects their decisions- making because health care options must be supported by their husbands. Women lack the power to spend money on their health without the approval of or permission from their husbands (Ahamed, Adams, Chowdury, &Bhuiya, 2000). The low socio- economic status of women puts them at greater risk of morbidity and mortality and this contributes to

women resorting to other options such as self-care/treatment that may jeopardize their reproductive health status (Mohindra et, al, 2006).

High levels of teenage pregnancy and complications from abortion have drawn national attention to youth reproductive health in Ghana. Teenage pregnancy and complications of unsafe abortion, a leading cause of maternal mortality among Ghanaian young women, are of critical concern to Ghanaian policy makers (Reproductive and Child Health unit, 2010). By the age of 17, more than 80 percent of young women are sexually active and 30 per cent of all births are to women aged 15 to 24 (Fayorsey, 1995). But as argued by Awusabo-Asare et al (1993), the lack of information and taboos concerning sexuality leave young women ignorant of almost everything about their sexual and reproductive health, thus depriving them of some control over their own babies. Thus adolescent girls in Ghana are more likely to seek abortion than older women and are more likely to seek the services of illegal providers and quack doctors. This is because the young girls in general and the *Kayayei* in particular are often unfamiliar with the laws regarding access to safe abortion.

The introduction of user fees in health facilities in African countries in the 1980s has also affected women's health care seeking behaviour (Nanda, 2002). In 1998, the government of Ghana introduced a policy that exempted all women seeking antenatal health care from paying user fees. Five years later, another policy was issued which extended women's exemption as long as they deliver their babies in a government health facility. Later in 2005 the policy was extended to the whole country. Although free antenatal care and

delivery for all women was meant to be a method for reducing maternal mortality in the country, there has been no significant change regarding reproductive health particularly in the rural communities (Biritwum, 2000; Witter, Kusi and Aikins, 2007). The lack of improvement in reproductive health delivery has affected health care delivery systems of migrants' communities.

2.9.3 Physical and Geographical Influences

Geographical or physical access to health care is a major barrier affecting health care seeking behaviours of people in Ghana and women in particular. In Third World countries including Ghana, several factors impede accessibility to health care including distance from home to health service provider, lack of available transportation, high transportation cost, and poor road network. All these factors increase travelling time and difficulty in accessing health service facilities (Shaikh & Hatcher, 2005), and they hamper access to health among the urban poor including the female porters (*Kayayei)*.

In Ghana, geographical accessibility remains a significant challenge to health service delivery. The scattered nature of settlements in rural Ghana, seasonal flooding and poor roads make it difficult for the health care system to meet the needs of the people in those areas (Nazzar et al. 1995). This lack of roads or poor road network is preventing people in rural communities from using health care services in Ghana. Most people living in remote areas, particularly in most districts in northern Ghana where most of the *Kayayei* migrated from, have little or no access to modern health care, a factor that seriously impacts on health care seeking behaviours. Physical and geographical inaccessibility

have a significant impact on the health seeking behaviour of women living in rural Ghana.

Pregnant women, especially women in labour, find it difficult to travel long distances on foot or on bicycle to access health care and their failure to access such services increases the risks of maternal and infant mortality.

2.10 Conceptualizing Migration and Health

Schenk's (2007) framework discusses the various determinants of migrant's health and factors that affect different types of accessibility to health care services by migrants at their destination. To begin with, the framework assumes that the condition at origin has an impact on the health of the migrants. That is, the condition at the origin can lead to deprivation which will have an effect on the health of the migrants, thereby leading to greater exposure to several vulnerabilities (Schenk, 2007). This means that conditions at the origin can have an influence on the health-seeking behaviour of the migrant. Availability of health care providers, the health care systems, the habit of the individual and the factors leading to migration, can have influence on the health of the migrant. Also, orientation, adaptation and process of integration into the host society can influence the health of the migrant at the destination.

The housing condition, the working environment and the health care system can either induce good or poor health at the destination (Schenk, 2007). The framework also postulated that the social network of the migrants at the destination can have a great

impact on the health of the migrant. The willingness of peers to contribute to pay the migrant's medical bills and the availability of health facilities in the urban environment can improve the health of migrants in the host community (Colins, 2006; Miller 2005). The model also shows the role of barriers to access health care and its utilization. Personal resources availability, individual health problems, the educational levels of the migrants and risks associated with the occupation of the migrant can also influence the health of the migrant (Yidana, 2010). The adoption of the model helps to highlights the migration processes and dynamics of the female porters and how it influences their health at their destination.

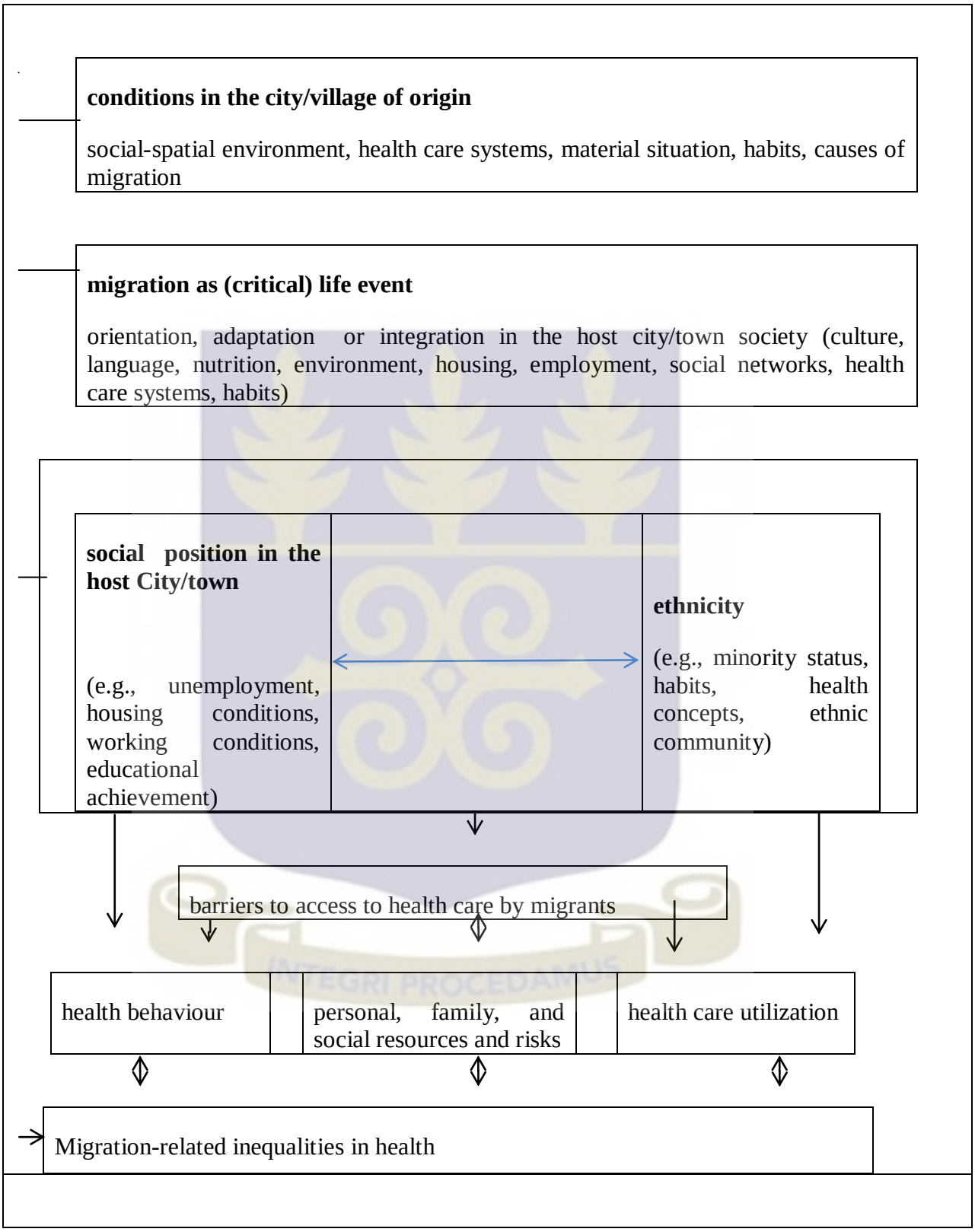


Figure 2.1: Structural Model of the Relationship between Migration and Health.

(Source: Adopted from Schenk, 2007)

Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available will go a long way to promote a change in individual behaviour towards more beneficial health seeking behaviour (Yidana, 2013). However, there is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote the change in behaviour. An abundance of descriptive studies on health seeking behaviour, highlighting similar and unique factors, demonstrates the complexity of influences on an individual's behaviour at a given time and place. However, these studies focus almost entirely on the individual as a purposive and decisive agent, whereas elsewhere there is a growing concern that those factors promoting good health seeking behaviours are not rooted solely in the individual, but they also have a more dynamic, collective, interactive element. Academics have therefore started to explore the way in which the local dynamics of communities influence the wellbeing of the inhabitants. It is against this background that this research explored the health seeking behaviour of the *Kayayei* as they moved from their local communities in the northern parts of Ghana to Accra, the capital city of Ghana.

Despite the lack of a comprehensive approach to the study of the relationship between migration and health, Razum and Schenk (2007) and Spallek (2008) propose some factors that have an influence on the health of migrants at their destination. They identified the following: generic disposition; environmental exposure or risk factors at the place of destination; factors relating to migration processes such as stress, loss of social networks; barriers to health care; health care utilization; individual health

behaviour; and social position at the destination. Some studies on the dynamics of the HIV and AIDS epidemic in Sub–Saharan Africa show that it bears many similarities with the earlier syphilis in Europe and is closely linked with rapid urbanization. Young women from the rural areas attracted by new urban opportunities are particularly susceptible to health risks such as sexually transmitted diseases, particularly those derived from multi-partnerships (Shorter, 1992). To study the relationship between migration and health, this study uses Schenks's structural model which identifies six important dimensions which distinguish an individual with and without migration background and which can bring out health differences between the place of origin and destination. These include:

1. Migration process itself (orientation and adaptation process).
2. Difference between the place of destination and the origin with regard to health influencing factors (e.g., environmental exposure, health care, life style and motive for migration).
3. Social situation of migrants at the destination (employment situation and social networks).
4. Ethnicity related factors (discrimination and intersectional identity).
5. Barriers to health care (language or cultural factor)
6. Health behaviour (eating habits, the nature of work).

The decision to engage with a particular medical channel is influenced by a variety of socio-economic characteristics such as sex, age, the social status of women, the type of illness, and access to medical services and perceived quality of the service (Segall, 1995). In mapping out the factors behind such patterns, there are two broad trends. In the first place, there are studies which categorise the types of barriers or determinants which lie between patients and services. In this approach, there are as many categorizations and variations in terminology as there are studies, but they tend to fall under the divisions of geographical, social, economic and cultural, and sometimes organizational factors. The health-seeking behaviour of the *Kayayei* can be categorized into this approach. Their health-seeking behaviour is controlled and driven by their economic status and their cultural background, and the kind of ailment they get is also attributed to the environment in which they find themselves at the destination.

Secondly, there are studies that attempt to categorize the type of processes or pathways at work. Bedri (2001) has developed the pathways to care model in her exploration of abnormal vaginal discharge in Sudan. She identifies five stages where decisions are made and delay may be introduced in the adoption of modern medical care. There are four sub pathways that women may follow, which range from seeking modern medical care immediately, to complete denial and ignoring of symptoms. This approach offers an opportunity to identify key junctions where there may be a delay in seeking competent care, and it is therefore of potential practical relevance for policy development.

The view is often that the desired health care seeking behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained allopathic health professional like a doctor in a formally recognized health care setting. In this regard gender is a recurring theme. For example, Yamakaki –Nakagawa et al. (2001) found that women in Nepal were more likely than men to seek help from traditional healers first. This finding may be reflected in the findings from a study by Rahman (2000) in rural Bangladesh, where 86% of women received health care from non-qualified health care providers. Even though these major worldviews of health seeking may not adequately explain the meaning of health-seeking behaviour held by all groups of people, they provide a baseline for understanding people's understanding of health and health-seeking behaviours.

2.11 Migration Process and Health Outcomes

Migration processes can positively or negatively impact health outcomes just as health status can affect migration outcomes. Conditions surrounding the migration process can increase vulnerability to ill health. This is true for those who migrate voluntarily, fleeing natural or man-made disasters and human rights violations as well as those who find themselves in an irregular situation, such as those who migrate through clandestine means or fall into the hands of traffickers and end up in exploitative situations (Hanson, 2005). Many migrants who lack skills and education like the *Kayayei* in southern Ghana form a large and vulnerable population. The process of migration introduces threats to psycho-social health and wellbeing in a number of ways.

The decision to move, for example, is often characterised by fear of the unknown, anxiety about those being left behind, and a sense of impending loss. Some observers have termed it a type of cultural death (Tizon, 1983) that seriously affects the wellbeing of migrants and their capacity to settle elsewhere, especially where there are additional obstacles of language, culture as well as policies and practices designed to make migration unattractive. People leaving their dear ones back at their source has a psychological upset and migrants getting new friends in new environment at the destination has a psychological implication. In the case of clandestine migrants, the process of moving is even more pregnant with problems. They are often required to pay large sums of money to be helped across borders, and from the very onset they are financially as well as economically burdened.

This illegality also means they live in constant fear and can be easily abused by employers and others. For women in particular, the need to pay with sexual favours is common, and rape and systematic sexual exploitation are frequent features (Yidana, 2013). The psychosocial well-being of migrants is also influenced by the growing tendency of partners not to be able to move together and with their children. Labour demands and labour migration regulations increasingly favour either men or women, but not both at the same time and not with their families. Many studies have reported that having a sense of coherence is an important factor in a migrant's capacity to cope with stress and improve quality of life during the early adaptation stage (Antonovsyk & Hintermair, 2004), but even when migrants do find work, job security is often lacking

and employment can mean having to accept work that is poorly paid, high risk and not consistent with their qualifications (Carballo et al., 2004).

This is certainly the case with unofficial migrants, though by no means limited to them, but when it occurs, the feelings of relative deprivation and loss of self-esteem that follow can be very psychologically erosive (Spitzer, 2003). Anxiety and homesickness are frequent problems that easily become chronic when not treated or resolved, and can present serious implications for overall psychological wellbeing, including depression and psychosomatic functional disorders such as stress-related ulcers, migraines and disabling back pain (Carballo, Divino & Zeric, 1998). Together with the challenge of resettling in new societies and cultures and doing so under difficult conditions, these problems often lead to a heavy reliance on alcohol and tobacco, and in the case of males who move alone, recourse to sex workers. In the case of clandestine migrants the constant fear of expulsion and the feeling that they are not wanted or appreciated exacerbate many of these problems even further and produce high levels of chronic anxiety and sense of isolation (Carballo et al., 2004). For close family and relatives left behind, the departure of migrants to seek a living elsewhere is also fraught with psycho-social difficulties, especially when the ones who move are heads of households leaving behind their spouses, partners, children and elderly relatives.

The relationship between psycho-social wellbeing and physical health is a close one and in the context of migration is often compounded by cultural differences in the ways people think of health and health care. It is also made more complex by the tendency for

some people from some cultures to romanticize psycho-social problems and to concentrate on physical symptoms although they have no clear diagnosis. This is nevertheless debilitating and costly in terms of work days lost (Zeric, 1998).

Psycho-social problems among children of migrants may reflect a lot of familial as well as social environmental circumstances, including problems of cultural conflict, job insecurity, regrets about leaving home, family disruption and poor expectations for the future (Divino, 2008). The fact that adult migrants are often forced to take low-status and difficult jobs also mean their work schedules often keep them away from home and from their children during non-school hours. Language differences between migrant parents and their children also create their own problems. Children appear to learn local languages more quickly and efficiently than adults, and this often creates a perceived gap between them and their parents. The latter fear is that their children are moving away into new environments and adopting their new values, culture and patterns of behaviours. The intra-familial stress and parent-child conflicts that emerge in situations such as these may be precursors to low self-esteem, feelings of guilt and psychosocial morbidity among the children of migrants (Carballo et al., 2004).

Migrant workers, especially the unskilled and the undocumented, who migrate for manual and low paying jobs, are often involved in dangerous and degrading work which exposes them to occupational hazards, but they have no health insurance to insure them against the hazards they go through. It is contrary to the notions of social justice that these migrant groups which are at high risk of abuse, exploitation and discrimination,

have the least access to health and other social services (Clapham & Robinson, 2009). Health risk factors are often linked to the legal status of migrants, determining the level of access to health and social services.

These include stigma, discrimination, housing, education, occupational health, social exclusion, gender, differences in language and culture, and socio- cultural norms (De-Haan, 2010). There have been several studies that have examined the relationship between migration and health status (Salahudin, 2005; Arifin et al., 2005), mortality rate (Mazharul Islam et al., 2005), exposure to disease (Zhenzhen Zheng et al., 2005) and risks of contracting HIV and sexually transmitted infections (Xiushi Yang et al., 2005). These studies generally show that the migration process has an impact on individual and community health at various levels (Brockerhoff, 1995; Soskolne & Shtarkshall, 2002 Findley, 1998; Van Landingham, 2003). Although much of the work on the impact of migration on health has focused on fertility, no consensus on the relationship between migration and fertility has been reached.

Some studies have indicated that fertility rates of migrants are lower than non-migrants in the place of origin and higher than permanent residents in place of destination (Oberai, 1988; Mondain, 2005). However, recent studies have shown that migrants and non-migrants have similar levels of fertility (Tungu, 2005). Studies have also revealed interesting findings on the relation between migration and maternal and child mortality. In developing countries, migrating pregnant and nursing mothers have a lower chance of survival during child birth (IOM, 2005). Also, children from rural areas have a lower

chance of survival than those born in urban areas (IOM, 2005). A study by Mazharul (2005) in Bangladesh has shown that the mortality rate of children less than five years old migrating from rural areas is 1.6 times higher than that of children born and resident in urban areas.

The survey on "Migration and Health" conducted by the Institute of Social Studies (ISS) in 2007 in six different provinces and cities reveals that two thirds of the migrants reported that their health was not worse than before they migrated. In the sampled cities the figure was 58 percent. Although there was no difference by sex, the health status of migrants varied depending on the time and destination of the migration. In the place of destination, the illness and disease status of migrants and non-migrants were similar. However, when they were ill or sick, most treated themselves or did nothing. Among the migrants, the temporary migrants were the most likely to self-treat, and the proportion going to see a doctor or to a medical facility was the lowest. The reason was that they could not afford the medical fees. This was an obstacle for spontaneous migrants in accessing medical services. Buying medicine was very easy. Drug shops were found everywhere and there were many drugs available. Therefore it is very difficult to conclude that migrant labour from other provinces is a burden on urban medical service (ISS, 1998).

In general, migrants are disadvantaged in accessing health care services (Gubry et al, 2004). The fact that migrants are not registered for permanent residence in the place of destination is one of reasons for that disadvantage (Vu Tuyet Loan, 2003). The living

standard of rural-urban migrants is said to be low. People have to struggle to earn a living and therefore they do not have time to pay attention to their health and that of their family members. Moreover, in this transition, health care for migrants in particular has changed significantly. The changes are both good and bad, and there are many problems to be solved. For example, people can spend more on medical services, but there are also many different services with different prices and quality for them to choose (Nguyen Duc Vinh, 1998).

Research on rural-urban migration to Ho Chi Minh City, undertaken by Van Landingham in 2004, indicated that migration had a large effect on the social welfare of migrants in many fields. New migrants coped with more difficulties than permanent residents on six issues of health. These are physiology, sentiment, exercise function, knowledge and conception about general health. It can be said that, to some extent, rural-urban migration may bring economic benefit to the migrants' family in their hometown, but at the same time, create disadvantages to migrants' health (Van Landingham, 2005).

Legally, sexual and reproductive health has been limited to the "reproductive" aspect which considers women in the reproductive age, particularly pregnant women. The needs of other migrants who do not fall under this category are not addressed and their rights are potentially breached. This is partly due to the language barrier which makes basic interaction a challenge, and mutual understanding of body language in health and illness through an interpreter is not satisfactory. Literature shows how perceptions of race, ethnicity and gender influence migrants' access to reproductive health services.

According to Wilson et al. (2005) and Zanchetta & Poureslani (2006), clinical encounters indicate that language and literacy are by far the most obvious cultural obstacle to providing health care. Sheridan (2006) and Rhodes et al. (2003) agreed and in addition to language, found miscommunication and dissatisfaction stemming from cultural differences and expectations which also contribute to suboptimal health care. Interpreters have a hard time doing their work due to privacy and secrecy. Wood (2007) calls it "safe space' which is essential to the effective wellbeing of migrant-friendly sexual and reproductive health.

In defining target groups for the sexual and reproductive health care of migrants, considering their behaviours, Jackson et al. (2011) identified, for example, pregnant women, STI patients, and adolescents, women without children, men and the elderly. There is a lack of information on these groups. Upon arrival, migrants' general health status might be comparatively better, a situation which Keygnaert et al. (2014) call the "migrant health effect".

According to Wolffers et al. (2003), the interaction between health and migration is a complex and dynamic one that is influenced by the socio-economic and cultural background of migrants, their previous health status and history, the nature and quality of the health care situation they had access to prior to moving, and their ability to access health care services at their destinations. The interface between health and migration is also influenced by the circumstances surrounding the migration itself, the social and health characteristics of re-settlement as well as the preparation to move (the pre -

departure). The type of work migrants are expected to perform once they arrive, the physical and housing conditions that are available to them, the access (perceived or real) they have to health and social services, as noted by Carballo et al. (2004), and the extent to which they are able to remain in contact with family members back at their origin or source, are important determinants of their health and well-being. Language skills and familiarity with the culture of the host community also play an important role in determining health outcomes. The language and the entire culture of the host population are important determinants of migrants' health. New migrants have to adjust to the eating habits and the type of food that is available at their destination.

In Denmark, the risk of delayed and poor obstetrical and gynaecological care for women migrants and refugees has been shown to be related to language problems and poor communication with health care staff (Jeppesen, 1993). Elsewhere, access to and use of health care services has been shown to be influenced by the trans-cultural skills (or lack of them) of health care staff and the availability of interpretation in clinics (Darj and Lindmark, 2002; McGuire and Georges, 2003; Carballo et al., 2004). Being able to understand the language and the total culture of the host population in itself is a way of accessing health care service at the destination. Though this literature deals with international migrants, it has a link to internal migrants, especially the female porters in Ghana, as it provides insights into the vulnerabilities and factors associated with health and migration in general.

In Ghana, the implementation of a National Health Policy was pursued and in this regard the health of migrants is taken care of and even in some cases the *Kayayei* are exempted from paying premiums before they can access the National Health Insurance Scheme. This was due to their vulnerable position at their destination and because most of them are under 17 years. The scheme exempts all children under 17 years from paying premium. On several occasions, the then Ministry of Women and Children's Affairs organized free registration of health insurance for the *Kayayei* and also organized them periodically for resource persons to give them education on sexual and reproductive health at their destination. Issues like HIV and AIDS and other related matters on the health of the people are explained to the migrants to prevent them from being infected (MWCA, 2006).

The implementation of the Primary Health Care (PHC) System as the main focus of Health care delivery in Ghana also ensures that vulnerable people like the female porters are catered for. Maximum community participation in the formulation and management of health services is promoted in the country to ensure that all people, poor or rich, take part in deciding about their health and welfare. Indeed this policy lacks certain important aspects like periodic screening of migrants, especially the *Kayayei*, to help them know their health status, as in the case of the developed world (Hashim, 2004). This therefore makes it difficult to ascertain the true health status of migrants.

2.12 Summary of the Literature Review and Identified Gaps

An overview of the relevant literature has revealed significant gaps in scholarly work. The meaning of health is subjective and varies from one individual to another and from one migrant group to the other. The meaning of health to migrants is not documented in the scholarly literature, suggesting that little is known about this phenomenon. There is a relationship between people's meaning of health, their life experiences, their perception of the health services and their health seeking behaviour at both their destination and their origin. This relationship is not explored and not reported in the literature on migrants, especially rural urban migrants.

Most of the literature on migration and health is on international migration and little is mentioned about internal migration. As migrants' experiences of migration and their cultural background have been shown to have a significant influence on their health-seeking behaviour and utilisation of health care services in their new destinations, it is important to examine migrants' cultural background. Doing so would enable medical officers and other health care providers to guide the migrants in their health care choices and provide appropriate care for them at their destination. Numerous studies on migrants' utilisation of health services have reported different patterns of health service utilisation. Studies conducted on migrants in many parts of the world revealed that female migrants under-utilise health care services. Age, length of stay in the new destination, and knowledge of available health resources are some of the suggested determinants of the type of service utilised by migrants in their destination.

The pattern of health service utilisation among migrant women is not documented in the literature. It is important to ascertain migrants' health service utilisation patterns in order to provide effective and culturally acceptable resources for migrants, including rural-urban migrants, especially the vulnerable ones like the migrant female porters in Ghana. Many Africans consult traditional healers, and they use medicinal leaves and herbs whenever they are ill. It is important to explore whether the traditional notion of health has been sustained by migrant women at their various destinations. The multicultural nature of migrants is a challenge to the health care providers to broaden their knowledge about the underlying issues that determine utilisation of health services by migrants at their destination.

This study provides an opportunity to fill the gaps in the literature by exploring the meaning of health for migrants. It explores the relationship between migration and the health of migrant female porters in Ghana as well as their understating of health, their experience of migration, their perception of health service providers and their health seeking behaviour at their destination.

CHAPTER THREE: STUDY AREAS AND RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses the study areas both in the origin in the Northern region and the destination in Accra. It also discusses the methodology employed in exploring the pertinent issues of the study. The specific issues discussed in the chapter are the background of the study areas and the methodology, which includes the sources of data, study design, sampling technique, method of data collection and management, description of variables and analytic techniques.

Since the study was conducted both at the origin and destination of the Kayayei, it is important to first of all discuss the profile of the origins of the Kayayei before discussing the destination area in Accra. in the northern region of Ghana five districts were noted to be the supply of Kayayei to Accra, these includes: the Savelegu/ Nanton Municipality, Tolon district, Kumbungu district, the West Mamprusi district and the East Mamprusi district. The profile of the various selected districts are discussed below.

3.1 Geography of the Northern Region

3.1.1 Physical Features

The Northern region, which occupies an area of about 70,384 square kilometres, is the largest region in Ghana in terms of land mass. It shares boundaries with the Upper East and the Upper West regions to the north, the Brong Ahafo and the Volta regions to the south, Togo to the east, and la Côte d'Ivoire to the west. The land is mostly low lying but the north-eastern corner is unique with the presence of the Gambaga. The region is

drained by the Black and White Volta Rivers and their tributaries such as the Nasia and Daka rivers. GSS, (2012)

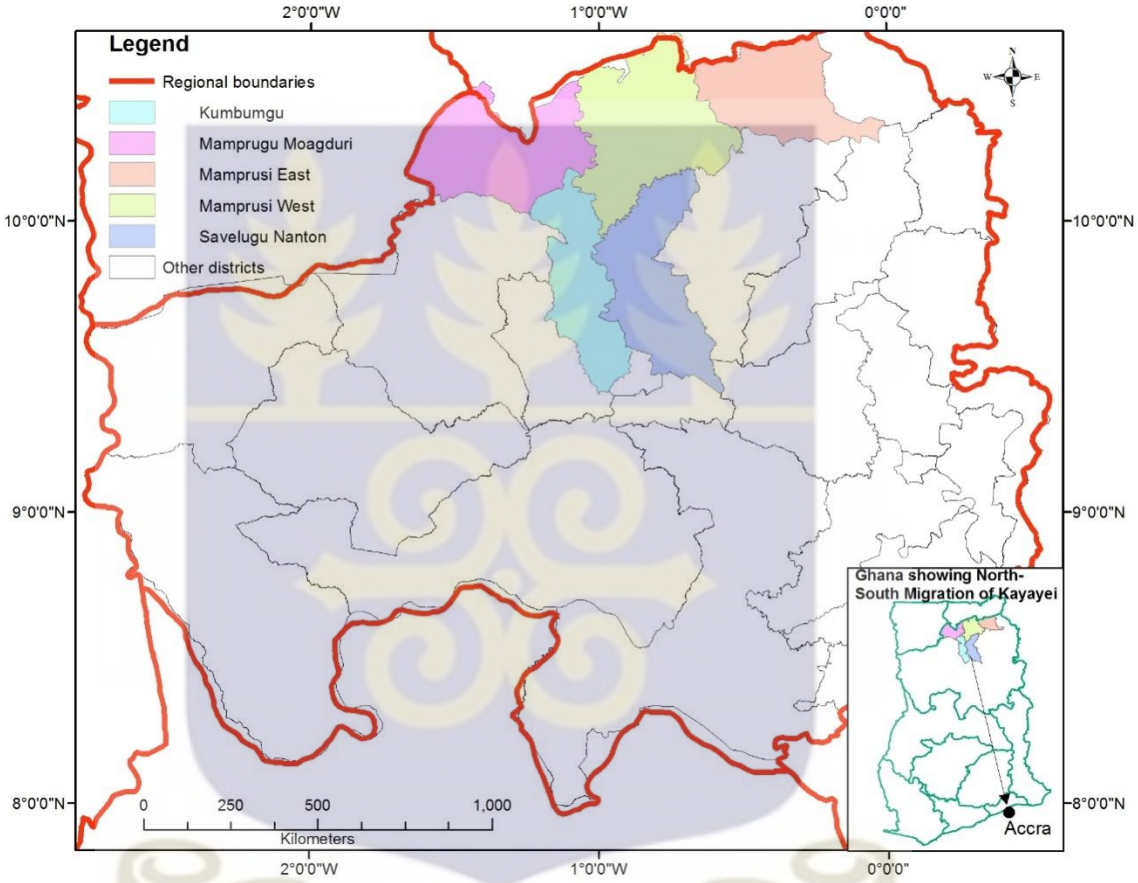


Figure 3.1: Map of Northern Region showing the selected Districts

Source: Department of Geography and Resource Development, University of Ghana, (2014.)

The climate of the region is relatively dry, with a single rainy season that begins in May and ends in October. The amount of rainfall recorded annually varies between 750

millimetres and 1,050 millimetres. The dry season starts in November and ends in March/April, with maximum temperatures occurring towards the end of the dry season (March-April) and minimum temperatures in December and January, (Deri,2004).

The harmattan winds, which occur from December to early February, have a considerable effect on temperatures in the region, making them vary between 14 degrees Celsius at night and 40 Degrees Celsius during the day. Humidity is very low, aggravating the effect of the daytime heat. The rather harsh climatic conditions adversely affect economic activity in the region and in the health sector, enable cerebrospinal meningitis to thrive, almost to endemic proportions, Deri, 2005). The region also falls in the onchocerciasis zone. Even though the disease is currently under control, a vast area is still underpopulated and under-cultivated due to past ravages of river blindness. The main vegetation is grassland, interspersed with guinea savannah woodland, characterised by drought-resistant trees such as acacia (Acacia longifolia), mango (Mangifera), baobab (Adansonia digitata Linn), shea nut (Vitellaria paradoxa), *dawadawa*, and neem (Azadirachta indica), Grenne, (2003)

3.1.2 Economy and Living Conditions in the Northern Region

The majority of people in the region are engaged in agriculture. The crops that they produce include yam, maize, millet, guinea corn, rice, groundnuts, beans, soya beans and cowpea. Some of the people are into mixed farming, that is, the rearing of livestock and the cultivation of crops. Animals such as cattle, sheep, goats, and poultry are reared in the region. Other activities that women in the region engage in are shea butter, groundnut paste and oil, and *dawadawa* processing. Women in the region are mostly engaged in the

trading of foodstuff and other goods in the major markets in the region. Poverty in the region has made most young girls in the area migrate to the big cities in Ghana to better their living conditions.

Trading and service activities employ about 3% of the economically active population. Trading in the region is dominated by agricultural activities, with a few employed in retail trading of provisions stores. The service sector comprises those in formal sector employment and constitutes less than 1% of the economically active population, (De Haas, 2008).

The region has the potential to increase food crop output if agricultural practices are modernized. However, the sector encounters problems such as food price inflation, high cost of farm inputs, post-harvest losses, and inadequate tractor services and over reliance on rain fed agriculture.

3.1.3. Topography and Geology

The Northern region is generally flat with gentle undulating low relief. The altitude ranges between 400 and 800 ft. above sea level, with the southern part being slightly hilly and sloping gently towards the North. The Middle and Upper Voltaian sedimentary formations characterise the geology of the Municipality. The middle Voltaian covers the northern part of the Region and comprises sandstone, shale and siltstone. The Upper Voltaian covers the southern part of the region and consists of shale and mudstone. Underground water potential is generally determined by this underlying rock formation, which has varying water potential for underground water compared to the upper Voltaian

formation. Consequently, borehole drilling is expected to have a higher success rate in the northern than in the southern section, making the people in the southern part of the area face severe water shortage, especially during the dry season.

3.1.4. Climate and Rainfall Pattern

The area receives an annual rainfall averaging 600mm, considered enough for a single farming season. The annual rainfall pattern is erratic at the beginning of the raining season, starting in April, intensifying as the season advances and raising the average from 600mm to 1000mm.

Temperatures are usually high, averaging 34^{o}C. The maximum temperature could rise as high as 42^{o}C and the minimum as low as 16^{o}C. The low temperatures are experienced from December to late February, during which the North-East Trade winds (harmattan) greatly influence the Municipality. The generally high temperatures as well as the low humidity brought about by the dry harmattan winds favour high rates of evaporation and transpiration, leading to water deficiency.

3.1.5. Drainage and Vegetation

The main drainage system in the region is made up of the White Volta and its tributaries. The effect of the drainage system is felt mostly in the northern part of the region covering the areas between Nabogu and Nasia. These areas are prone to periodic flooding during the wet season, thus making them suitable for rice cultivation, and it also makes life difficult for the people, some of whom become environmental refugees as a result of the

flooding. The region finds itself in the interior (Guinea) Savanna woodland which could sustain large scale livestock farming as well as the cultivation of staples crops like rice, groundnuts, yams, cassava, maize, cowpea and sorghum.

The trees found in the area are drought resistant and hardly shed their leaves completely during the long dry season. Most of these are of economic value and serve as important means of livelihood, especially for women. Notable among these are shea trees (the nuts which are used for making shea butter) and *dawadawa* that provides seeds used for condimental purposes. The sparsely populated north has denser vegetation mostly with secondary forest. The populous south, on the other hand, is depleted by human activities such as farming, bush burning and tree felling, among others.

3.1.6. Natural Resources

The region is blessed with vast arable land with potential for both livestock and crop production. The region is however faced with unfavourable natural environmental conditions. There is little tree-cover and it experiences harsh harmattan seasons, which leads to many bush-fires caused by farmers clearing their lands and hunters searching for game. The greatest threat however is the rate at which the tree vegetation is being cut down for fuel wood. Farming along river courses has also caused vast silting of the few drainage systems, which therefore dry up quickly in the dry season and flood easily in the wet season. Another issue of concern is recent gravel winning on good farmlands alongside the major trunk road and sand winning, of which a greater percentage is used for construction works without efforts at reclamation. Public places of convenience are

inadequate and scarce in the area, leading to indiscriminate defecation and waste disposal. The problems of poor disposal of solid and liquid waste are causing sewage degradation of the physical environment.

3.1.7 Livestock Rearing

Effective livestock rearing has not really caught up with the population. Despite the presence of the Pong-Tamale Veterinary College in the region, farmers' attitude towards proper animal health care services has been lukewarm. Animal rearing perhaps is considered a hobby rather than a business. This attitude and the lack of needed infrastructure render the sector a poor source of income for the people. However, almost all farmers keep a few animals/birds such as goats, sheep and fowls, with a few of them rearing cattle.

3.1.8. Soil and its Suitability for Agriculture

There are two major soil types in the region. These are the Savannah Ochrosols and Groundwater Laterites. The Savannah Ochrosols which cover almost the entire District, is moderately drained and the upland soils developed mainly on Voltain sandstone. The texture of the surface soil is sandy to sandy loam, with fairly good water retention. The Groundwater Laterite covers a smaller portion of the District and is mainly found in the southern part of the District. These are concretionary soils developed mainly from Voltain shale, mudstone and argillaceous sandstone materials. The texture of the soil is sandy loam which is suitable for the cultivation of annual food crops such as maize, millet, sorghum, watermelon etc., and tree crops with long gestation periods such as shea nut, *dawadawa*, and cashew which are of economic importance.

3.2 The Destination - Accra

3.2.1 Location and Size

Greater Accra has a coast line of approximately 225 kilometres, stretching from Kokrobite in the west to Ada in the east. The soils have low organic contents with shallow top soils which limit the capacity for crop production. Even though some trees are found in the Dangme West, Ga South, Ga East and Ga West districts, the vegetation is mainly coastal savannah shrubs interspersed with thickets. The region falls within the dry, coastal, equatorial climatic zone with temperatures ranging between 20° and 30° Celsius, and annual rainfall ranging between 635 millimetres along the coast and 1,140 millimetres in the northern parts, (Zhao,2003).

Central Accra is compact, centered on the historical British, Danish, and Dutch forts. Over the years, however, with immigration from rural areas, the city has expanded with no regard to zoning, giving it a sprawled attribute. The city of Accra has a total area of 200 square kilometres (77 sq mi), and is the anchor city of the Greater Accra Metropolitan Area (GAMA), which is made up of the Accra Metropolitan District, Tema Metropolitan District, Ga South Municipal District, Ga East Municipal District, Ga West Municipal District, Adenta Municipal District, Ashaiman Municipal District, Ledzokuku-Krowor Municipal District, and the town of Kasoa in the Awutu Senya District of the Central Region, (Degrat Johnson,1977).

The intersection of the Lafa stream and Mallam junction serves as the western border of the city, while the Nautical College forms the eastern border. The Gulf of Guinea forms the southern border. These borders notwithstanding, points of conflict with adjoining districts exist, resulting in a *de facto* shrinking of the city limits in recent years

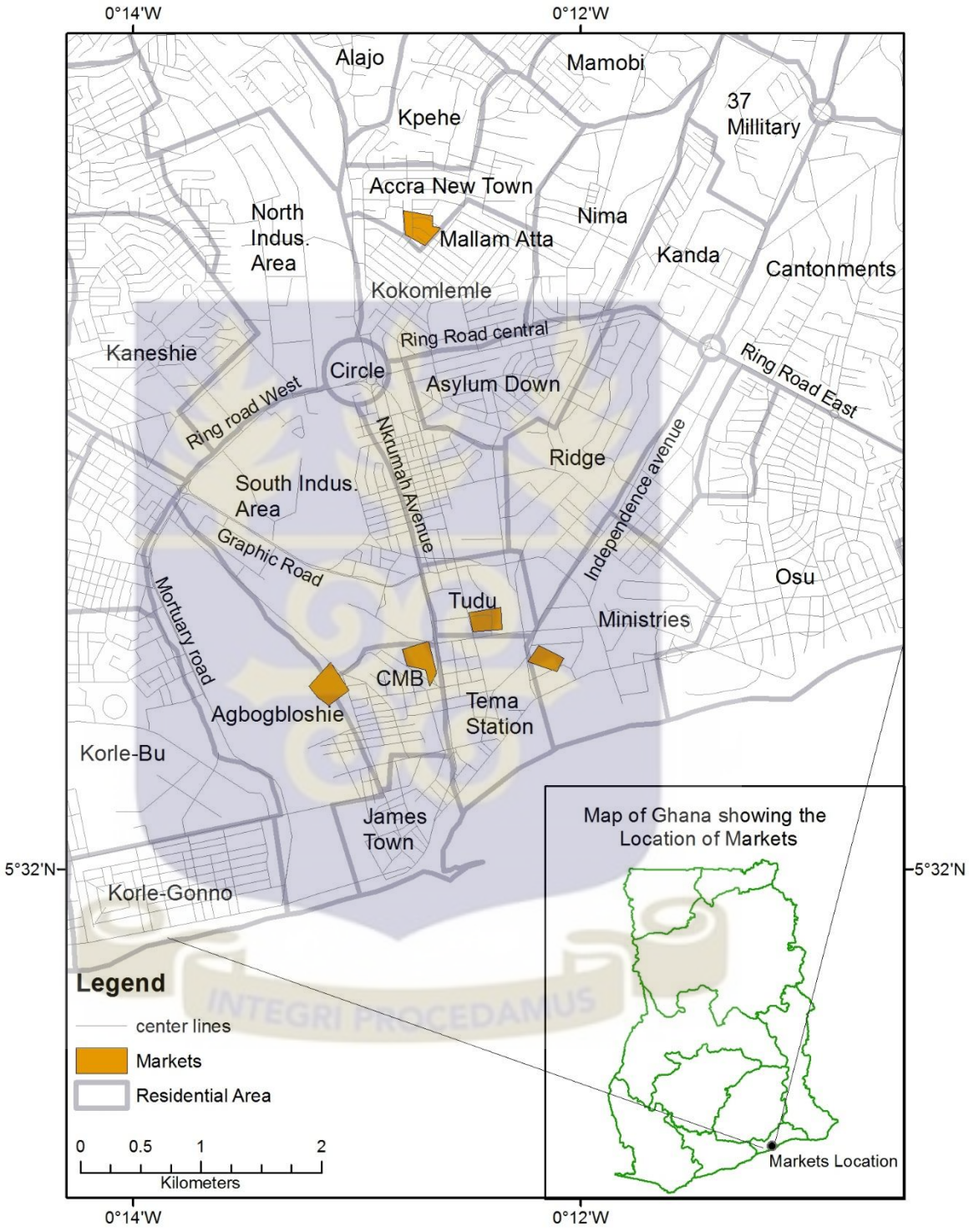


Figure 3.2: The map of Accra showing the Study Areas

3.2.2 Economy

In 2012, the World Bank estimated that Accra's economy constituted around US$3 billion of Ghana's total gross domestic product (GDP). The economically active population of Accra is estimated to be 823,327. Accra is a centre for manufacturing, marketing, finance, insurance, and transportation. The economic features of Accra consist of the primary, secondary (manufacturing, electricity, gas, water, construction) and tertiary sectors (supermarkets, shopping malls, hotels, restaurants, transportation, storage, communication, financial intermediation, real estate service, public administration, education, health and other social services). The tertiary service sector is the city's largest, employing about 531,670 people. The second-largest, the secondary sector, employs 22.34% of the labour force or around 183,934 people. About twelve percent of the city's workforce are reportedly unemployed, totalling around 114,198 people,(World Bank, 2014).

Accra's smallest economic sector, the primary sector, employs approximately 91,556 people. The predominant economic activities are fishery and urban agriculture, with fishery accounting for 77.8% of production labour. Urban agriculture in Accra centres on the growth of vegetables, several crops and poultry. The fishery industry is the most important sub-sector, with 10% of the catch being exported and the rest consumed locally. The industry is characterized by extreme reasonableness, operating primarily between June and September. Although most deep-water Atlantic fishing around Accra takes place in the June–September period, fishery operations take place close to the shore throughout the year, and there are clear indications of the depletion of fish stocks in the

near future. Fishing operations are most prominent at the Jamestown, La, Teshie, Nungua and Chorkor fishing shores, (Abrefa.G, 2002).

3.2.3 The Destination area Agbogloshie

The slum of Agbogloshie was a wetland prior to 1960. But as the city of Accra began to urbanize rapidly, it attracted migrants from many parts of the country. Those from the north of the country, particularly those fleeing persecution from the Kokomba and Nanumba wars, settled in the wetland of Agbogloshie, changing its ecological function to a residential and economic hub, (David .F, (1972).

The economy of Agbogloshie is largely based on distribution of food stuffs which are imported from all parts of the country, particularly the north. Onion, yam, tomato and dry fish are among the major commodities. The migrants living in this area also control large parts of the market and are largely responsible for the importation of the commodities. The Dagomba are the majority in this group of migrants and this also reflects their share of control in the market and in the political sphere of interaction in the area. The transport of goods within the market is mainly done by truck pushers and women. Most of the women that transport the goods are migrants mostly from the north (Whitehead & Hashim, 2005). These women are considered the most exploited of labour in that micro-economic economic zone as they earn little money for the loads they carry. Meanwhile, the work is tedious and comes with several health risks (Awumbila & Schandorf, 2008).

The area has also become an important source of electronic scraps as a major dump site has evolved over the years. Thus some immigrants engage in the activity of extracting metals or parts from electronic equipment, mostly computers, and selling them for re-use or recycling. This activity is, however, a fairly small one at the market. The population of Accra is largely made up of migrants including those from rural parts of Ghana, particularly the north. Rural poverty has over the years contributed immensely to the seasonal migration, circulation, and permanent migration of some rural people to areas in the city of Accra (Yaro, 2004; Awumbila & Schandorf, 2008). These migrants, particularly female porters, largely live in very poor conditions due to low incomes and unavailability of decent housing and associated amenities. Dwellings are mostly wooden shacks that lack water and toilet facilities and are generally poor in sanitation. Rubbish is either dumped within the living area or heaped in dump sites very close to the living areas. These dumpsites expose people to several health risks. Malaria, cholera and typhoid are common in the area and oftentimes out-breaks of cholera originate from the area.

The residential area is also home to many armed robbers and drug dealers who largely pose risks to migrants who spend the night in the open. Besides stealing personal belongings of the migrants, the rubbers and drug peddlers also engage in rape. Several migrant girls have children as a result of rape and have to go through tough times raising these children (Awumbila & Schandorf, 2008). Agboglosie is perhaps the most noted for its harsh living conditions which have earned the area the nickname "Sodom and Gomorrah," after Biblical cities that were condemned.

The dumping and processing of electronic waste in the area also poses a serious health risk. Agbogloshie is polluting the area and creating serious environmental concern. The processing or breaking down of electronic waste emits toxic chemicals into the ground, water and atmosphere—Poisons such as lead, mercury, arsenic, dioxins, furans, and brominated flame retardants permeate the surrounding soil, water and air, posing a serious health risk. Greenpeace reports that the concentrations of toxins in the area are one hundred times above the allowable limits.

3.3 Research Methodology

To achieve the objectives set for this study, this thesis draws on a wide range of methods in the collection and analysis of data. As Bryman (2008) advises a combination of methods to enable triangulation that capture different dimensions, the choice of different methods provides this synergy in data capture. The research therefore employed the mixed method (both qualitative and quantitative) approach with multiple locations and respondents. This is methodologically superior in meeting the complexity of explanations needed for human behaviour, perceptions and outcomes (Kitchen, Tate, 2000).

A mix of quantitative and qualitative methods is useful because they complement each other and thus provide an enhanced understanding of the issues under investigation. In social science research, this is deemed necessary due to the increasing recognition that research concerns in the discipline straddle the dualistic modes of analysis across economic, cultural and physical concerns (Demerrit, 2009). In addition to the survey method, the study employed the following qualitative methods: expert interviews, focus

group discussions, personal observation, key informant interviews, and individual interviews. Social researchers argue that a hybrid research approach in which a variety of perspectives play a function in dealing with the problem under investigation is most appropriate for research bordering on social issues (Batterbury, 2008; Simon, 2004).

3.3.1 The Survey

The survey method was deemed relevant for this study because it was the most convenient and effective way of reaching the target population scattered in four selected geographically dispersed locations (Couper, 2000). This allowed for the collection of data using both pre-coded response categories. The survey involved administering a questionnaire with a set of questions and standard responses (appendix 1). In conducting the survey, two hundred and sixteen (216) questionnaires were administered to two hundred and sixteen (216) migrant female porters in four (4) different locations at the destination in Accra.

The areas selected for the survey at the destination of the female porters in Accra were Agbogloshie, Tema lorry station, Mallam Attah market and the Cocoa Marketing Board market (CMB). These areas were purposively selected because they were noted to be the major areas in Accra where migrant female porters live and work. The themes covered by the questionnaire reflected the objectives of the study. The survey instrument contained questions that focused on the following thematic areas of the study: the socio-demographic characteristics of female porters, the migration processes and dynamics of

the female porters, housing and sleeping arrangements of female porters and migration and health related issues of the female porters at their destination in Accra.

The number of female porters selected in the various communities at their present destination in Accra was based on the total number of female porters given to me by the leadership of the *Kayayei* at their various locations in Accra. From the list given to me, at Tema Lorry Station there were 258 female porters, Mallam Atta market, 263 female porters, Agbogloshie, 162, and CMB Lorry Station, 76 *Kayayei*. It was based on these numbers that Tema Station and Mallam Atta had a high number of respondents for the study than the others as indicated in Table 3. 1.

Table 3.1: Sample Communities in Accra and Number of Respondents

Communities Selected at the Destination (Accra)	Total Number of head porters(Kayayei)	Number of respondents
Tema Lorry Station	258	69
Mallam- Attah Market	263	65
Agbogloshie Market	162	47
Cocoa Marketing Board Station (CMB)	76	35
TOTALS	759	216

Source: Field work, 2014.

Sampling is very important in both quantitative and qualitative research; it is used when it is not possible to include the whole of a population in research projects (Williamson, 2002). A multi stage sampling technique was employed to select respondents for the survey. A simple random sampling technique was adopted in selecting the respondents at their various locations in Accra. This was done by first contacting the leaders of the *Kayayei* in their various locations at their destination. The leadership then provided the list of all female porters under their care. With the list that was obtained, and with the help of the leadership of the Kayayei, the numbers 1 to 6 were written down on pieces of paper from which the *Kayayei* were asked to pick.

Whoever picked the number 2 was part of the sample for that area. The process was repeated several times with different clusters of *Kayaye*i because these clusters also represented different girls from specific origin areas such as districts and even villages. The questionnaire administration was done in either Dagbani or Mampruli, depending on the language the participants preferred. Most participants, especially the female porters, were more comfortable using the local language (Dagbani or Mampruli) than the English language.

3.3.2 Focus Group Discussions (FGDs)

Focus group discussions were employed to capture the wide range of experiences of the *Kayayei* which are useful in complementing the data collected through the survey and the individual in-depth interviews (Johnson & Onwuegbuzie, 2004). Focus group discussions allow the individuals in a group context to express their personal views, knowledge and

experiences in an informal way. In this study nine focus group discussions were conducted – two each in all the selected areas for the study, namely Tema Lorry Station, Mallam Atta Market, Agbogloshie, and Cocoa Marketing Board (CMB) Lorry Station, and one at the origin of the female porters in the north.

The reason for conducting one FGD at the origin of the female porters was to interact with return migrant female porters to ascertain their views, perspectives and experiences in the big cities. I selected those who had returned just a month before the interview to ensure that they remembered events and experiences more accurately. The focus groups were constituted taking into consideration age, level of education, sleeping environment, district of origin, and willingness to participate in the study. The issues discussed were the health seeking behaviour, the living and working environment of the migrant female porters and the migration processes and dynamics of the female porters.

3.3.3 Observation

Personal observation was employed to provide perspectives on issues normally not discussed in interviews because they are taken for granted. Observation was used in this study to capture speculations, feelings, ideas, problems, impressions and prejudices (Creswell, 2009). Observation is described as the fundamental base of all research methods in social science. It is essential as it enables the researcher to note the body language of the interviewee to obtain a complete picture of the situation, especially in studies that are mainly on interview as a basic data collection technique (Alder and Alder, 1994). Social scientists observe human activities and behaviour as well as social settings

in which they take place (Angrosino, 2005). Observation was an on-going process that continued throughout the research process. The observation conducted during the fieldwork was of the work and living arrangements of migrant porters both during the day and at night. The nature of their rooms, the nature of the loads they carry, and their social activities were observed. According to Silverman (2005) observation helps to produce a rich account of the phenomenon being studied. The observation method enabled the researcher triangulate information from the other methods and also clarifies misunderstandings.

3.3.4 Key Informant Interviews

A key informant interview is a standard anthropological method that is widely used in health related research and other social development enquiries. It is one of the methods used in rapid assessment for gathering information from the affected people or community (O'Leary, 2008). The term key informant refers to anyone who can provide detailed information and opinion based on his or her knowledge on a particular issue or subject of investigation. A key informant interview seeks qualitative information that can be narrated and cross-examined with quantitative data.

The interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview (Kearn, 2000). Seven key informants were selected to share their opinions about the *Kayayei* and their activities in Accra and how their working and living conditions in the city affect their health. The key informants selected were four women and three men from institutions that work with the Kayayei. They were the care

taker chief of the *Kayayei* in Agbogloshie, an officer of the Ministry of Gender and Social Protection, the women's leader of the *Kayayei* in Accra, an officer of Stephen Appiah Foundation, an officer from the Accra Metropolitan Assembly (AMA), and at the origin of the *Kayayei*, two experienced returned *Kayayei* were also chosen. A Catholic Priest in Tamale was also chosen in this regard.

The Catholic Priest was chosen because the church has established a training programme to rehabilitate the *Kayayei* in Tamale. These people were selected because they work with the *Kayayei* daily and some are experienced *Kayayei* and have in-depth knowledge about the activities of the female porters in the city of Accra. They provided valuable background information about the *Kayayei* and their vulnerability to specific health risks.

3.4 Methods of Data Analysis

The analysis started with the organisation of data from audio-recorded interviews, fieldwork notes from observations, interviews, focus group discussions and documents from the Ministry of Gender and Social Protection and that of the National Health Insurance Authority. Two analytical procedures were used since a mixed-method approach has been employed. The quantitative data analysis followed the conventional variable identification, entry and manipulation using the SPSS software, while the qualitative data analysis used manual coding procedures. First, the qualitative data were analysed using thematic and content analysis approaches. Second, the survey data were analysed by means of univariate, bivariate and multivariate analytic techniques.

As recommended by Bryman (2008), procedures for qualitative data analysis should ensure data coding. Data coding involves a systematic examination of the text in order to identify certain ideas, phrases, sentences and quotations that represent certain phenomena and show what the data represents (Kitchen and Tate, 2002). The quotations and sentences identified were then highlighted and a descriptive label was assigned for each phenomenon expressed. The interpretation of results was done by relating these categories to research questions and theoretical ideas underpinning the research.

The quantitative data analysis involved the use of descriptive tables to show patterns, while cross-tabulations enabled relations between various variables. Various theoretical propositions have been subjected to the test by assessing the socio-demographic background of the respondents in relation to the main variables that measure migration dynamics, health, livelihoods and outcomes. Both individual and community-wide variables were used to assess the influence on patterns and relationships.

A chi-square statistical test was employed to examine the statistical association between the dependent variable and the independent variables. Finally, a multivariate analysis of the independent variables on the one hand, and the dependent variable on the other, was examined while controlling for a number of factors that act as barriers to health seeking behaviour of female migrant porters. In all, two models were run for the study. The first model established the socio-demographic background characteristics of the female migrant porters that predict their health seeking-behaviour. In the second model, the barriers that affect health seeking behaviour were controlled to test the robustness of the

socio-demographic factors that predicted health seeking behaviour of the sampled population.

3.5 The Positionality of the Researcher

According to Teye (2012), the concept of positionality is based on the assumption that the researcher's characteristics in relation to the research participants can impact the results that are produced. Researchers are part of the world they investigate, and as such bring their personal biases into the analysis and findings. This has been the major criticism of postmodernists against positivist science which argues for objectivity. In conducting this research, the challenges of the sense of attachment to the respondents through ethnicity and background bore heavily on even the identification of the research problem. This introduces the second dimension of the relationship between the researcher and the researched.

The objects of study in the social sciences cannot be compared to the rocks studied by geologists, hence the relationship between the two needs a careful understanding. Since poor migrants facing multiple social, economic and health problems is a question of social justice, the tendency to be sympathetic is very high and can constitute a hurdle to the objectivity demanded by positivist science. Also, as an academic of middle class status interacting with poor street porters, there are bound to be power dynamics at play that may influence responses. In dealing with these issues, an important aspect of the solution is to identify all these positionality dimensions and acknowledge how they can influence the research. Considerable care was taken in defining the researcher's status

and role, and how these affect both the collection of data and analysis and conclusions of the study. Objectivity is not the objective, but conscious efforts to reduce personal distortions of the space of the *Kayayei* and influence responses and outcomes of the research.

Most important are strategies designed to minimise the power imbalance between the researcher and the porters by coming down to their level through conversations, sharing siting and eating spaces, and winning their confidence through telling stories of the researcher's background as a struggling young man. The fact that the researcher chose to study them *(Kayayei*) helped to bridge the gap between the researcher and the respondents. The female porters really appreciated the fact that someone cared about them and wanted to listen to their stories. The research team's relationship with them helped to eliminate any power relationships that existed and created an atmosphere of trust and openness between the two parties.

Sharing personal experiences in a research process is a researcher's way of doing research and Oakley (1981), for instance, states that such sharing is an effective way to overcome hierarchical relations. In this research, the relationship with the respondents through ethnicity did not influence how the former saw the social problem. The study was driven by the researcher's conviction that the migrant porters' life situation should be improved and that science should lead to the emancipation of mankind by rendering useful information and analysis of the human condition to which policies can apply corrective measures. The researcher built a good working relationship and won the trust

of the respondents in the various selected communities for the study. Indeed, this process was also important in understanding the socio-cultural issues and matters that could raise ethical challenges in the research, such as the type of questions to ask and, as a male researcher, how to relate to a group of predominantly female research participants, in view of the cultural norms and values of northern Ghana where the research participants migrated from.

By using mixed methods, the research minimises the effects of poor and distorted responses which mar data quality and analysis. Where particular issues were not well dealt with using a particular method, the use of triangulation resolved the issues. Complementation and corroboration of findings with multiple methods increases the credibility of the findings in the context of problems with positionality.

3.6 Ethical Considerations

In this study it was necessary to collect a lot of information of a highly personal nature. For this reason anonymity was of vital importance to protect the personal identity of the individual respondents. Necessary precautionary measures were taken to protect the confidentiality of the respondents. Participants were duly informed about the purpose of the study. They were also educated on the main components of the research design. Respondents were assured of confidentiality, though they were told, for instance, in the case of the life history interviews, that their voices would be recorded. No participant was coerced by any means to take part. They willingly accepted to actively participate in the

study. Pseudonyms were used in the study report to conceal the identity of all the respondents.

Another area of interest was the relationship between the researcher and the subjects of the research. It has been argued by feminist researchers that conducting research on women's issues, especially their reproductive health and general health issues can pose special ethical problems for those who are part of the feminist tradition (Wolf, 1996). At times both the researcher and the respondents were conscious of the social distance that affected effective communication and rapport. The solution adopted by the researcher to address this challenge was to play down or suppress matters concerning his social position and background. By doing this the researcher started helping the female porters to carry their goods, sharing food and drinks with them and also visiting and attending social activities with them on Sundays.

3.7 Fieldwork Experience and Limitations of the Research

The fieldwork process is an important part of the thesis. The fieldwork for this research was difficult, but very rewarding and informative. During the fieldwork process, the researcher encountered a number of challenges related to the data collection process. One of the major challenges that nearly marred the data collection process was the problem of trust. The respondents at their destination complained of having been deceived by government officials and other non-governmental organisations (NGOs) who came three months earlier to register them for a free health insurance scheme and for free mosquito nets. As a result of this, they viewed the data collection process as another ploy by

political authorities to buy their votes, especially when the data was collected in the heat of serious political campaign in Ghana. That hurdle was overcome very conscientiously when the researcher showed them his student identification card so that they would understand that the researcher was a student.

The issue of funding was another big setback. This challenge was overcome through the assistance of family members and friends. The language barrier was another challenge. It was realised that the majority of the female porters speak Mampruli and Tamplisi, languages of the Mamprisi and the Tampulma respectively. This challenge was overcome by using one of the research assistants who understands the languages very well. Another challenge encountered during the data collection was the high illiteracy rate among the female porters at their destination.

Most of the respondents lack formal basic education. Some could not tell their actual ages when they were asked, and such respondents had to guess their age. To overcome this problem, landmarks and past events were used to help determine the years in which some of them were born. Some indicated that they did not know their ages. The researcher used events such as the elections in Ghana, democratically elected governments such as the People's National Party (PNP), first National Democratic Congress (NDC), and second NDC and the first New Patriotic Party (NPP) and second NPP government. Other helpful events, especially for the younger female porters who were younger than the research team, included the years of ethnic conflict in northern Ghana, an example being the

Konkomba-Nanumba conflict (the guinea fowl conflict) which occurred in 1981 and in 1994, natural events such as disasters, and national events. .

Conducting interviews at the time respondents were working made the research process burdensome to the participants. The research team did not want to interfere with their work because they needed their daily earnings and there was competition on the job. Although they were compensated for their time and energy, interviews were arranged and scheduled in a way that enabled them to perform their jobs and also participate in the study. The focus group discussions (FGDs) and the individual in-depth interviews were scheduled on Sundays when the respondents were not working. Even with these there were problems as some of the Sundays were set aside for social events. The focus group discussion and the in-depth interviews took longer than the survey and also required concentration as well as vivid interaction between the researcher and the participants.

One problem with the group discussions was that some participants tried to dominate the discussions, but the research team encouraged them from time to time to allow other participants to contribute. A few of the women were reluctant to contribute in the group discussion, but they were encouraged by being called upon to contribute.

CHAPTER FOUR: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND MIGRATION PROCESSES OF THE *KAYAYEI*

4.1 Introduction

This chapter discusses the socio-demographic and the migration patterns and processes of the female porters in Accra. The issues examined include the socio demographic characteristics of the *Kayayei* such as age, marital status, educational background and ethnicity. Also in this section, the migration decisions, reasons for their migration, means of financing the trip to their destination in Accra, migration capital, types of *Kayayei* and the route(s) taken to the destinations are discussed.

4.2 Socio-Demographic Characteristics of Female Porters

4.2.1 Age Distribution

Table 4.1 shows the percentage distribution of the age of the Kayayei. The highest percentage of the respondents falls within 15 and 19 years (41.1 %); 12.9 % of the respondents were aged 10 to 14; 25.8 % were aged 20 to 24; while those who were 25 years and above constituted 20.09 %. The *Kayayei* are mostly young girls and women as can be observed from the age distribution on Table 4.1. Some of them have dropped out of school and are preparing for marriage. This finding corroborates that of Bemah (2010) that most of the *Kayayei* are very young and in their reproductive ages.

Table 4.1: Age Distribution of the *Kayayei*

Age Group	Frequency	Percentage
10-14	27	12.9
15-19	86	41.1
20-24	54	25.8
25 +	42	20.09
Total	209	100

Source: Field survey, 2014.

The total number of respondents who actually responded to this question were 209 some of them said they did not know when they were born**.** In all seven of them could not tell their age.

4.2.2 Marital Status

The number of respondents who had never married is higher than those who were married. As shown in Table 4.2, 59.1 percent of the respondents reported that they had never married. Approximately 16 percent of the female porters interviewed were currently married. Almost 20 percent of the *Kayayei* interviewed indicated that they were co-habiting at the time of the interview. Those who reported to have divorced were 5.6 percent of the total number of the respondents. The number of *Kayayei* who were co-habiting at the time of the study supported the findings by Yidana (2012) that some of the *Kayayei* cohabit with their male counterparts because of shelter at their destination.

Table 4.2: Marital Status of the *Kayayei*

Status	Frequency	Percentage (%)
Never married	126	59.1
Married	34	15.9
Co-habiting	42	19.7
Divorced	11	5.6
Total	213	100

Source: Field survey, 2014

Four of the migrant female porters refused to response to the question on marriage that is why the total respondents was 213 instead of 216 the same applied to the question on level of education.

From Table 4.2, it is clear that the *Kayayei* business is dominated by young women and girls who engage in it to prepare themselves for marriage. As some of them reported, they have come to the city to engage to earn income to enable them get money to buy items that will adequately prepare them for marriage. As reported by Adisa, a 17-year-old *Kayayoo* during an individual interview: she spoke in Dagbani.

> *"I am working as a Kayayo to be able to get money to buy my cooking utensils and other important items that a house-wife should have by the standard of a northern woman. In my community before you marry, there are certain basic things that you need to have. And to get them you need money. So when a man pays the bride price (asadaache) it is now left to you the woman to adequately prepare yourself for the marriage. And to do all these you need money, that is why I am here to work so that I will be able to buy the things I need, if not all but the most important ones that will enable me to marry by next year".* Adisah, 17 years, *Kayayo* from Kanshagu in the Savelegu/Nanton district

4.2.3 Educational Status

Education is an important indicator for development. With regards to education, the study revealed that 25.4 percent of the *Kayayei* reported that they had not had any formal education, 54.5 percent had had primary education, and 17.4 percent had completed junior high school, while only 2.8 percent reported having completed senior high school and vocational school.

Table 4.3: Percentage Distribution of Educational Status of Kayayei

Status	Frequency	Percentage (%)
No	54	25.4
Primary	116	54.5
JHS	37	17.4
SHS/Vocational	6	2.8
Total	213	100

Source: Field survey, 2014

The 25.4 percent of the respondents who reported that they had not had any formal education is high considering the report by UNESCO in 2010 that approximately 87 per cent of children in Ghana are currently enrolled in primary schools (UNESCO, 2010). More importantly, the introduction of the capitation grant in basic schools in Ghana has led to an increase in primary school enrolment.

This may be an indication that Ghana is not near meeting the Sustainable Development Goal 2 (SDG 2) (ensuring that children everywhere, boys and girls alike, will be able to complete a full course of primary education), as some of the *Kayayei* interviewed reported that they had had no formal education. The low educational attainment of the female porters can be attributed to poverty and culture. Filmer and Pritchett (1999), in a cross national study of thirty-five countries, observed that low enrolment or high school dropout rates are very common among poor households. Poverty is endemic in the three northern regions of Ghana where most of these *Kayayei* migrated from.

These regions suffer from a disproportionately higher level of poverty compared to the other regions in Ghana (World Bank, 2014). This low enrolment or lack of formal education among female porters mirrors the general low enrolment of girls in the northern part of Ghana. Approximately 40 per cent of girls of basic school age in the Northern Region are not in school (USAID, 2012). It was also reported by Fusieni (2006) that Muslims' attitude towards girl-child education has contributed to the low enrolment of Muslim girls in schools in Ghana, especially those in rural communities in the north.

When some of the female porters were asked about the reasons why they had not had any formal education, they reported that their parents did not have the money to send them to school. They also reported that in the eyes of their parents, investing in a girl's education is a waste of time and resources. This again is consistent with the observation by Filmer and Pritchett (1999) about the relation between poverty and high dropout rates.

Chambers (1989) also makes the assertion that poor households do not value investment in education when they can depend on the labour of their children. Parents in the northern part of the country need to be educated on the need to give the girl child an equal opportunity for education. Some of the respondents indicated that their parents did not find it necessary to send them to school. They noted that their parents consider it a waste of resources and time to send the girl child to school. This is illustrated by Awabu, a 16-year-old Kayayoo and a primary six school dropout, during an individual interview: The interview was done in Mampruli

> *"My father in the village prefers to send my brothers to school than the girls. In the house back in the north, we are six girls and four boys, all the boys are in school but none of the girls are in school. One day I asked my father why we the girls are not in school and he said that we are not members of the household; that very soon they will marry us out of the house and whatever benefits we get will be enjoyed by our husbands and that the boys will always be within the same compound".* Awabu, a 16-year-old *Kayayo* from Linginsi in the East Mamprusi District.

Many reasons have been given for the gender bias in education, but they are largely explained by cultural or social traditions and economic factors that make parents invest in their boys' education and not in the girl child's.

Table 4.4: Percentage Distribution of the Female Porters by Ethnic Background

Ethnic Group	Frequency	Percentage (%)
Dagomba	76	35.6
Mamprusi	89	41.7
Tamplinsi	47	22.0
Others	4	1.8
Totals	213	100

Source: Field survey, 2014

4.3 The Migration Process and Experience

Until recently, analysis of the migration process as a whole has received very little or no attention (Schapendonk, 2011); rather, there have been a focus on different areas, particularly causes and consequences. The actual process involving the reasons, the nature of movement and the arrival and settling of the migrant have been either viewed separately or ignored. This has led to suggestions that to obtain a nuanced understanding of people's migration, it is imperative to consider the entire process as a whole. This section of the thesis examines the following: the reason for migration, persons who assisted the female porters to migrate, migration decision making, financing the trip of the *Kayaye*i to their destination in Accra and the types of *Kayayei* at their destination in Accra.

4.3.1 Reasons for Migration

Table 5 illustrate the reasons for the migration of the female porters to Accra by age. The reasons for migration include water shortage/crisis, forced marriage, lack of jobs, quest for wealth or 'looking for money' and poverty. A little over two-thirds of the female porters (68.4%) reported that the reason why they moved to Accra was to look for money, and more than one out ten (13.9 %) of the respondents reported that they migrated to Accra due to poverty. Nearly five out of ten (4.8%) mentioned water shortage/crisis at their various home towns and villages as reason for their migration. A small percentage (1.0%) attributed their migration to Accra to forced marriage while about 3.3 % mentioned lack of jobs at their origins in the north as the reason for their migration.

Across all the age groups, the most significant reason for migrating was either to look for money or to escape from poverty. In all, 73.3% of the respondents aged 15-19 years migrated to look for money while those aged 10-14 years had the highest percentage (27%) of respondents migrating as a result of poverty. Those who migrated as a result of forced marriage were in the age group 15-19 years and 20-24 years. There was also a significant proportion of respondents in the age group 25 years and above who migrated for other reasons such as running away from conflicts, joining a partner and family pressure at place of origin.

Table 4.5: Percentage Distribution of Most Important Reason for Migrating to Accra by Age of the Migrant (N=209)

Most important reason for migrating	Age group				
	10-14 (N=27)	15-19 (N=86)	20-24 (N=54)	25 and above (N=43)	Total (N=209)
Water shortage/crisis	3.8	4.7	3.7	7.0	4.8
Forced marriage	3.8	1.2	0.0	0.0	1.0
Lack of jobs	0.0	3.5	5.6	2.3	3.3
Quest for wealth	61.5	73.3	72.2	58.1	68.4
Poverty	26.9	8.1	13.0	18.6	13.9
Lack of social amenities	3.8	9.3	5.6	14.0	8.6

Source: Field survey, 2014

Seven of the respondents refused to answer to the question on the most important reason for their migration.

In an interview with Abiba, a 16 year old *Kayayo* on the reason for her migration and how she left her hometown, she reported the following:

> *"That day I did not goodbye anybody, I planned alone, so in the early morning I packed my things up and left. My friends came from Accra the previous year with a lot of things (assets) so I also wanted to go and see what I can get. I started on the road to Accra…I got money from my own work from the village. I harvested groundnuts from people's farms and was given my share which amounted to four bags. So I borrowed money from a woman under the pretext of buying a nice cloth a friend had brought from Accra to sell. Then I told the woman I would pay her by selling my food stuff when the price was good, may be, the next two markets (in two weeks' time). When I run to Accra, the woman went and reported to my mother and she was paid after they sold two bags of the groundnuts…we took a vehicle to the Tamale town from our village where we boarded a bigger bus to Accra".* Abiba, 16 year old Kayayo from Linginsi in the East Mamprusi district.

As depicted in the narration of Abiba, this section discusses the processes and dynamics involved in the trip to Accra by the female porters. It discusses the reasons and decision to migrate, issues of finance and the nature of the trip.

"I migrated to Accra from Zian in the Savelegu-Naton District. The very day I left the house, a friend I had already planned to travel with came to my house with the intention that we were going to the river to fetch water. I took some of my important things along with me. I did not inform my father, it was only my mother that I informed about my trip to Accra which she agreed to, but advised me not to inform my father. It was my mother who assisted me with transportation cost and some monies for my upkeep on the way. When we got to the river, I left my container with my friend and joined my boy lover on a motor bike to Tamale to join a car to Accra. Here in Accra, I am a happy Kayayei.…I wanted to go to Accra to find money to prepare myself for marriage; to buy the customary goods for the occasion and also to have capital to start a small retail business when I marry. When you are able to acquire the basic things for marriage your husband and the people around you give you the needed respect". Salma, 20 year old Kayayo from Zian in the Savelegu-Nanton District of the northern Region.

As illustrated by the cases of Abiba and Salma, some women provide assistance to their daughters to migrate since they share in the aspirations to migrate. Also, the case of Abiba shows that the boyfriends of some girls provide their initial transport and other related cost of travelling. This is understandable because the items bought by these girls form the basis for subsequent marriage. Unless a female partner has accumulated basic 'feminine' assets such as cooking utensils and cloths a marriage cannot be consummated. Since mothers and boyfriends are the main actors who desire a speedy marriage process, it is understandable that they would support and facilitate the migration process. Since most of the girls did not inform their fathers before migrating it is a sign of the objection of men to such migration which is deemed dangerous, disgraceful and unnecessary. It could also be argued that the male dominance in migration over the past is still stuck in the minds of elderly men who oppose female migration.

These findings support those of Abdulai (2000) who argued that mothers are the main propellers of their daughters' migration process while fathers oppose the process. Also, the findings support those of Awumbila (1997) who found that family relations tend to provide the financial and moral support for rural migrants leaving for cities. Table 4.5 further shows that the lack of social amenities, especially water and good roads, which are important in sustainable livelihoods, are critical push factors associated with the migration of girls. This is because women and girls are responsible for fetching water and carting produce from the farm to the home and then to the market. The poor roads and long distances to water sources increases the drudgery women suffer in their daily activities.

This finding resonates well with the findings of Awumbila & Schandorf, (2008) that the reasons for migration from the rural north to the urban south include not only the limited economic opportunities but also the poor social amenities and cultural restrictions which partly account for female poverty. Gendered poverty in the north is an important factor in the migration of females, particularly head porters. Females are generally poorer and less endowed in resources in rural areas of Ghana, particularly in the north (GSS, 2007). Gendered poverty is partially attributed to male supremacy over females. Northern Ghana is a patriarchal society where males hold the main productive resources in trust for the people and determine their use and the income accruing from them (Yaro, 2004). This situation alienates or limits females from full participation in economic and social arenas of life As shown by the case of Salma, an important reason for migrating is to prepare the

young girls for marriage, which also includes boosting one's income to enable one start a business in the marital home.

While socio-economic and cultural factors act as push factors for female migration from the north, relatively favourable factors act as pull factors in various destinations in the south. For example, Awumbilla (1997) argues that the pattern of internal migration in Ghana has also been influenced by the stark differences in the levels of poverty between the north and the south. Employment opportunities resulting from the growing of industries in urban areas like Accra have contributed to the rise in the movement of young people from the north to the south (Yaro, 2004; Van der Geest, 2011).

Table 4.5 also shows that culture, specifically forced marriage, is an important determinant of female migration. Since focus group discussions and individual interviews considered this a very important factor in the migration of females, in spite of the perceived decline in forced marriages in the villages it is still an important issue to be examined. In these discussions an interesting dimension about marriage and migration emerged. Focus group discussions and interviews with female porters at their destination revealed that some females who were unwilling to get married, in spite of attaining the age for doing so, migrated to Accra and eventually worked as porters. The explanation is that some of these females either are not yet ready to marry or have not yet found a suitable male. Thus to avoid embarrassment by their parents and other members of the community, some of these females migrate to the south where they usually stay for a while. One of the females recounted her case during a focus group discussion:

> *"I came earlier with my elder sister to spend six months here in Agbogloshie, Accra. I have spent one year, two months since I returned. This time I came alone. My parents did not encourage me. They rather discouraged me from coming because they said I was due for marriage but I refused and followed my friends all the same because I didn't have the man to marry and everyday my parents were disturbing me about marriage. Sometimes, it makes me feel embarrassed when the smaller girls in the village who have married meet me on the dam road. To avoid this kind of embarrassment and disturbances from the people in my community, I moved to Accra here where nobody cares for the others business. Here in Accra everyone is busy working and has no time to discuss other people's issues".*Safiatu, 16, from Mankarigu in the Tolon District.

Focus group discussions involving female porters also show that some females migrate to Accra with the hope of finding a suitor. "*It is easy to find a husband here"*, says Sakina, a 35 year old female porter. '*You see each other often and there are no older people or parents to make comments about the worthiness of a girl or boy"*. The relative freedom enjoyed at the destination seems to enable young people participate more freely in the 'marriage market', allowing for one to easily find a 'heart's desire' as interpreted by a female porter during a focus group discussion in Accra.

Forced marriages have been seen as an important social determinant of migration, particularly on the African continent (Amin, 1974). But the literature capturing the link between marriage and migration seems to have laid less emphasis on marriage or to have ignored it, so that attention is given to situations where the reason for migration is a female's family choosing a suitor for her, while less attention or none at all is given to cases where migration results from culturally propelled coercion to marry without imposing a suitor, as one acquires the age of marriage. Some of the female porters

reported that they migrated from northern Ghana to Accra due to the ethnic conflict in their area of origin.

> *"I migrated to Accra here because of the conflict in my area. We are not safe and free to move about. Almost every week there is gun shots in my community. To avoid death, the best thing is to migrate to the Accra to have my peace, and also make money to be able to buy my basic needs and also cater for my children at home"* Saratu, 27 year old *Kayayo* from Bimbilla.

As shown by Saratu, some of the young girls migrated to Accra not just because of the poverty situation in northern Ghana but also as a result of frequent occurrence of ethnic conflicts in the area**.** These findings support those of Fuseini (2009) who argued that most people in northern Ghana, especially women, are forced to move out of their place of origin as a result of the perpetual ethnic conflicts there.

4.3.2 The Decision to Migrate

The percentage distribution of the main person involved in the female porter's decision to migrate to Accra is shown in Table 4.6. As can be seen from this table, most of the female porters (68.4%) made their decision to move to Accra. In addition, 21.2% were influenced by their mothers. Siblings (1.9%), aunts (2.4%) and friends/boyfriends (4.7%) also have some kind of influence. The least proportion (1.4%) was mainly influenced by recruiting agents to move to Accra.

Table 4.6: Percentage Distribution of Persons Involved in Decision to Migrate to Accra

Who was involved in decision to migrate	Frequency	Percent
Self only	145	68.4
Mother	45	21.2
Siblings	4	1.9
Aunt	5	2.4
Friends/boy friend	10	4.7
Recruitment agent	3	1.4
Total	212	100.0

Source: Field survey, 2014

The decision-making process, however, is more complex than what the quantitative data depicts. The quantitative data only depicts the main sources of influence in the decision making to migrate and does not tell how the various sources interact to result in the decision. How is the role of other people or intermediaries in the decision to migrate played out? Focus group discussions suggest that aunts and sisters play substantial roles in the decision making process. In the following statement a female porter shares her story on how the decision to migrate was arrived at.

> *"Based on what I saw from those girls in our community who had come to Accra and returned home, I also wanted to come to Accra. So I talked to my mother and my father. My father strongly disagreed and it was a very difficult thing for me. It was my mother who agreed that I should go and even supported me with GH¢ 30 for transport. When I finally got here I had the phone call from my father that if I fail to return to the village within 3 days he will disown me and that I should look for my father. I had to get an elder in our village to talk to my father on my behalf and the first thing I did to make my father happy was to buy him a bicycle within my first month of working as a Kayayoo. In the third month I sent to him an amount of GH¢ 100 to enable him buy fertilizer for his farm. All these I was doing for him to forgive me and also to know that my being here is not to misbehave but*

> *rather to look for money to support the family and to prepare myself for marriage".* Azara, 19, Tibungu in the Kumbungu District.

As shown by the case of Azara, most fathers in rural Ghana are not in support of the migration of their daughters to the city to work as *Kayayei*. This finding resonates well with Abdullai (2010) who argues that the reasons why most fathers oppose the migration of their daughters to the city is that it tarnishes their image and reputation, especially when the girl is given out in marriage. He further argued that some of these girls returned home pregnant.

In an individual interview with Mba Alidu, an elder at Wulgu in the West Mamprusi District in the Northern region of Ghana, he reported the following.

> *"The Kayayei is good, but girls of today can do anything to disgrace the parents. I don't support it because am a victim because my first daughter was given to a man to marry we collected the bride price and she requested to go to Accra to work and get money for the marriage. Hmm! After 4 months I was told that a different man in Accra has put my daughter in the family way. It was a big disappointment and disgrace to the entire family. Since then I do not encourage any girl in my house to go to Accra for Kayayei."* Mba Alidu, an elder at Wulgu in the West Mamprusi District.

While fathers strongly oppose the migration of the girl child, mothers support it and reported otherwise. A mother of a Kayayoo said the following in an interview:

> *"When my daughter asked for permission to go for Kayayei, I said she should go but her father has the final word because in our tradition our husbands are the heads of the family and whatever they say is final. We (father and mother) discussed it and agreed that she should go and advised her to behave well there, get something for herself and send some home"* A 45 year old mother from

Tampin in the Savelegu-Nanton District whose 16-year-old daughter was in Accra working as a Kayayoo.

A 48-year-old mother of four explains her role in her daughter's migration in the following statement:

> *"As a mother, it is my responsibility to provide the basic needs which are food, clothing and shelter. I don't have a job. How then do I cater for her? More importantly, there is nothing in this village that she could lay her hands on to get money. So I decided that she should go to Accra and work so that she can take care of herself and help me cater for the younger ones. But you see, I can't tell the father that I was part of the decision, they don't like that. If the father get to know that I was part of the decision I will leave this house".*

Another parent in Kasulyili in the Tolon District whose 17-year-old daughter had migrated to Accra explained:

> *"If I had the means in providing her all what she need to prepare her to join her husband, or if I could send her to learn a profession or provide her with capital to do business, then she would not go. But because we can't provide her any of these, she has to go". .*

This quotation, similar to that of Salma presented earlier in this chapter, demonstrates the position of focus group discussions that most women provide assistance to their daughters to migrate as they share in their daughters' aspirations to migrate. These findings support that of Abdulai (2000) who argued that mothers are the main propellers of their daughters' migration process while fathers oppose the process. Also, the findings support that of Teye (2011) who found that family relations tend to provide the financial and moral support to rural migrants leaving for cities.

Other factors too emerged from the in-depth interviews with parents at the region of origin, including the influence of peers, with peers acting not only as a major source of information about the destination areas, but also as persuasive agents who ask their colleagues to come along 'to see and enjoy the city life'. According to some of the parents, when young women and girls see their peers returning home from Accra with items like clothing, cooking utensils and cell phones, among others, the girls at the origin also yearn to go in order to acquire some of these items. During a focus group discussion, one parent whose daughter migrated without her knowledge corroborated this when she said:

> *"Their peers go and come back with clothes and home utensils, so if they see these, they also feel the urge to migrate to Accra so that they can also come with those items. And when these nice looking or bleached girls ask them to join them, that is it, they just jump high in sky and go along, they hide away usually in the morning or late in the evening when we thought they have gone to search for water at the river".* Mba Salifu, a 51 year old father from Zangbalin in the Kumbungu District whose daughter was in Accra working as a Kayayo.

This is supported by a number of migrant female porters as illustrated by the following comments:

"I did not know anything about Accra except what I saw those who returned from Accra to my village. They looked good in terms of beauty and had a lot of utensils, cell phones, clothes and their parents were also happy about what they acquired. One of the girls who was my friend told me to also come with her the following week when she was going to return. I didn't have money but she showed me how to steal my mother's money and run away with her. I was not doing anything back home so I decided to come to Accra and also work as a Kayayoo so that my parents will be happy when I return with cooking utensils, cell phone, clothing and also look like a returnee from the capital city" 18 year old female porter from Logri No 1 in the West Mamprusi District.

This issue of stealing money indicates that the young girls are exposed to life and behaviours in urban areas, which can breed deviance in the migrant once she returns to the rural setting. Stealing and other kinds of bad behaviour that are common in the urban areas are not very common in most rural areas in northern Ghana. Focus groups and interviews further indicated that the mere presence of both family and friends in destination areas and the demonstration effect of the material possessions they bring along during visits also act to attract new female migrants who later became head porters. Some head porters explained that they first travelled to visit friends and relations or went on a holiday to see where they lived and eventually ended up as head porters and staying longer. Focus group discussions of female migrant porters revealed that such visits often did not result in one staying and working as a *Kayayei* the first time but rather on subsequent visits after the potential migrant had made a comparative benefit analysis regarding staying at the origin versus the destination.

Some accounts also tell of relations and friends convincing the visitors to stay on as a way to gain from their labour or to help them get better jobs compared to the origin. An in-depth interview with a female porter also showed that owners of productive capital and service outlets such as in the cities also do ask neighbours to allow them to employ their visiting relations. On the basis of longitudinal survey data, Lansing and Mueller (1967) found that family and friends in the potential areas of destination had an enhancing effect on migration decisions. As shown in the foregoing discussions, Lansing and Mueller's observation is still valid today.

4.4 Recruiting Agents

Although the results of the data analysis show that recruiting agents play a smaller role in the decision to migrate, their influence seems to be on the rise. Focus groups and interviews with the female porters in Accra showed that the '*master Kayayei*'-experienced *Kayayei* with various links to jobs and who now act as job brokers – are the most important recruiting agents. These master female porters either return to their home villages and surrounding villages to recruit more workers or they send word to people they know to invite their relations and friends. Recruitment in this manner is said to be carried out when the *master Kayaye*i has job openings or requires 'fresh migrants' to exploit.

> *"The master Kayayei know a lot of people, and they have plenty of work to give out. They make their money from the people they employ or recruit for market women but the experienced ordinary Kayayei often agitate for more money which reduces what the masters' gain. This is why they are always looking for new faces".* Alima, 19 year old Kayayo at the Tema lorry station in Accra.

Besides the master Kayayei, family members and friends also recruit people from the origin to fill gaps they find to be rewarding, as a female porter explained:

"One day, I saw a fat woman in the market and she told me to bring someone I trusted, someone like me, the fat woman owned a big store adjacent my madam's store, I have a contract to carry goods from my madam's house to the store and take it back in the evening and I have never stolen anything. My madam is happy with me and always tell the friend that I am a good girl. For this reason, the fat woman asked me to get her a girl like me. So I quickly called my brother's daughter who had failed her JHS exams and was just sitting in the house doing nothing. She was happy and I sent her money to come the following week to *help the woman in her shop"* Amina, 30 year old Kayayo at Makola market in Accra.

The focus groups suggested that the form of recruitment depicted in the narration of Amina was becoming rather common. This is said to be facilitated by telephone communication as the messages and discussions can be communicated rather quickly than passing it through returnees. Recruitment in the migration industry is increasingly becoming an important factor in the migration of females worldwide. Empirical works on this topic have however been limited in the case of internal migration (Adepoju, 2010). Several emerging studies accounting for the processes or reasons for international migration of females show that recruitment agencies, both formal and informal, are increasingly recruiting females, particularly from Asia, to work in the service industry in Europe.

These agencies sometimes also smuggle or facilitate the movement of these females to Europe (Adepoju, 2010). The rising trend of agencies might pose a danger or help to formalise *Kayayei*, which can lead to contracts and therefore some guarantees for the migrants. On the other hand, if it takes the form as described in the literature for Asian girls, then it could be exploitative with more consequences for the migrants.

4.5 The Journey to Accra

This section explains the strategies that young girls from the north adopted when preparing to migrate to Accra to work as *Kayayei*. The study revealed that some of the young girls leave their houses without saying goodbye to their parents or guardians. The following quotation illustrates some of the strategies they employed when planning to migrate to Accra.

> *"Before coming here I made a stop in Tamale to work in a chop bar for 14 days, which enabled me to get money to transport myself to Accra. I would have wished to continue working in Tamale but the daily wage was very small…my people in the village always knew that I was in Accra but about a week after I arrived in Tamale I called my mother on phone and told her I was in Tamale. Although I didn't tell anybody I was going to Tamale or Accra they guessed that I had run away to Accra to look for money to buy nice things. I had planned to go to Accra but the money I took from my mother was not enough. I didn't even have time to count the money, I just run to the station and waited for a bus, but I realized that If my mum looked for the money and didn't see it she would immediately look for me, so I joined a tricycle and left to Walewale where I then boarded a big car. It was when I was going to pay the collector that I saw that the money couldn't take me to Accra…What did I do?* I could go back home of course, would you have? *So I paid the bus collector to drop at Tamale and looked for work to get money to continue my trip to Accra".* Asana, 21 year old *Kayayo* from Nasia in the West Mamprusi District.

Two key issues are depicted in Salmas's and Asan's narrations: migration capital (financial capital and network capital), and the nature of the journey, i.e., whether it is made at one go or in a stepwise manner. This section is concerned with how potential female migrants finance, begin their journeys and arrive at their intended destinations.

4.6 Financing the Trip to Accra

This section of the thesis looks at how the female porters' journeys to Accra were financed. Here the study tried to analyse the various mechanisms the female porters adopted to obtain money for their journeys to Accra. The percentage distribution of how the female porters' travel to Accra was financed is shown in Table 4.7. The highest percentage of females (46.7%) said that they used their savings to make their journeys. In addition, about one-quarter (24.8%) of them obtained money for their travel through sale of assets. Others paid for their journeys through borrowing from family members (8.4%). Some migrants used other means (12.1%) while 4.2% said their travel did not involve any

cost. Those who took a loan (usually from a friend or relation) constituted the least proportion of the female porters (3.7%). Those who reported that their journey did not involve any cost were those who were assisted by recruiting agents.

Table 4.7: Percentage Distribution of How Journey to Accra was financed

How did you finance your travel to Accra	Frequency	Percent
No cost	9	4.2
Savings	100	46.7
Sale of asset	53	24.8
Loan from friends	8	3.7
Borrowing from family members	18	8.4
Other	26	12.1
Total	214	100.0

Source, Field survey, 2014

Two of the *Kayayei* refused to tell how their trip to their present destination was financed.

Some migrants secure loans for their travel by presenting an asset to the lender as collateral. This, according to several focus group discussions, is a new way of sourcing loans. Amma offers an example of such an instance when she explains as follows;

> *"Before I came here I sold all what I had during the harvesting season and all the savings that I made. My intention for the savings was to get lorry fare to travel to Accra to work as Kayayoo. It was not easy getting money in the village up to GHS 100. All what I got from the sales of my assets and saving was GHS 80. I went to a friend to give my cloths as a collateral for her to get me GHS 20 to add. Hmmm is better to borrow and come because here we are able to make enough monies to buy some of our needs".* Amama, 19 years old Kayayo, Jana in the West Mamprusi District.

The practice of offering collateral is said to have evolved as a result of failure of migrants or returnees to honour their debts. This finding supports the argument by Azongo (2012) that the female porters use their assets at their origins as a collateral to be able to get money to transport themselves to the city to work as head porters. There were various ways of financing the trip of *Kayayei* to Accra. In an interview with one of the respondents at the Tema Lorry Station, she reported the following:

> *"My coming here was supported by an agent. She came to our village and requested the service of young girls she will send to Accra to assist her in her business. My aunty handed me over to her. She paid for my transportation. I cannot even say the amount she paid in transporting me here. Even when we were coming, she bought food for me and when we got to Accra she took a taxi cab that brought as to our present location. For this reason I did not pay anything in coming here".* Amama, 17 year old Kayayo from Tibali in the northern region.

Amama was one of the respondents who reported that they did not spend any money of their own in travelling to Accra. These findings support that of Abdullai (2010) that most of the migrations of migrant female porters' are financed by agents who come to the rural areas, recruit young girls and transport them to the south to work for them for a fee.

While some migrant female porters went directly to Accra from their villages, others had to stop temporarily in towns along the route before eventually arriving in Accra several months or years later, depending on the intervening circumstances. The places at which they stopped over on their way to Accra included Tamale, Kintampo, Techiman, and Kumasi. In terms of the nature of the trip embarked on by the female porters, far less than one tenth (6.6%) of them stopped somewhere before coming to their current place of residence, while the majority (93.4%) did not have any stop before moving to their current place of residence in Accra. Of those who migrated to Accra from another place

rather than directly from their home village, the majority (64.2%) had intentions to eventually migrate to Accra while a smaller proportion (35.7%) continued to Accra after their initial destinations were unfavourable or perceived to be less beneficial. Thus 64.2% embarked on stepwise migration.

According to the focus group discussions and interviews, the main reasons for stepwise migration include the lack of capital to reach Accra as depicted in Asana's situation narrated earlier, and the need to garner information from friends and relations about the location of other friends and relations in Accra. Some of the migrants explained that they had to stop in places 'to look for money' that would enable them pay for their transport to Accra. A 16 year old porter in Agbogloshie market revealed that 'it is important to stay over for a few days so that they can teach you a few things about Accra before you enter that city'.

Asked whether learning some things about Accra was the reason for her stepwise migration, she answered in the affirmative. She further explained:

> "*I was not the only one who stopped over for fear of just coming to Accra without knowing someone; this one sitting here also did the same".*

A 30 year old woman Mariama, a mother of two, was the one referred to by the above respondent. Mariama shares the story of the earlier respondents when she stated*:*

> *"That place (Accra) is not home and most of these people living on the way to Accra have worked in Accra before and have tasted the life in Accra before, so they know what it is. They know people in Accra who could help you, they will also not let you just go like that, some want you to stay and work with them, others want you to return home, but you want to go on the road and also to see things for yourself"*. Mariama, 30 year old *Kayay*o from Mankarigu in the Tolon District.

One could then say that the friends and relations who are located on the way to Accra enable the process of migration by offering migrants a place to stay, jobs, moral support, advice and by acting as 'information brokers'. Thus the need to earn enough money for the journey to Accra and the fear of migrating to Accra without the necessary networks is an important factor for stepwise migration among female porters. Stepwise migration enables female porters access important information and establish networks at the destination, which helps in 'settling down'. As early as 1867, Ravenstein already noted the relevance of stepwise migration. He noted that this was crucial for migrants as it enabled them make enough money and find out enough about the advantages of the next destination. Stepwise migration could result from intervening obstacles or deliberate stop overs (Raveinstein, 1867).

4.7 Social Capital and Social Networks of Female Porters

Social network is a resource that migrant female porters rely on. It entails a network of support and reciprocity that exists between individual porters within communities (Meikle ei al, 2001: Moser, 1998; Derham and Gzirishvili, 1998). Such social support, according to Carney (1998), can be grouped into two, namely personal social resources and public good social capital. The public good social capital allows other resources to be

utilized in a community. These include community based organisations capable of negotiating on behalf of poor people. The personal resources on the other hand include personal loans, child care support, sharing of food and accommodation, as well as information sharing. The social networks of migrant female porters are demonstrated by their ability to migrate from their origins in the north to Accra. The study revealed that the female porters rely heavily on their personalized social networks in Accra.

In a focus group discussion with some female porters in Mallam Atta Market in Accra, the porters mentioned that they always get information about Accra and the *Kayayei* work and other economic activities in the city before making a decision to migrate. Such information was obtained from friends, family members and most young girls and women in their villages that have already been to Accra and survived there as *Kayayei* (Beuachemin, 2000; Tanle, 2003). During the migration process these young girls are usually escorted to Accra by friends, sisters and other girls from their villages that have already been to Accra to work as porters.

In situations where an individual girl had to travel alone to Accra, word is sent out to friends and relatives or community girls or any acquaintances of the girl to meet her at the bus station before the individual girl or woman arrives. In this era of communication technology, the female travelling called at intervals to inform her host about where she has reached. In an interview with Damata, a 17 year old Kayayoo from Wungu in the Northern region, she reported the following:

> *"Before coming to Accra, I had never been here before. So the day I was to leave I called Amina who is working here as a Kayayei on phone for her to assist me to come. She asked me to go to Tamale and ask of Imperial Bus Station. When I got to Tamale I went to the station and had my ticket ready for the journey to unknown Accra. Amina had already told me to arrive at the last stop. So when we got to Accra in the morning by 4 am my friend was there to receive me. She picked me to her sleeping place and there I saw about ten young girls from my village. Amina took me through the work for almost two weeks just to introduce me to the Kayayei work. The first day she gave me a head pan and led me to the market. Hmmm friendship is good."* Damata, a Kayayoo from Wungu in the northern region

Reliance on social network goes beyond information sharing to include care, financial assistance, sharing of food and tools for the work between old and new arrivals in the *Kayayei* business. According to the migrant female porters, when one does not have money to travel to the city one relies on friends in Accra to lend one money which one pays back after one has arrived and worked for some days. The following was an illustration of Zelia, a 20 year old Kayayoo from Bagliga in the Northern region.

> *"Before coming here I called my friend Amina who has been working here for four month to help me with transportation cost and also share information with me about my new destination. She agreed and sent down to me one hundred Ghana cedis (GHS 100) through mobile money transfer. She also told me which car to take and how to get to the station. She directed me to a young man in Tamale called Abukari who is a loading boy at the Tamale station who always assist new Kayayei to get to Accra. When I got to Tamale, Abukari handed me to the driver of the Benz bus and instructed him that my friend Amina would be at the station to receive me. With this assistance it was easy for me to find my way to Accra to join my friend for Kayayei business".* Zalia, a 20 year old *Kayayo* from Bagliga in the Tolon District of the Northern Region.

The statement above was confirmed by a driver in Tamale who indicated the role drivers play in the migration processes of the female porters who often join their vehicles to Accra and Kumasi. He narrated the following:

> "*Most of the young girls who migrate from the north to the south especially Accra do not know their way to their destination. What we do is that those who are there direct them to come to us at the station in Tamale. So when they come, their friends will call us on phone and plead with us to bring them to Accra. Because they are to depend on us till we hand them over to their friends in Accra, their lorry fare is different. We charge them additional ten Ghana cedis (GHS 10) because we have to make series of phone calls before we hand them over to their friends and also the risk involve in carrying them".* Haruna, 38 year old bus driver in Tamale.

The finding here supports the argument by Abizari (2010) that migrant female porters are usually aided by transport owners and drivers to get to Accra, and this is done through the networks of their friends from their home villages who are already working in Accra as porters and other domestic workers.

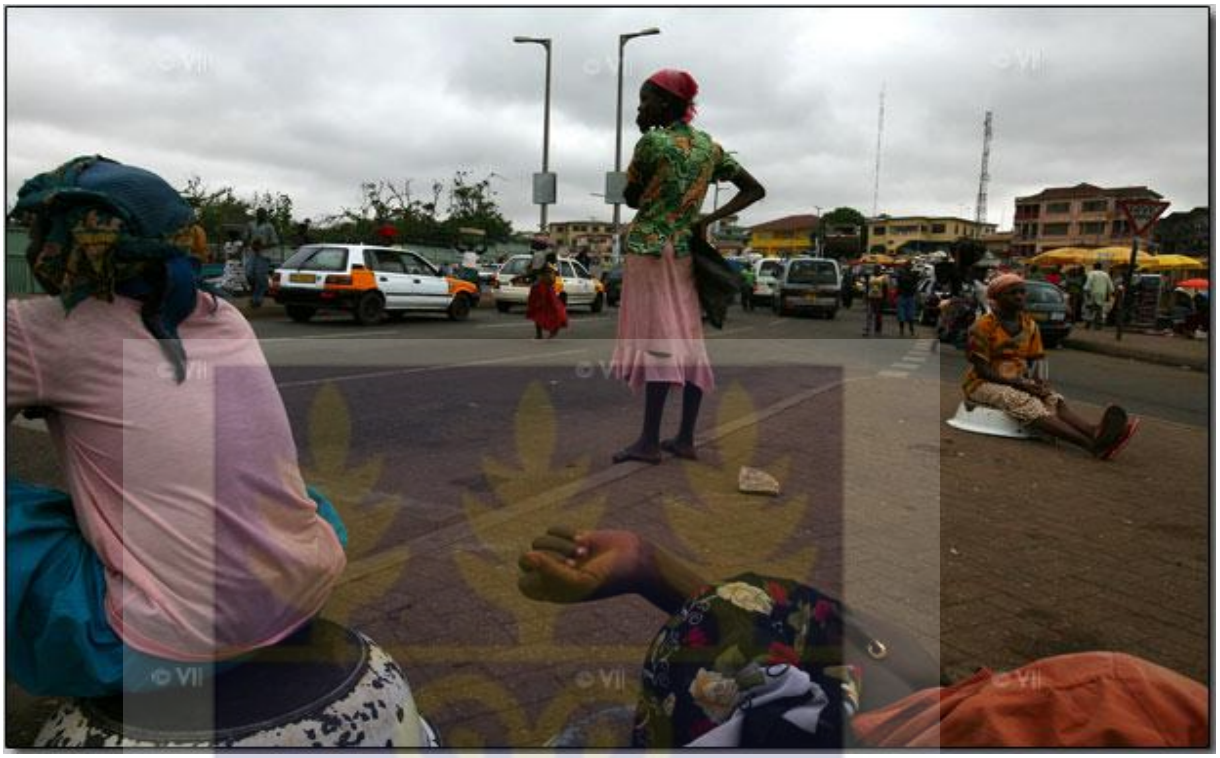
4.8 Categories of Female Porters (Kayayei) in Accra.

The study revealed that there are four (4) different types of female porters operating in the city of Accra. They are identified as Street *Kayayei*, the *Kayayei* who doubled as store assistants, the retired *Kayayei* and the master *Kayayei* (*Mbeli*) who are also called 'senior sisters'.

4.8.1. The Street *Kayayei:*

The street *Kayayei* are the female porters who stand on the main streets or in front of shops daily looking for customers or traders to carry their loads.

Plate 1: Some street *Kayayei* on the streets of Accra.



Source: Taken by researcher, 2014

This category of *Kayayei* face a lot of challenges because they do not have regular customers and quite often they can stand on the street the whole day without getting any load to carry. They are also the most vulnerable among the *Kayayei* in the city. They do not have regular income as do the other categories of porters in the city. Plate 1 is a picture of some of the street female porters who at the time of the study were waiting on the streets hoping to get goods to carry for a fee. Most of them do not have decent accommodation and they usually sleep in front of shops and lorry stations. In an in-depth interview, Abibata, a street *Kayayei* from Diko in the Savelegu –Nanton District, reported the following:

"*This time the Kayayei business is not good. We used to make more monies but now the market is not good. I came out from my sleeping place around 4am and up to now I got only GH¢3. Today is even better. Yesterday I stood here in the hot sun till evening without getting a load to carry".* Abibata, a 14 year Kayayo from Diko in the Savelegu- Nanton District.

Plate 2: A street *Kayayo* on the job

Source: Taken by researcher, 2014).

4.8.2. The *Kayayei* who Doubled as Store Assistants:

These categories of *Kayayei* are better off than the street *Kayayei*. They are employed by shop owners to assist them in their shops, but also when a customer comes to the shop to buy goods they assist in carrying them to the station or the destination of the customer for a fee. These categories of *Kayayei* are fortunate because some of the shop owners offer them sleeping places, provide them food daily and pay them daily or monthly as well. Some of them also serve as house girls or maids for their employers; they are therefore better off than the street porters because they have a regular daily income which they

supplement by carrying goods of customers who buy from the shops that they work in as store or shop assistants.

> *"I have no problem because I work with my madam here in Makola. She takes good care of me. Every day, she gives me (GH¢10) ten Ghana cedis which I use to pay for lata[1] lata (Susu). I contribute eight Ghana cedis (GH¢8) every day for the latalata and use the remaining two Ghana cedis to buy food during the day. In the night my madam gives me food because I stay with her. I help her in the house so on Sundays I wash her clothing and do some cleaning in the house. In the shop too I get small, small monies from the customers who sometimes come to buy goods, I help them to carry the goods to the station and some of them give me money for the service, some also think it's my duty to carry so they don't pay me, but all the same I am better off than my colleagues on the streets"* Fatima, a 20 year old *Kayayo* working at Tudu in the Accra Metropolis.

4.8.3. "Master" *Kayayei*:

The third group of *Kayayei* are called master *Kayayei*. They are the porters who have worked as *Kayayei* for a long period and have a lot of experience in the trade. Some of them have been in the business for more than ten years and they have their own wooden structures which they rent out to other *Kayayei* at the Konkomba market and Agbogloshie. Some of these master *Kayayei*, commonly called *Mbeli*, visit northern Ghana to recruit young girls to work as *Kayayei*. The young girls they bring from the north work for them and they pay their masters (the *Master Kayayei*) five Ghana cedis (GH¢5) daily. The master K*ayayei* do not carry loads any more but rather supervise the young girls that they bring to work and pay them daily. They provide accommodation for the *Kayayei* they supervise. The *Kayayei* who do not work directly for the *master Kayayei* but occupy their structures are made to pay two Ghana cedis (GH¢2) per night for the accommodation. The master *Kayayei* are the type of *Kayaye*i who promote the

[1] Latalata is a form of informal savings whereby the Kayayei pay their daily savings to a collector and collect the money at the end of the month.

migration of young girls from the north to the south to work as *Kayayei*. A *Kayayo* who works for a master Kayayo (*Mbeli)* reported the following in a focus group discussion.

> *"I came from Zagayuri in the Tamale Metropolis; my master (Mbeli) brought me from Zagayuri .Before she brought me here, she told my mother that there is work here in Accra and that if I join her to this place I would be able to make money to solve the problems that we are facing back home. But ever since she brought me here I only work for her because in my good days, I earn (GH¢6) six Ghana cedis and she takes GH¢5 daily. I only have 1 cedi left. This time I am preparing to run away from her and to join my colleagues on the street and work for myself if not working under some body in this trade is not good".* Zuwera, a 16 year old *Kayayo* at Agbogloshie, in the Accra Metropolis.

4.8.4. Retired *Kayayei*

The retired *Kayayei* are few in the system. They are the type of *Kayayei* who have worked as porters for a long time and yet are not able to establish themselves in their communities in the north. They are mostly older women in their fifties. The retired female porters do not carry loads anymore but take care of the children of the younger female porters for a daily fee. For this reason, they are described as care takers. The explanation of their work is given by one of them below:

> *"I came here since the Konkomba war in 1994 since then I have not gone home. That time I could work and make money because I was strong. But now am old and cannot carry the load. What I do now is to take care of the babies and the property of the young Kayayei and each of them pay me GH¢1 daily". Mma* Samata, a 51 year old retired Kayayoo at old Fadama in the Accra Metropolis.

> *"I have a child who is about one year old. I cannot carry her while carrying the load. Every morning I send my child to the old lady to take care of her for me so that I can go and work. The old lady is helping us a lot, without her some of us could not be able to undertake the kaya business. I pay her one cedi every day and in my good days I buy food for her and my child".* Alima, 22 year old *Kayayo* at the Mallam Atta Market in the Accra Metropolis.

The statement by Alima supports that of Bemah (2010) that the migrant female porters who are at the destinations with their babies employ the services of old women to take care of their babies and pay them a daily wage for the services they render.

4.9 A Glance at the Current Situation of Migrant Female Porters in Accra.

Most of the migrant female porters (80.4%) considered their situation to have improved compared to that prior to migration. The common reasons given for this are: the availability of jobs, higher wages and the ability to acquire important capital assets like sewing machines. Freedom to decide who to marry was also mentioned as reason for the improved situation. This particularly concerns those who found themselves in the situation of forced marriage. For those who were not in that situation before, having the freedom to select their 'soul mate' was possible as long as they were away from home.

Yet for some others, getting around the situation of forced marriage was not important as 'it was no longer much of a problem in their communities'; rather, getting married to someone from another ethnic group was. Migrating to Accra made it possible for some of them to marry from another ethnic group as long as they loved each other. Samata, a 23 year old female porter reported that her situation has changed dramatically as compared to when she was in her village in Zapkalsi in the Northern region. Samata throws more light on how poverty forced her to migrate to her present destination in Accra and how her situation has changed.

> *"I migrated her because I could not get money to buy the basic needs like cloths, bathing soap and even food. I thank God that my situation has change dramatically. I can now buy what I want with the little money that I make here and even remit some to my people in the village. Here I have been able to send money to my father for tractor service, send rooting sheets and other things. Hmm! Coming here has helped a lot in improving my situation from a very poor person to someone who can now change cloths when I return to my village".* Samata, an 18 year old *Kayayo* from Zakpalsi in the Savelegu-Nanton District.

The finding here supports the argument by Quartey (2006) that most of the migrants are able to buy their needs and even send remittances in the form of cash and other things like building materials to their people back home in their villages. Have some female porters regretted taking the decision to migrate to Accra? The majority of the female porters did not regret migrating to Accra. Specifically, while about 85% said they had not regretted coming to Accra, about 15% of the female porters said they had. Among the reasons given for the regret are failure to get regular income, sometimes resulting in indebtedness to their colleagues, poor accommodation, poor sanitation and theft of their properties.

In a personal interview with Adama, a migrant female porter from Jimli in the northern region, she observed:

> *"Migrating to this place has helped me a lot because I have been able to pay the loan I was owing. Also, I can boast of paying my child school fees. Even though, I face a lot challenges I cannot say that I regret for coming".* Salima, a 22 year old Kayayo at Tudu in the Accra Metropolis.

Would they have migrated if they had known of the difficulties? The percentage distribution of the female porters in terms of whether they would have migrated if they

had been aware of the difficulties involved showed that close to six out of ten said they would have still migrated if they were aware of the difficulties, while about 41% said they would not have taken that decision. Although some of the migrant female porters knew the challenges at their current destination, they still decided to migrate. Adisa, an 18 year old female porter, reported that she knew about all the difficulties in Accra before coming, but she had no option than to migrate to Accra because of the situation and the difficulties at her village. She illustrated as follows:

> *"I knew all the difficulties in Accra before coming. The fact is that every migrant who want to improve her life would not regret for migrating because you migrate to find solution to a problem. Friends told me all the difficulties here but is normal. One need to suffer to gain. If I say because of the difficulties I would not migrate to my current destination, who would buy me all the materials that I have acquired here"?* Amina, an 18 year old Kayayo at Agbogloshie in the Accra Metropolis.

What are the intentions of female porters on staying or returning home? With regards to intentions to stay permanently in Accra, while slightly more than one out of ten of the female porters (14.2%) have the intention of staying permanently in Accra, more than eight out of ten (85.8%) did not have the intention of staying in Accra permanently. Amina, a 20 year old migrant female porter reported that she was in Accra for a purpose and not to stay permanently. She reported the following:

> *"My intention is not to stay here for more than six months. This is my fifth month and I will be returning to the village by next month. I cannot be here forever because, this is not my home I came for a purpose and even if I don't get all what I intended to buy I will go back home. By next month it would be time for women in my village to be picking shea nuts and this is where we make our monies in the village, we called it our cocoa season so I must go and harvest".* Aminata, a *Kayayo* from Tibungu in the Kumbungu District.

This confirms the point by Yidana (2009) that young girls who migrated to the south to work as *Kayayei* return to their villages in the north during the *shea* nut picking season.

Another *Kayayo* had a different view with regard to staying permanently in Accra as she noted:

> *"Why should I go home for? I don't know when I will be going. My intention was to come and get money that will enable me to prepare myself for marriage. Now I don't have the intention of going home because I got a man who is ready to marry me, so there is no need to go back home unless there is a funeral and even with that my man has to give me the go ahead before I go. I make a lot of money here, I cook rice in the night to sell to my fellow migrants here hence there is no need of going back to the village to stay without a man and money".* Mariama, a 23 year old Kayayo at Tema lorry station in the Accra Metropolis.

4.10 Assets of Female Porters

The livelihood strategies of the migrant female porter (Kayayei) are directly or indirectly linked to several socio-economic and socio- cultural factors in the environment or the context in which they live and work (Kayayei) in Accra, especially their work environment, their sleeping environment and their access to resources, particularly health care. The migrant female porters interviewed for this study engaged in various livelihood activities to support themselves and their families back in the north. The type of activities they undertake at their destination is based on the type of assets available to them and their ability to access them. Assets and the way people access them are important building blocks that combine to shape the livelihood activities that people engage in and the possible outcomes (Ellis, 2000). The assets of the migrant female porters are therefore very essential in discussing their livelihood.

4.10.1. Human Capital of Female Porters

The human capital of female porters includes the skills, ability to carry load and good health. Their human capital is one of the most important resource or asset for livelihood engagement. Porters in the city of Accra rely on the sale of their labour for survival in Accra. Chambers, (1989) reported that the main asset of the poor is their body in the form of labour or 'man power' used to generate income. For the female porters their main activity in the city is the carrying of goods from one location to the other in the Central Business District (CBD) in Accra. Most of the migrant female porters lack education and adequate skills to enable them to participate in the formal sector of the economy (Bueachemin, 1999; Opare, 2003). The major form of human capital the migrant female porters rely on is their physical strength; their ability to use their strength in transporting goods, as it is argued by Chamber (1989) that the body is the man's greatest uninsured asset. Salwa attest to this assertion in the following words:

> "*My strength is the biggest thing God has given me to use to work as a Kayayo. God cannot give you all the things at the same time. I am not educated and for that matter the only way I can work to get money is to make good use of my body and the physical strength God has given me. I have no choice than to carry the load. Is it not better than stealing or prostitution*"? Salwa, 17 year old Kayayo at Mallam Atta market in the Accra metropolis.

As reported by Salwa, a female porter at the Tema station, physical strength is an essential capital requirement for the *Kayayei* business. Because *Kayayei* depend so much on their physical body they take good care of their bodies by eating nutritious food in order to replenish their strength and maintain good health that will enable them continue with their daily activities. Meikle et al (2001) are of the view that sale of labour is essential for poor people in an urban economy and that adequate health care is important

in determining the quality of labour. In the case of the female porters, it is unfortunate because with their income level they cannot afford a balance diet and also eat less than they should.

4.10.2 Social Capital and Social Networks of Female Porters

The social support according to Carney (1998) can be grouped into two, namely personal social resources and public good social capital. The personal resources on the other hand include personal loans, child care support, and sharing of food, accommodation and information. The social networks of migrant female porters are demonstrated in their ability to migrate from their origins in the north to Accra. The study revealed that female porters rely adequately on their personalized social networks in Accra. In a focus group discussion with some female porters in Mallam Atta market in Accra, the porters mentioned that they always get information about Accra and the *Kayayei* work and other economic activities in the city before making a decision to migrate. Such information was obtained from friends, family members and most young girls and women in their villages who have already been to Accra and survived there as *Kayayei*.

During the migration process these young girls are usually escorted to Accra by friends, sisters and other girls from their villages that have already been to Accra to work as porters. In situations where an individual girl had to travel alone to Accra, word is sent out to friends and relatives or community girls or any acquaintances of the girl to meet her at the bus station on her arrival. In this era of communication technology, the females travelling always call to inform the persons to receive them about where they have gotten

to. Getting settled, particularly in terms of accommodation and getting a job, can be a difficult endeavour for those with inferior connection and less capital while it could be easier for those with better social connections and economic capital. Although the survey in this research did not ask female migrants how they got their first job, qualitative data reveals that social networks are crucial in that regard.

Some female porters who already knew some people at the destination found it relatively easier to get settled, find a place to stay and get a job. Those of them who had multiple connections are able to either diversify income earning opportunities by getting different opportunities to transport goods or change jobs when there is the need. Others were also able to use their own money brought along from the origin to rent spaces to sleep and to feed themselves till they got jobs. The normal work of a *Kayayei* is to stay in the market and look out for prospective customers who need to transport the goods they have bought to their cars, bus stations or to other parts in the market, and sometimes to their homes. According to focus group discussions, the *Kayayei* have over time considered contract work as an important source of income.

Thus diversification of income sources in the *Kayayei* business mainly involves having one or more contracts to transport specific goods daily to and from the market at a fixed rate. Reliance on social network goes beyond information sharing to include care, financial assistance, sharing of food and tools for the work between old and new arrivals in the *Kayayei* business. According to the migrant female porters, when one does not have money for food and other basic needs one relies on friends to lend one money which one pays back when one has settled down and saved some money.

> "*When I first got here in Accra, I did not have money for food and even to pay for bathing and visiting toilet. Here whatever you take including drinking water you pay for it. It was my friends who always buy food, drinking water, and paid for my toilet visit. It was so embarrassing, but thanks to friendship, I was at home because my friends were there to share whatever they have with me".* Pagnaa, 20 year old *Kayayo* from Zakpalsi in the Savelegu –Naton District.

At the work place and in their living environment, migrant female porters' support systems and networking are manifested through their communal engagement and provision of security. It was observed on various occasions that female porters congregate at vantage locations to solicit for customers, to rest and also to provide security for each other. Such gathering provides them the opportunity to work in groups. Goods that are too heavy for one person to carry are usually shared among the individual porters in groups to transport. In the living environment of migrant female porters, their social network systems are seen in various ways. A typical situation observed during the field work was where the elder female porters were acting as heads of family or parents of the younger ones. The heads did not only provide physical protection but also financial security for the younger ones.

The older ones also served as advisors to the younger ones and protected their property such as clothing, cooking utensils and other belongings. In return the younger ones were also observed to be running errands for the elder ones they commonly called '*Mbeli* 'This goes to confirm the role social networks play in the migration process.

4.10.3 Physical Capital

Physical capital is a form of asset available to the migrant female porters. Physical assets consist of capital created by economic production processes such as roads, buildings of all kinds, tools and machines to work with (Ellis, 2000). The respondents do not use sophisticated tools or machines, but rudimentary ones in the execution of their work. The tool the female porters use in carting goods is the head pan. They complained that the male porters carry heavier loads than they do because their male counterparts use a simple technology to help them carry the load. The men porters use four wheel truck usually operated by two people, with one person in front pulling the truck and the other one at the back pushing it. The gender nature of the profession with men making more money with the truck technology makes it difficult for the women to compete with their male counterparts

A female porter at Tudu, reported the following:

> *"The men get more money than we the women. They use a truck but we use just the head pan and at times when the load is too much we just tie it in a sack and carry it. We exert more energy in carrying the good and this affect our health. I wish we the women could also identify a technology that will aid in carting the good. We met one NGO called SNV and they promised assisting as with a machine that we can use in carting the goods, we are still waiting for them".* Napari, 19 year *Kayayoo* from Kasulyili in the Kumbungu District.

4.11 Chapter Conclusions

The chapter presented the demographic characteristics and examined the migration process and dynamics of the migrant female porters. The chapter also examines the various categories of Kayayei at their destination in Accra and analyses how the various

categories influence their health-seeking behaviours. Reasons for the migration of female porters include water shortage/crisis, forced marriage, lack of jobs, and quest for wealth and the quest to know the capital city. The need or want to secure alternative or extra income appeared to be the most important reason. Migration is seen by the female porters as a means to gain autonomy in their lives, a means of livelihood diversification or a source of alternative livelihood. Migration has always been an alternative source of livelihood for rural people in times of crisis (Ellis, 2000). In Ghana Structural Adjustment Programmes (SAPs) of the 1980s contributed immensely in creating poor livelihood conditions that propelled out-migration in northern Ghana.

The migration process of female porters is enabled by their mothers and their social network including boy lovers, friends and family at the origin, along the way and in the destination. While en route to Accra, social networks provide safe nets for female porters and the urban poor residents by increasing their social asset base (Meikle at al., 2001). For the migrant female porters, social capital enables access to information about Accra, housing needs at the destination, job information and other vital information that may help the potential migrant to migrate. At their destination, the migrant female porters develop a communal living strategy.

Such communal activities, though informal and based on familial, ethnic and village or home town affiliations, go a long way in providing support for the porters. Living communally and engaging in communal activities are the main processes by which traditional societies and women's productive activities have been recognized in African

societies (McCusker, 2006 and Steady, 1987). Findings from the study support the African feminist argument that communalism is an instrument that women have used to gain autonomy and leverage in African societies.

The gender dimension of the profession make the male to get more money than the females in the *Kayayei* trade making the men to have an upper hand over the women, thereby taking advantage of wooing the young girls.

Culture and structural conditions in the origin of the migrant female porters shape their strategies. The porters migrated from traditional societies characterised by patriarchal tendencies and power relations that put men in a relatively better position than their female counterparts. Right from the time of migration, men make decisions for their families, including influencing where they stay. It is evident that the local culture in the north dictates and structures the strategies available to women. Some cultural and social factors are specific to this group of people. Cultural practices related to marriage and motherhood, land an inheritance rights, and societal gender ideologies, affect the economic opportunities of women in northern Ghana and contribute to rural-urban migration. The findings provide empirical evidence for a stress on the importance of culture and the local context in which women operate, and the need to address factors that disempower women in their local context (Steady, 2003).

CHAPTER FIVE: THE LIVING AND WORKING ENVIRONMENTS OF THE FEMALE PORTERS AND THE RELATIONSHIP WITH THEIR HEALTH

5.0 Introduction

This chapter examines the living and the working environment of the female porters at their destination in Accra and how these conditions affect their health. It examines and analyses their accommodation types, sleeping arrangements, water and sanitation situation as well as access to toilet facilities. The chapter also examines the nature of their work and its relationship with their health.

5.1 Housing Condition of Porters

The health of an urban individual and the household is significantly affected by their access to basic social necessities, which include adequate shelter. Health is regarded as an important asset on which other livelihood activities depend (Wood & Salaway, 2000; Payne, 2002). For the migrant female porters *(Kayayei*) in Accra, economic factors outweigh the need for decent accommodation and these are the reasons why they reside as squatters on restricted space. *Kayayei*, like any other poor person in urban areas, live on the margins due to numerous factors. These include: their social classification, the nature of their migration, their employment situation and housing conditions in the urban environment (Abizaari, 2010). They also need to fulfil other financial and social obligations back at their source.

Though *Kayayei* perform a vital role in facilitating trading activities in the cities of Ghana, their living and working conditions make them vulnerable and pose a serious threat to their health (United Nations, 2009). The living environment of the migrant

female potters is not in line with all the indicators stated by the United Nations, as accommodation was reported to be among the most important issues of concern to the female porters. The greatest obstacle that migrant female porters face in the city is decent accommodation. The living arrangements of *Kayayei* put them into several distinct groups. Some of them live in groups where they share kiosks and contribute two Ghana cedis (GH¢2) daily towards their rent. Others live as squatters in uncompleted buildings in and around the city of Accra. The most vulnerable among them are those who sleep in front of shops and on pavements during the night. Others live with relatives and care takers, but those in this group, according to the survey, were very few.

5.2 Residential Arrangements in Accra

With regards to where the female porters currently live, Table 5.1 shows that many of them (72.6%) live with friends. The other people the female porters live with are: parents (1.4%), recruitment agents (5.8%), partners (5.3%) and others (6.7%). Further, 8.2% of the female porters currently live alone.

Table 5.1: Percentage Distribution of who Respondents Live With in Accra

Who did you live with in Accra	Frequency	Percent
Alone	17	8.2
Parents	3	1.4
Recruitment agent	12	5.8
Partner	11	5.3
Friends	151	72.6
Other	14	6.7
Total	208	100.0

Source: field survey, 2014

The sleeping places of female head porters have implications for their health. The poor living conditions of most of the female head porters expose them to the poor weather conditions and physical attacks, which have implications for their health. The poor financial standing of most of the head porters makes it impossible for them to rent decent accommodation in the city. As a result, most of them sleep on pavements on the streets. Others sleep in kiosks made of low quality wood and placed on gutters or rubbish dumps. It is rare to find migrant porters living in designated accommodation sites and in decent rooms.

Those who live in kiosks complained that the kiosks are too small for the number of people who usually share them and they have multiple uses too. They put their items in

the kiosks for safe keeping and for protection especially during the rainy season. This makes the kiosks crowded and congested. This crowdedness in the kiosks, coupled with their multiple uses, usually has serious health implications for them. Some of the respondents reported that due to the overcrowded nature of their rooms they only registered as members of those rooms to enable them store their belongings for safekeeping, but sleep on the street or in front of shops in the market. The picture below depicts a number of *Kayayei* sleeping in front of shops.

Plate 3: *Kayayei* Sleeping in front of a Shop at Tudu, Accra

Source: Field work 2014.

Salima, a 20 year old Kayayoo reported that:

> *"I live in a room with 19 other Kayayei but all of us migrated from Tampin, in the Northern region. In the night we only use the room when we take our bath to dress up and then join our colleagues to sleep outside. It is only those with babies who sleep in the room because of their babies. All of us cannot sleep in the room because it is too small to accommodate us. The people here use it to make money, each occupant pay GHS 2 per night. But when looking for the rooms they will not tell you the number of people staying in it, you only get in to find out about 19 or more people already in the room. All the same is good because I have a place to keep my things*". 20 year Kayayoo from Tampin in the Savelegu –Nanton District.

Nafisa, a young *Kayayo*, also explained the difficulties she goes through in one of the kiosks with her colleague *Kayayei:*

> *"The kiosk that I live in is overcrowded. We are about 12 to 14 people sleeping in that small kiosk with our belongings. Each one of us bought items such as various cooking utensils, cloths, mats, bags and other important things we need to send home that will prepare us towards marriage. This makes us prone to all kind of diseases and sickness. Look at my body! My skin is full of rashes. The kiosk is not for us and the owner because he wants money continue to bring in more people and when we complain to him, he threaten us with eviction. What can we do? Since we need a place to lay down our heads and for the safe keeping of our belongings. We cannot complain than to just have to continue perching till our time is up for us to return to the North".* Nafisa, 17 year old Kayayo at the Tema lorry Station in Accra.

Besides the overcrowded nature of kiosks, they are generally unsafe, as rapists find it more convenient to attack the *Kayayei* inside than on the open pavements. The open pavements provide security, not only from passer-by and security men, but also from the collective strength of the many porters who sleep together in long rows. By acting together, porters are able to scare or attack and beat up attempted rapists. Samata, a 21 year old migrant female porter in Accra explains this situation in the following words:

> *"I enjoy sleeping in the open with my friends because rapists and thieves who sometimes come to steal our money and attempt to rape us find it difficult to come closer because of our numbers. On several occasions men attempted to rape us and*

with our large number we were able to control them and chased them away. The only problem here is during the rainy season.
When asked what they do when it is rains? She had this to say:

Hmm my brother! When it is raining we use large pieces of rubber to cover ourselves but in most cases, we run for shelter in nearby shops or any building around and stand by the building till the rain stops, such nights are difficult times for us because on such nights we will stand throughout the night without sleeping and when the day breaks, we cannot get a place to sleep so we go to work like that and be dozing whiles working". Samata, a 21 years old Kayayo in Mallam Atta market in Accra.

In spite of the difficulties faced and the health risks associated with sleeping in the open, most *Kayayei* still maintain that they preferred doing so to spending all their earnings on accommodation in the city or sleeping in kiosks that provide less security. A cross tabulation of sleeping place and diseases suffered shows some reported common diseases suffered by those who sleep outside. Table 5.2 presents the relationship between the sleeping place of the head porters and the diseases they suffer from. In terms of diseases often suffered by the migrant female head potters, more than half (62.4%) of them mentioned malaria while 15% mentioned headache. There were other diseases that were mentioned by the head porters, such as pain in the body, especially in the neck and waist, stomach pains, the cold and the flu.

Table 5.2: Percentage Distribution of Sleeping Place of Head Porters by Reported Diseases they suffered from

Diseases Porters often suffered from	Sleeping Places of Kayayei				
	Rented kiosks	In front of shops and Kiosk	Rented space	Other	Total
	(N=66)	(N=38)	(N=65)	(N=24)	(N=193)
Malaria	68.2	76.3	58.5	50.0	64.2
Cold/flu	4.5	0.0	7.7	4.2	4.7
Stomach pains	4.5	5.3	3.1	8.3	4.7
Body pains	1.5	2.6	13.8	16.7	7.8
Headache	16.7	10.5	15.4	16.7	15.0
Other	4.5	5.3	1.5	4.2	3.6

Source: Field Survey, 2014.

The female porters who sleep in rented rooms and in front of shops reported more malaria cases than those who sleep in rented space and other places. However, more of the migrant female head porters who sleep in rented space and other places complained of bodily pain. This could be a result of the sleeping materials that are used in such places.

The finding here supports the argument of Bemah (2010) that migrant female porters in Kumasi usually live in a very poor environment, which has a great impact on their health.

Some of the *Kayayei* explained that they migrated to avoid poverty, but they were rather confronted with various kinds of illnesses.

5.3 Water and Sanitation Facilities at Place of Residence of Female Porters

The percentage distribution of water and sanitation facilities at place of residence of migrant female porters is shown in Table 5.3. The majority of the respondents had their facilities outside of their residences. Specifically, 89.8% of the female head porters had their water outside their residences and about one 9.0% had their water within their residences. With regards to toilet facilities, more than nine out of ten (90.7%) had these outside of their residences and about 8.0% had theirs within their residences. Further, while about 85% of the female porters had their waste collection outside their residences, slightly more than one-tenth (12.5%) had their waste collection within their residence.

Table 5.3: Percentage Distribution of Water and Sanitation Facilities at Place of Residence of Female Porters

Environmental factors	Percent
Water	**(N=213)**
Within residence	8.8
Outside residence	89.8
Total	98.6
	(N=213)
Toilet	
Within residence	7.9
Outside residence	90.7
Total	98.6
Waste collection	**(N=211)**
Within residence	12.5
Outside residence	85.2

Source: Field survey, 2014

With regards to water and sanitation, not all the respondents responded to the questions, some of them refused to answer question on where they source such facilities, this counted for the percentages to be less than 100.

Water has a profound influence on human health. At the household level, a minimum amount of water is required for consumption on a daily basis for survival, and therefore access to water is essential for both the poor and the rich. However, water has much broader influences on health and well-being, and issues such as quantity and quality of

water supplied are essential in determining the health of individuals and the whole community (Erik, 2008).

The priority of the state must be to make water accessible to all irrespective of race, gender, economic and social status (WHO, 2009). However, access to water may be restricted by low coverage, insufficient quantity, poor quality and excessive cost relative to the ability and willingness to pay. Water quality, while important, is not the sole determinant of health impacts. The quality of water does, however, have a great influence on public health and the microbiological quality of water is important in preventing ill-health. Poor microbiological quality is likely to lead to outbreak of infectious water-related diseases and may lead to serious epidemics (Makens, 2010)

During the focus group discussions with the female porters, it was clear that water was not much of a problem to them. They reported that they bath twice in a day, unlike in some parts of the origin where they bath only once daily due to water shortage. They remarked that their problem is not the physical access, but financial wherewithal. The respondents made it very clear that potable drinking water is not much a problem because they get good water anytime they needed it. Some even mentioned the availability of water at their destination as a pull factor that attracted them to move to the city and to work as *Kayayei*, as illustrated by the case of Azaratu, a 21 year old Kayayoo who migrated from Tolon in the Northern region below:

"*Water is not a problem here, we bath with pipe born water at our destination here. Unlike our origin we only see clean water only when you go to the regional capital in Tamale. Here we drink "pure water" sachet water and some of us bath with the pure water. Back at our village in the north we travel more than 6 km to access water that is not even clean. As a result of this my friend Baraka and I always come to Accra during the dry season to escape from travelling long distance in search for water in our village. The only challenge here is that if you don't have money then forget getting water. We pay GH¢1 for using the bath room, so if you are to bath twice you pay GH¢ 2. Everything here is about money"*. Azaratu, 21 year old *Kayayo* from Tolon in the Tolon District.

The statement by Azaratu goes to support the work of Van der Geest (2004) that environmental factors also serve as a push factor for north-south migration. The same findings here also support the argument by Godana (2012) that migrant female porters in the cities of Ghana are able to meet their water needs after migrating from the hinterlands in the north to the cities in the south.

Plate 4: Commercial Public Bathing place of Female Porters in Agbogloshie.

Taken by researcher, 2014.

Plate 4 shows a public bathroom in the neighbourhood of the female porters in Agbogloshie. The *Kayayei* reported that they normally use the facility in the night after they have returned from work. They complained that the amount of money they pay (GH¢1) before using the facility is too high. Some of them reported that on bad days when they are not able to make much money, it becomes difficult for them to use the facility, which results in some of them bathing outside by the gutters.

5.4 Sanitation Conditions

In the survey, as reported in Table 5.3, the respondents access toilet facilities in two main ways: from within their homes or, for the majority, outside their homes. The interactions with the respondents further revealed that those who access the facility outside their homes do so in various forms. They indicated that some of them patronise public toilet facilities while others resort to a free range system in times of difficulties. Those who use the public toilets complained that the facilities are not clean, and this, they think, might have an effect on their health. As indicated by Apanga (2012), sharing toilet facilities can result in feaco-oral infectious diseases such as typhoid fever, cholera, and diarrhoea.

Katumi, a female porter in Agbogloshie who migrated from Kasulyili in the northern region, talked about how she felt when she first visited the public toilet at her current destination in Agbogloshie in the following words.

> *"The first time I visited the facility, I could not use it. The place was very bad, feaces on the floor and used paper everywhere. That day I could not eat because I have never in my life seen such a thing before. I was vomiting and my friends picked me to a chemist who prescribed some medicine for me. Since then I resort to defecating in a polythene bags and throwing it in the gutter. I do this every night after work"*. Katumi, 17 year old Kayayo at Agbogloshie in Accra.

Plate 5: Public Toilet Facility Used by Female Porters at Agbogloshie

Source: Taken by researcher, 2014

The toilet facilities of the respondents were examined and it was realized that respondents did not have much challenge in this regard. They only complained that the amount they pay was high and then also they spend a lot of time in queues to access the facilities. The major obstacle they mentioned also was that the facilities were not neat, and this, they think, can have an effect on their health. This was illustrated by Amina, an 18 year old Kayayo when she spoke about the challenges she faces when it comes to access to the public toilet at their destination in Accra.

"I do not have problem when it comes to the use of the toilet facility. My only challenge is the money I pay to access the facility and the time I always spend in queuing before accessing the facility. In this our Kayayoo business, we wake up very early in the morning so that we can meet the customers who have arrive from their various destinations in the morning. But you wake up at 4 am spend more than 30 minutes queuing to access toilet facility after which you go to queue again to bath before going to work. At times we are forced to embark on free range where we look around if no one is coming, and you defecate in the open gutter and off you go. My major challenge in the open defecation is that, if you are not fortunate and caught by the AMA people, you will use all your earnings to pay for fines." Anima, 18 year old *Kayayo* at Agbogloshie.

It came out in the discussion with the female porters that, for fear of not meeting their customers early in the morning, the majority of them decided not to visit the toilet facility in the morning and only do so at night after the close of work. This, to some of them, makes them uncomfortable and often gives them stomach upsets, especially when they are carrying the loads.

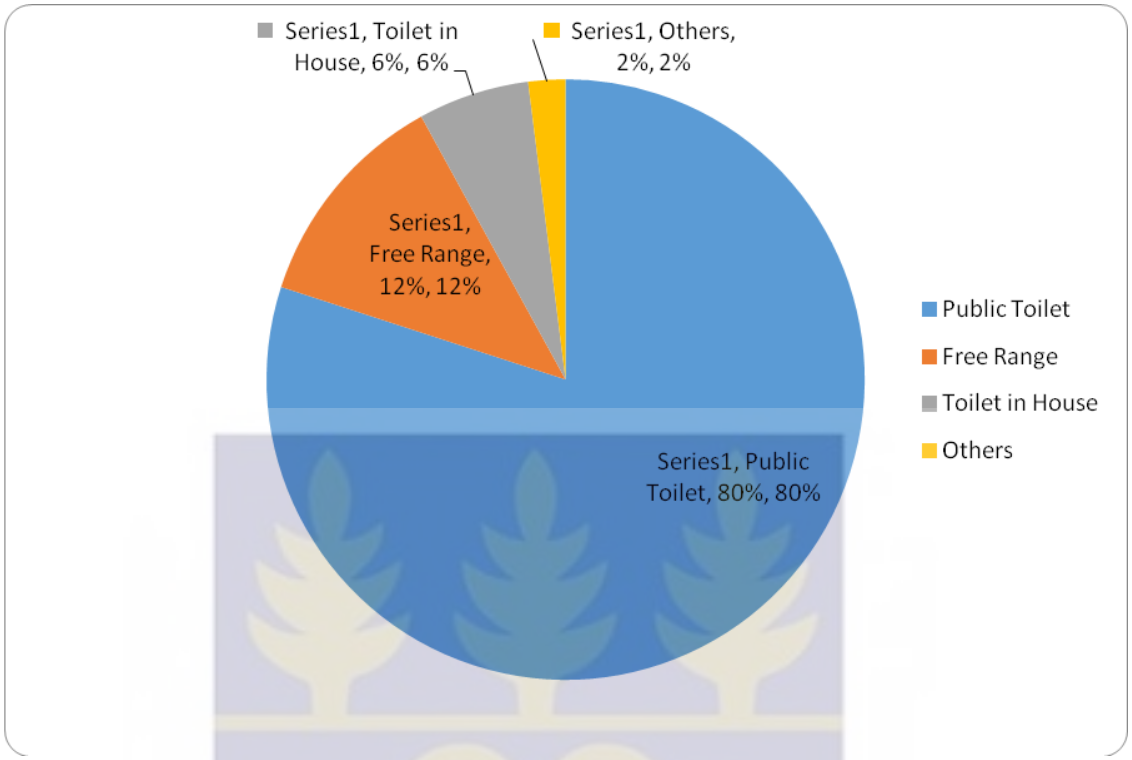


Figure 5.1: Toilet facilities of respondents (Source: Field survey, 2014)

From figure 5.1, it was clear that the majority (80%) of the female porters use public toilet facilities, others resort to open defecation and a few of them use toilet facilities in their homes. The finding here supports the argument by Yidana (2013) that the migrant female porters are usually poor and live in shanty areas or slums, and due to their income levels they patronise cheap facilities in the cities.

5.5 Risk Factors Associated With the Health of Female Porters at their Destination

Table 5.4 shows the problems faced by female porters with regards to health. The results show that more than half (50.7%) had severe or extremely severe health problems, which correlates with over 86% living and working in very poor sanitation conditions. Sanitation and health are strongly correlated. Sanitation constitutes an important risk factor which defines the health status of the female migrant. In terms of harassment by Accra Metropolitan Assembly officials, about 40% of the female porters experienced horrible harassment by the AMA officials. Further, Table 5.4 shows that about two-thirds of the female porters experienced either severe or extremely severe harassment by rapists (64.3%). More than half of the female porters had experienced extremely severe crime, about 27% had experienced severe crime while almost 20% had not experienced severe crime.

Table 5.4: Percentage Distribution of Problems Faced by Female Porters at Their Destination in Accra.

Problems	Frequency	Percent
i. Health	(N=203)	
Not severe	100	49.3
Severe	76	37.4
Extremely severe	27	13.3
ii. Sanitation	(N=202)	
Not severe	27	13.4
Severe	47	23.3
Extremely severe	128	63.4
iii. Harassment by city officials	(N=201)	
Not severe	119	59.2
Severe	39	19.4
Extremely severe	43	21.4
ii. Harassment by rapist	(N=207)	
Not severe	74	35.7
Severe	61	29.5
Extremely severe	72	34.8
v. Crime	(N=216)	
Not severe	43	19.9
Severe	58	26.9
Extremely severe	115	53.2

Source: Field Survey, 2014

5.6 Exploitation and Harassment of Female Porters

Generally, there are varying degrees of vulnerability among the migrant female porters. However, common trends such as exploitation and harassment, poor housing, poor

sanitation and other contingencies as well as competition in the market affect female porters at their destination in Accra. The city environment poses a lot of difficulties to the porters (Kayayei*)* as they are identified as a social group belonging to the larger category of urban poor. The various forms of exploitation that make the *Kayayei v*ulnerable in the city and measures adopted to overcome them are presented in this section of the thesis.

Employment continues to be the major form of vulnerability among the *Kayayei* because of their lack of knowledge and skills, and they continue to shift in the skill requirements for urban employment (Woods & Salaway, 2000). The structural adjustment programme and industrial restructuring continue to affect people without education and workable skills needed for urban employment. The female porters, like any other urban poor people, operate in the informal sector that is not governed by any laws and associations to regulate and assist them in times of difficulties. For this reason, they operate in a precarious labour market without any security, and clients who use the services of the female porters exploit them in various ways. Clients also harass the porters, especially when accidents occur and goods or items they are carrying get damaged. Chambers' (1989) argument that a decline in patron-client obligations serves as a form of vulnerability for poor people is illustrated by female porters and their clients in Accra.

Clients usually pay the porters less than the agreed fee principally due to the large numbers of female porters in the market. Normally, clients insist that porters transport their goods to their destination before a fee is determined, and since porters do not want to lose their clients, which would result in loss of income, they agree to this arrangement. Once the good or items have been transported, the client has the upper hand in the

negotiating process and often offers a very low fee for the service provided. The *Kayayei* are forced to accept the low fees or risk losing out since there is nothing they could really do if the client refused to pay.

Adama, a 17 year old *Kayayei* in Accra, illustrated her experience about such exploitation in the following comments:

> *"Our clients are the people who exploit us most because they pay as less or they don't pay at all for the services we render to them. I carried one lady good from Mallam Atta market to Neoplan station at Circle. The woman told me that since I do not know her destination, we should get there before we can negotiate on the fee. I agreed but it took us almost an hour before we got to her destination. I asked her to give me ten Ghana cedis (GHC 10) considering the nature of the goods and the distance involved. She said she will offer me two cedis. I said no to her offer but she told me that was what she could offer, I left her without collecting the money and curse her that God should punish her for me. That is what we are going through in this work".* Adama, 17 year old Kayayo working in Accra.

The lack of a mechanism for price negotiation or an institutionalized system for porters to operate in is a problem. Opare (2003) also observed an incident in his study of porters in southern Ghana where a woman exploited a 19 year old porter and paid her less than the agreed fee. Porters operate in an informal sector with no regulatory mechanism, as argued by the Modernization School of Thought (ILO, 2002).

5.6.1 Dangers Posed by Thieves and Rapists

Social vices in Accra, especially the activities of armed robbers and thieves, affect the effective operation of the *Kayayei,* and this makes the young migrant female porters the most vulnerable, especially those who lodge on pavements at the Tema lorry station and

Mallam-Attah market. Although nearly two thirds of *Kayayei* reported having experienced severe or extremely severe harassment by rapists (64.3%), only 1% said they had been raped before.

Fatima, a 19 year *Kayayoo* narrated how she was raped by an unknown man at her destination in Accra in the following words:

> **"***I was raped by an unknown man who asked me to give all the monies that I have with me but I told him that I have no money with me. Before I realised another man came from behind and carried me up. He run into a nearby shop and forcefully had sex with me. I cried but nobody came to my aid. But strangely in Accra here no one cares about the other. When something is happening to you and you are even crying, nobody will come to your aid, unlike the North where everybody is the others keeper. In the North when you hear a cry for help, people will run to find out what is happening to the person crying. In this case I was however, fortunate they did not take my money because that night I was keeping 48 Ghana cedis with me. Because these people after raping, will want to take the little monies that I have with me in addition. This has happened to some of my friends and now some of them are pregnant and others have even delivered the babies, but some cannot trace the fathers of their babies. Just last week one of us went back home to Logri her village with a baby and upon arrival her parents asked her to come back to Accra and bring the father of the child. It is seriously forbidden for a child to be born in Northern Ghana without a father. She has come back to Accra here but now she cannot locate the father of the baby. These are some of the things we are going through as we try to make our daily bread in the city"***. Fatima a 19 year old Kayayo from Logri in the West Mamprusi District.

This finding here supports that of Yidana (2012) that some of the *Kayayei* in Accra have babies and that they cannot return to their villages because their bride prices were paid and they cannot go home with pregnancies or babies. The *Kayayei* also noted that some young men in the city sometimes visit their sleeping place to tell them to pay for the floor they are sleeping on, with the reason that they are custodians of the land. They reported that such men always tell them to pay for the sleeping place either with cash or with sex.

The *Kayayei* have always relied on their ethnic space and communal living to defend themselves against such men who try to rape and exploit them. They however find it difficult to sleep at night because of this situation, and their inability to have adequate sleep affects their work and health.

5.7 Knowledge of sexually transmitted diseases and contraceptive use

Knowledge of the ways in which STIs are contracted is shown in Table 5.5. From the Table, more than four out of ten (42.6%) of the female porters knew that having sex with multiple partners or with infected persons without a condom or any form of protection (43.3%) can lead to infection. More than one out of ten (11.4%) and about 3% knew that STIs could be transmitted by tooth brush and unhygienic genitals respectively.

Table 5.5: Percentage Distribution of How Sexually Transmitted Infections are Contracted (Multiple Response Analysis).

	Responses	
Knowledge of how STIs are contracted	N	Percent
Having sex with multiple partners	175	42.6
Having sex with infected person without a condom	178	43.3
Sharing of tooth brush	47	11.4
Unhygienic genitals	11	2.7
Total	411	100.0

Source: field survey, 2014

A *Kayayei* at the Agbogloshie market reported that they know how STIs are contracted but in their present circumstances they are sometimes faced with some difficulties that make them forget about STIs. She reported the following:

> *"We know all these but at time we are forced to have sex without even thinking of the deadly disease. This is so because of the circumstances in which we find ourselves. At times you asked your partner to use condom but if he refuses what can you do than to comply. This issue of unprotected sex usually happen during the raining season. We exchange sex for shelter with our male counterparts who are fortunate to rent the wooden structures at old Fadama''.* Safura, 19 year old Kayayo, at Tudu in the Accra Metropolis.

This finding also supported the argument by Yidana (2012) that some female porters exchange sex for shelter at their destination in Accra and Kumasi.

Table 5.6 shows the time that the female porters heard about HIV/AIDS. Specifically, the majority of the female porters (83.7%) heard of HIV/AIDS before moving to Accra. About 13% heard of HIV/AIDS after migrating while the least proportion (3.2%) could not remember when they heard of HIV/AIDS.

Table 5.6: Percentage Distribution of Place Heard of HIV/AIDS

When heard about HIV/AID	Frequency	Percent
Before migrating	159	83.7
After migrating	25	13.2
Don't know	6	3.2
Total	190	100.0

Source: field survey, 2014

With regards to the sources of knowledge about HIV/AIDS, Table 5.7 shows that respondents heard of HIV/AIDS from the radio, television, community meetings, friends, the work place, and other sources. The Table specifically shows that the highest proportion of the female porters (52.5%) heard of HIV/AIDS from the radio. About 7% heard about HIV/AIDS from the television, community meetings (22.9%) and friends (10.1%), while equal proportion heard from the work places and other sources (3.9% respectively).

Table 5.7: Percentage Distribution of Sources of Information about HIV/AIDS (Multiple Response).

From which source did you hear about HIV/AIDS	Frequency	Percent
Radio	94	36.4.
Television	56	21.7
Community meetings	41	15.8
Friends/Family	38	14.7
Work place	19	7.3
Other	18	6.8
Total	258	100.0

Source: Field survey, 2014.

Half of the female porters had knowledge of the use of contraceptives and the other half did not. Table 5.8 shows the use of contraceptive among the female porters. The Table shows that more than eight out of ten of the female porters (85.4%) were currently using contraceptives and about 15% had ever used contraceptives.

Table 5.8: Percentage Distribution of Use of Contraception among Female Porters

Use of contraceptive	Frequency	Percent
Currently use contraceptives	76	85.4
Ever used contraceptives	13	14.6
No Response	89	100.0
Total		

Source: field survey, 2014

Table 5.9 illustrates that about 127 of the female porters refused to response to the question on the use of contraceptives. This is an indication that discussing sexual relation is with young girls from the northern part of the country is still a big challenge since majority of them are not ready to discuss it.

From Table 5.9, nearly all of the female porters (97.3%) used contraceptives at their current destination while about 3% used contraceptive in their place of origin.

Table 5.9: Percentage Distribution of Where Female Porters Used Contraceptive

Where did you use contraceptive	Frequency	Percent
Origin	2	97.3
Current destination	71	2.7
Total	73	100.0

Source: field survey, 2014

There is the belief that the migrant female porters use contraceptives mostly at their current destination in Accra. There is also the general fear by some of the *Kayayei* that if any of them were found using contraceptives in her place of origin she will be branded a prostitute, and such a negative impression would make it difficult for her to get a responsible husband in the village or the surrounding communities. The report of 21 year old Zainabu below illustrates how difficult it is to use contraceptives at their origin in the north:

> *"In our village, it is only bad girls who keep condoms and if a girl is found keeping condoms they will use your name to sing in a simpa dance (simpa is a local dance by young Dagomba girls and boys in northern region of Ghana) and you will even find it difficult to come out. Also girls in the rural settings find it very difficult to go to the seller and request for a condom or seek advice on any of the family planning methods. Some of us were given the education in our communities in the north by the community health nurses but it was always difficult for us to contribute to the discussion on family planning and the use of condom and other methods of contraceptives use because if you open your month to contribute in the group they will see you as a bad girl and it may be difficult for you to get a husband in the village to marry because of the bad tag on you. Family planning and sexual intercourse related topics are seen as a taboo in the rural communities in the north and we don't often discuss them. But here in the city we are free to discuss it. This is actually affecting us because we refused using the condom and we are always found in the web of teenage pregnancy".* Zainabu, 19, a kayayo in Malam Attah in the Accra Metropolis.

As reported by Chimbiri (2003), perceptions about condom usage and talking publicly about sex in most African rural communities are grounded in the taboos that surround such topics in traditional African communities. Therefore, discussion of condoms and AIDS is limited (Brown, 1994). Reticence regarding sexual issues is instilled from a young age and adolescents are prohibited from attending talks and plays about reproductive health (Ashwood-Smith, 2000). This has therefore affected most young girls in most rural communities in Ghana, especially those from the hinterland in the northern

part of the country, where discussions on sex related topics are seen as a taboo. Yet the young girls indulge in sex to satisfy their desires and are easily impregnated by the men because they lack knowledge about protective and safe sex. This situation makes the *Kayayei* vulnerable to teenage pregnancy and other related sexually transmitted diseases.

Table 5.10 shows the type of contraceptives used by the female porters. The Table specifically shows that the highest proportion of the female porters (61.4%) used the pill, about 19% used condoms, 2.9% used periodic abstinence and about 17% used injection.

Table 5.10: Percentage Distribution of Type of Contraceptive Used

What type of contraceptive do you use	Frequency	Percent
Pill	43	61.4
Condom	13	18.6
Periodic abstinence	2	2.9
Injection	12	17.1
Total	70	100.0

Source: field survey, 2014.

With regards to the types of contraceptives used by the *Kayayei*, Amina, a 25 year old Kayayoo from Gundaa in the northern region, illustrated the following.

> *"The pills are good for us. Almost all of us have it and we even called it "ashile" (secret). When I need, what I need to do is to see one of my friends and tell her that I want "ashile" all of us know it by that name"* Amina, 25 year old Kayayo from Gunda in the Kumbungu District.

Although some female porters would wish to use the other types of contraceptives, they reported that some of them are expensive and also expose them to outsiders. They used the injection as an example. As illustrated by Salmu, a 22 year old Kayayoo in Tema station, Accra:

"The injection is good, but it is expensive and also sex is something we hide to do but with the injection, the person going to inject you will know why you are doing it. Also some of our colleagues are saying that constant taking of the injection will make one barren. And I want to give birth in future that is why I don't patronize the injection". Salmu, 22 year old Kayayo at the Tema lorry station in the Accra Metropolis.

From this illustration by Salma, it was clear that they use contraceptives mainly to prevent pregnancy and not to protect themselves against any sexually transmitted diseases (STDs). In terms of the percentage of female porters who have ever been pregnant, about 44% have been pregnant before and more than half (56.2%) have never been pregnant before.

Table 5.11 shows where the female porters got pregnant. The Table shows that about seven out of ten of the respondents (70.3%) got pregnant in their place of origin while almost 30% got pregnant in their place of destination.

Table 5.11: Percentage Distribution of where Female Porters Got Pregnant

Where did you get pregnant	Frequency	Percent
Place of origin	52	70.3
Place of destination	22	29.7
Total	74	100.0

Source: field survey, 2014

5.8 The Abuse of Drugs among the *Kayayei*

The abuse of drugs among the *Kayayei* was found to be high. During all the focus group discussions with the *Kayayei* it was reported that most of them resort to drugs that will give them the needed energy to be able to carry their load without feeling pains. They use some stimulants to enhance their energy and endurance. They mentioned the following drugs that they often take during the day to aid their work: *Daridari, blue blue, china bone (China kobli) and volume*. Sala, a *Kayayo*, reported the following:

> "*The nature of the work is such that we cannot use our natural strength to carry the load. At times we need support from the stimulants. Every day I take two different types of drugs before I can work effectively. In the morning after eating I take daridari, when I get to the market and get heavy load I take China kobli (China born) in addition. With that I can work till night without feeling any pain or tiredness. But this has both positives and negatives effects. When you take the drugs you need to eat heavy if not you will collapse especially, the China bone. I normally take it after making my first trip so that I can get money to buy TZ or banku that will complement the drug to give me the required energy"*. Sala, 17 year old Kayayo at Tudu in the Accra Metropolis.

These drugs are however said to make people weaker as they grow older. A study by Van der Geest (2005) in the Upper West Region of Ghana indicates that the use of stimulants could have devastating consequences for the health of the people. He found that in some cases the drugs were said to have caused madness among the Dagaaba migrants in the

Brong Ahafo Region of Ghana. The *Kayayei* therefore have health risks that are associated with their use of drugs to aid them carry heavy loads.

5.9 The "Accra white lady" syndrome and its impact on sexual and reproductive health

The results of the survey show that the use of beauty creams and lotions is a common phenomenon among the female porters in Accra, especially among the unmarried young ones. The aim is to become fairer and more attractive to the opposite sex both at the destination and at home on their return. This practice is, however, said to be uncommon with married women in the *Kayayo* trade. The bleaching creams and lotions make their skin fair that young men in the villages at the origin of the porters described them as the "Accra white ladies". The *Kayayei* reported that three months before returning to their home towns and villages in the north, they spend part of their earnings buying beauty creams and lotions that change their skin from dark to fair. For this reason the people in the villages in the north call them the Accra white ladies.

Some respondents at the origin of the *Kayayei* in the north reported that young men have preference for fair women. A male interviewee said that 'it seems that a fair woman is like the proverbial beautiful woman who is said to be like an olive tree standing by the road side; every man sees her on his way up and down the road'. During a focus group discussion an old woman stated "....*my son, parents get more money from the 'asalache'* [dowry] *of a fair coloured woman.*" Not only do the parents get a bigger dowry from their daughter's husbands, but also they derive some pride and a good reputation in and

around the neighbouring villages by their daughter getting married to a responsible man and giving them a good dowry, as other informants brought to light.

This, therefore, suggests that bleaching among the *Kayayei* is done not only to make themselves more attractive to men but also to attract more wealthy men as husbands and enjoy all the advantages of such a marriage. The first negative health effect of bleaching is probably the itching of the skin when the exercise is discontinued due to the inability to afford the cosmetics needed. According to some respondents at the origin, the young girls who do not get the lotion to continue the bleaching look darker than before or have patches of black and white skin, and when the sun is very hot they experience skin rashes.

On arrival back home, the fairer girls are met by richer boys and men who pick them home with motorcycles rather than bicycles (group discussion in Savelugu). This has an implication for both sexual reproductive health and physical health. On reproductive health, because of their colour they are attracted to many young men and this can lead to multiple sex partners. And if care is not taken it can lead to sexually transmitted diseases including HIV\AIDS. This situation is common among the young girls who at their destination in Accra may engage in the sex trade as a secondary source of livelihood in addition to the *Kayayei* business.

Concerning their physical health, bleaching the skin can lead to the removal of the upper skin, which would pose a problem in cases where a surgical operation is needed because it would be difficult to find a vein. Also, it makes their faces a patchwork of different

colours. Another health effect of bleaching is probably the itching of the skin when they fail to continue the use of the "efficacy" due to their inability to afford it.

"*The skin bleaching or whitening is good for us. Because of the nature of our work, we don't have time for ourselves. We only get time when we are about going home so during that time we bath well use the best pomade that will make our skin more attractive. We are doing all these because we want to get home looking beautiful so that young men would compete for us. Everyone in our village is aware that when a lady goes to Accra and does not get anything at all but for beauty and good hair style is assured".* Rakia, 18 year old Kayayo at Mallam Atta market in the Accra Metropolis.

5.10 Chapter Conclusion

The chapter examined the living and the working environment of migrant female porters at their destination in Accra and how these conditions affect their health. One of the main forms of vulnerability to the migrant female porters is the nature of their living environment, which has posed serious health challenges to the migrant female porters at their destination in Accra. Their living environment has exposed them to mosquito bites and thereby led to the majority of them suffering from malaria and other environmentally related diseases. The participation of female porters in the informal economy, a sector that lacks proper and effective regulatory processes, is a main source of health vulnerability (ILO, 2002; Chen, 2004). There is lack of security, no legal protection and no union for the *Kayayei* at their destination in Accra. The precarious nature of their activity and the continuous influx into the *Kayayei* activity of more girls and young women lead to high levels of exploitation and low earnings.

Poverty and low incomes of the Kayayei limit their spending capability and consequently, migrant female porters resort to poor accommodation and indecent facilities or simply sleep in the open, thus exposing themselves to several health risks.

CHAPTER SIX: HEALTH-SEEKING BEHAVIOUR AMONG FEMALE PORTERS

6.0 Introduction

This chapter examines the health-seeking behaviour of the migrant female porters. Specifically, the chapter focuses on a descriptive analysis of environmental factors, other control variables and the variable on health-seeking behaviour. Also, the chapter examines the relationship between the socio-demographic characteristics, environmental factors and other control variables and the health seeking behaviour. A chi-square test on these relationships was performed. Finally, two logistic regression models were run to examine the predictors of health seeking behaviour among the female migrant porters.

6.1 Knowledge of Existing Health Facilities

Awareness of the health services in one's locality is a requirement for their consequent usage. In this study, therefore, an attempt was made to find out whether the *Kayayei* were aware of any health care facilities at their destination. Approximately two thirds of (65.5 %) of the respondents indicated that they knew at least one hospital or a clinic and some pharmacies where they could access health care services. More than a third (35.5%) of the respondents reported that they were not aware of any health facility at their destination. Sanatu, a 19 year old migrant female porter from Gymsi in the northern region, reported the following:

> *"I don't know the location of any health facility in Accra here. The only health care provider I know here are those who sell drugs to us in the market. I always pray not to have serious sickness here in Accra because I don't know the location of any health facility here"*. Sanatu, 19 year old Kayayo from Gymsi in the West Mamprusi District.

The respondents who were pregnant at the time of the study were further asked whether they knew about the free maternal services introduced by the government of Ghana in 2008. The majority of the respondents reported being aware of the free maternal and child health services in various health facilities in the country. Few of them indicated that they were not aware of any free maternal and child health services in the health facilities. Amina, a pregnant migrant female porter, reported the following:

> *"Free maternal services? Hmmm! Am not aware of that. In Accra here nothing is free. Even if it is free and they get to know that you are a Kayayei they will make you pay for the service. Especially if you cannot speak the common local language here which is Twi. Last week I went for antenatal service and also paid GHC 20 and paid GHC 10 for the card. People are taking advantage of our vulnerable situation to exploit money from us".* Amina, 20 year old Kayayo at Tudu in the Accra Metropolis. Other respondents, like Amina, noted also that the inability of some of the migrant female porters to speak the local language at their destination constrains their access to health care.

Respondents were also asked how they obtained the information on free maternal health services. They reported that they got the information from the nurses at the hospitals and the clinics they visited for antenatal care. A few of the respondents indicated that they got the information about the existence of these services from local FM stations back at their origins in the northern region. This is an indication that the nurses at the hospitals and the clinics where these migrant female porters visited for their antenatal services are providing education and counselling, which is very important to the first time mother. This is also useful to the campaign on safe motherhood. It also revealed that the local radio stations are doing a lot of health education and sensitization in the respective

locations. As reported by Samira, an 18 year migrant porter from Lingisi in the northern region:

> *"I got to know about the free maternal services at my village. Every Saturday, Radio Savanna has a program at 8: 30 pm on health issues and they educate people in the catchment area on a lot of health issues including maternal and child health issues. Is very educative and it has helped us a lot. Through that I got to know what to do when I am sick or when am pregnant".* Samira, 18 year old *Kayayo* from Linginsi in the West Mamprusi District. This finding supports that of Amin (2012) that local radio stations help in dissemination of health information and other developmental issues in the country, especially in the hinterland.

6.2 Where do Female Porters Seek Health Care When Sick?

Table 6.1 shows major places where the respondents sought care when they were sick. About one-quarter (24.5%) sought care in a health facility and the rest (75.5%) sought care outside health facilities when they were sick. The health facilities where the respondents sought care include clinics, polyclinics, hospitals, maternity homes and private health centres in the communities. Those who sought healthcare outside the health facilities reported that they used chemists' shops or resorted to local herbs.

Table 6.1: Percentage Distribution of Major Places where Respondents Seek Care when they are Sick

Places/ Health Facilities	Percent (N=216)
Place Sought Health Care When Sick	
Hospital	8.5
Clinics	16.0
Chemical shops	51.5
Herbalist	17.8
Others	6.2

Source: Field survey 2014

Some of those who sought health care outside health facilities mentioned that they bought medicines from drug peddlers and chemists' shops in the market. Others used traditional medicine that they brought along from their origins in the north. Those female porters who sought health care from a health facility indicated that at their destination in Accra, the hospital or the clinics were the safest places to receive health service when sick. This is an indication that at the hospital or the clinics the professionals are always available to attend to patients, as captured in the statement below by Memuna, a 20 year old Kayayoo, during the individual interview.

> *"The hospital is the safest place to go when sick. I fell ill last month and my friends ask me to go home for treatment. My madam who I help in the market to carry her goods any time she come to market asked me not to go. She sent me to the hospital and after taking the medication I was better to work continue with my work. I thought I was dying but the doctors are good and caring. I advise all my fellow Kayayei to visit the hospital when sick".* Memuna, 20 years, *Kayayo* from Logri in the West Mamprusi District

The migrant female porters who reportedly sought health care from outside the health facility were asked to explain why they did so. One of the reasons that they cited was the long distance to the facilities and time spent in going there. They reported that most of the facilities are geographically inaccessible to the *Kayayei* considering where they live at their destination. Only a few of the respondents indicated that they lived close to a health facility, implying that the majority have to travel long distances to be able to access health facilities. In fact, most of the respondents complained that the long distance they have to travel to access health care was a big challenge to their use of the modern health services.

Some of the respondents who patronized the service of chemists' shops in the market explained that they did so because of the distance to the health facility. According to one of the respondents in Agbogloshie market, there is only one clinic in Jamestown, a nearby community where they attend health services, and the facility is more than 2 km away from where they lived. Given the fact that the migrant female porters, who are described as poor, cannot pay for the service of taxicabs, the long distance to health facilities is a serious setback to their use of such facilities. These findings support what has been

known in the literature that long distance is one of the factors that affect health care accessibility in many developing countries (Ramachandran 1989; Sahn et al. 2003).

The long hours of waiting at the modern health facilities at the destination of the migrant female porters also prevented some of them from accessing the services at the facilities. Those respondents who indicated that they accessed health care services at the clinics and the hospitals reported that the long hours of waiting before being attend to is a challenge to their use of the services. In an interview with Serina, a 23 year old Kayayo from Chaayili in the Northern Region, she reported as follows:

> *"The first time I went to the hospital when I was sick of malaria, I spent almost the whole day at the facility before seeing the doctor. What worried me was that I spent money to travel to and fro the facility and spent the whole day. It is not the money I spent but the time I spent at the health facility. Since then any time that I am sick with the same symptoms I just walk to the chemist shop and buy the same medication that was given to me at the hospital. I prefer that to spending the whole day without working"*. Serina, 23 year old Kayayo from Chaayili in the Savelegu Nanton District.

The problem of long delays at health facilities is a common phenomenon at most hospitals in Ghana, (Onokerhoraye, 1999). Under such circumstances, the sick persons can lose confidence in modern health care and therefore resort to other means of seeking healthcare. Apart from the distance and the waiting time at the modern health facilities, the migrant female porters also stated that they could not afford various services at the facilities because of economic difficulties. Some of the *Kayayei* preferred traditional healers to the hospitals, and this explains why some of them did not go to hospital when they were sick. This finding resonates with the argument that belief in the effectiveness

of a health service predicts the likelihood of using that service than those that are not noted to be effective, (Rosenstock et al.1994).

Some of the *Kayayei* believed in the traditional medicine and could rely on it anytime they were sick. According to them, in most of the rural communities at their origin there are no health facilities; therefore, attending such facilities is a new thing to them. As reported by Mamata, an 18 year old Kayayo at the CMB lorry station in Accra:

> "*In my community in the north, there is no clinic or hospital and most of the people resort to herbs when sick and if serious they go to Tamale for medical checkup. We use the herbs to treat ourselves in the village. Some time we buy medicine from those who sell the white man medicine using motor bikes during market days in the village. So here when I feel that I am not feeling well I use the local herbs I brought from the village or I buy the medicine from those selling at the market. I don't want to be used to hospital attendance because there is none in my village in the north. In my village is only the rich who offer to aatend hospital when sick*

Another *Kayayo* from the Mallam Atta market also confirmed the use of herbs and traditional medicine both at their origin in the north and at their destination in Accra. She reported that she came to Accra with her local herbs that she use any time she is sick. She explained that some of them use the medicine based on their previous experience back at home in the north.

> Ayishatu also had this to say: *"I have a normal health problem that is my monthly mensuration, any time I am to menstruate, the pain I go through is beyond explanation. The pain is too much that I always cry. For this reason my uncle gave me some local herbs which I normally take during my monthly menstruation. The herbs is good for me and some of my fellow Kayayei facing the same problem use it. Now I have it in large quantity. Also my main sickness is headache and have a local medicine called dirgu tim that I apply any time I feel the pain".*

Ayishatu, 21 year old Kayayo at Mallam Atta market in the Accra Metropolis. As noted by Twumasi (2005) and Wolffers, Verghis and Marin (2003), people can maintain a parallel set of orientations and may be positively oriented both to traditional and modern scientific medical practices. This illustrates the contribution of traditional medicine in dealing with ill health in the Ghanaian society, especially in the rural areas.

6.3 Factors Associated with Health Seeking Behaviour

Table 21 shows the distribution of female porters in terms of the factors that assisted them in accessing health care. The Table shows that savings, receipt of assistance from institutions and NHIS status were factors which aided the female porters to accesses health care at their destination. From Table 6.2, about 14% had no savings and about 35% had saved less than GH 100. While 37.5% saved GH 100-GH 200, about 13% had savings of GH 201 and above.

Table 6.2: Factors that Influence Accessibility to Health Care Services

Characteristics	Percent (N=216)
Savings	
Less than GH 100	34.7
GH 100-GH200	37.5
GH201 and above	13.4
Have no savings	14.4
Receive Assistance from Institutions	
Yes	19.9
No	80.1
Have NHI Card	
Yes	45.8
No	54.2

Source: Field survey, 2014

The survey also revealed that 19.9 % of the respondents reported having had some kind of assistance from faith- based groups like the various Christian groups, the Federation of Muslim Women in Ghana, (FOMWAG), the leadership of some political parties, governmental and non-governmental organizations, while 80.1 % reported not having received any assistance from any institution or organization. They also indicated that the Federation of Muslim Women organized health screening for them and those who were found to be sick were given treatment. The porters also indicated that on several occasions some of them were knocked down by vehicles, and when they rushed them to

hospital it was the Ministry of Gender and Social Protection (MGSP) that paid the hospital bills. In an interaction with one of the leaders of the porters she said:

> "*Here we have been getting assistance from several people, the northern members of parliament (MPs), the religious groups and the political parties. But this assistance cannot sustain us. They give us things like 5 bags of rice, cooking oil and GHC 500. Any time such assistance are given it is always difficult to share them among ourselves. The only good assistance is what we receive periodically from the Ministry of Gender and Social Protection. They organized health screening for us and give us health education. That one is very good and should be continued".* Adama, 18 year old *Kayayo* at Agbogloshie in the Accra Metropolis.

6.4 Bivariate Analysis of Female Porters' Socio-Demographic Characteristics and other Control Factors by Place Sought for Health Care

This section presents an analysis of socio-demographic characteristics of the sampled population, environmental factors, other control variables and the variable on health seeking behaviour. The section also examines the relationship between the socio-demographic characteristics, environmental factors and other control variables and health-seeking behaviour.

Table 6.3 shows the association between the background and social characteristics of female porters and places where health care was sought. The results show that marital status and level of education were significantly associated with the places where health care was sought. However, places where health care was sought does not vary by age group and number of living children.

Specifically, the largest proportion of those who sought health care in a health facility (50.0%) were cohabiting, followed by those who were widowed (40.0%). Also, a quarter

(24.4%) of those who had never been married sought care from a health facility when sick. The least proportion (17.2%) of those who sought care from a health facility when sick was those who were married. Those who had children were noted to have experienced in child bearing and did not see the need to visit the hospital when pregnant. Further, the proportion of those who used health facilities when they were sick increased with level of education. None of those with no education used health facilities when they were sick; and about one-fifth (19.9%) of those with primary education and one-fourth (25.0%) of those with middle/JHS education used health facilities when they were sick. In addition, while about 29% of those with vocational/technical/secondary education sought care from health facilities when they were sick, half of those with tertiary education (50.0%) did so.

Even though age did not show a significant association with place where health care was sought, there is a kind of pattern observed. The proportion that use health facilities when sick was highest among those in the older age-groups. For instance, the use of health care facilities such as the hospital, clinics and health post when sick keeps increasing as the as the ages goes up. For example, those 10-14 years, 15-19 years, 20-24 years and 25 years and above. The proportion increases but not consistently as they are 17.2%, 24.7%, 21.8% and 32.6% respectively for age group. With regards to the number of living children, the highest proportion of female head porters who used health facilities when they were sick are those who have one child (28.6%), followed by those with four children (27.3%). None of those with five and six children used health facilities when they were sick.

Table 6.3: Percentage Distribution of Socio- Demographic Background and Social Characteristics by Place Health Care was Sought from

Characteristics	Place sought care when sick			
	In a health facility	Not in a health facility	N	X^2
Age Group	(N=53)	(N=163)		5.451
10-14	17.2	82.8	29.0	
15-19	24.7	75.3	89.0	
20-24	21.8	78.2	55.0	
25 and above	32.6	67.4	43.0	
Marital status				9.011**
Never married	24.4	75.6	135.0	
Married	17.2	82.8	58.0	
Co-habitation	50.0	50.0	8.0	
Divorced/widow	40.0	60.0	15.0	
Number of living children				1.896
Have no living children	24.7	75.3	146.0	
1	28.6	71.4	28.0	
2	25.0	75.0	20.0	
3	12.5	87.5	8.0	
4	27.3	72.7	11.0	
5	0.0	100.0	1.0	
6	0.0	100.0	2.0	
Level of education				7.845*
No education	0.0	100.0	2.0	
Primary	19.6	80.4	102.0	
Middle/JHS	25.0	75.0	68.0	
Vocational/Technical/Secondary	28.6	71.4	28.0	
Tertiary	50.0	50.0	16.0	

Source: Field Survey, 2014

** P < 0.01, * P<0.05

In an individual interview, Samiratu, she revealed the following:

> *"Any time I am sick or if any of my children is not well, the first contact is the hospital. The hospital is the best place. My husband used to send the children for treatment at the clinic back at our village. Now with my little education I got to know that the best health care for a sick person is the modern health care".*

Samiratu, a 26 year old *Kayayo* who hold SSCE certificate. From the narration of Samiratu, it was clear that those *Kayayei* with education sought health care at health

facilities when sick. This finding supports that of Apanga (2012) that females with some form of formal education sought health care at health facilities when sick and that those without any form of formal education sought healthcare outside health facilities.

6.5 Financial Accessibility to Health Care Services

There is no doubt that financing health care can be a constraint to accessibility to quality health care service delivery (Miller, 2005). Given that the Government of Ghana has introduced the National Health Insurance Scheme and the free maternal and child health policy, the study attempted to find out if the respondents are benefiting from the Health Insurance Scheme and the free maternal and child health policy.

In interactions with individual respondents who were pregnant and nursing mothers, they reported that even though the free maternal and child health services were introduced by the Government of Ghana, such services are not completely free as respondents reported purchasing drugs and materials needed for delivery. Also, respondents reported paying informal fees for health services which acted to deter them from accessing these facilities as noted by one respondent in the following words:

> *"I don't think that is free. Is only free on paper but in reality is not. I went to the Jamestown clinic to deliver. I was made to buy the items needed for delivery, buy the drugs and after I was discharged from the clinic I was made to pay GHC 230".* Rakia, 21 year old *Kayayo* at Tudu in the Accra Metropolis.

This statement supports the argument made by Gertler (1988) that informal fees that are charged and paid in Ghanaian health facilities has a direct influence on the health seeking behaviours of the people, especially those with little or no formal education. As indicated

earlier, access to health care depended largely on the income and savings of the individual. The survey revealed that the *Kayayei* who were able to, save more used some of their savings to pay for health services when ill (Table 6.2). Those who saved less or did not have any savings at all resorted to all kinds of treatment when sick. During a focus group discussions, some of the porters reported that the purpose of their savings is not just their health care needs but also to make money and go home. This was confirmed by a *Kayayo* at the Malam Atta market.

> *"The savings I am making here is to help me gather enough money so that I can buy my cooking utensils and also get capital to start business when I return to my village. At times when sick it is difficult to take part of my money for treatment unless the sickness is so serious that I cannot work. In Accra here if you go to the hospital by the time you return you might spend not less than GHC 100. How much is my savings for me to spend GHC 100 in accessing health care?"* Samata, 22 year old *Kayayo* at Mallam Atta in the Accra Metropolis.

The survey revealed that 45.8 % of the respondents reported that they had valid health insurance cards which they used anytime they were ill, while 54.2 % of them said they did not have valid health insurance cards. Some of those who had valid health insurance cards reported that they received the cards free of charge from the National Health Insurance Scheme. An interview with one of the leaders of the head potters suggested that this was the result of a social intervention programme for the poor by the National Health Insurance Scheme. The majority (54.2%) of those without valid health insurance cards indicated that some of them had the cards but could not use them because they were expired and they had no money to pay for the renewal, as reported by Fati, a *Kayayo* during a focus group discussion:

> "*Hmmm!! I came with my health insurance card from my village. But when I was seriously ill and went to the hospital after queuing for more than four hours I was told that my card had expired. I asked them what to do and they directed me to go*

to the office of the health insurance Scheme operators for the renewal. Since I could not speak the English language and my Twi too is very poor I decided not to go to avoid any embarrassment. I was not having the money for the renewal. My brothers, I always pray not to fall sick, is hell in attending hospital in Accra here". Fati, a 23 year old Kayayo from Taali in the Tolon District.

6.6 Environmental factors and health

Table 6.4 shows the association between environmental factors that predisposes the respondents to sickness and place from which care was sought when sick. The Table shows that all the environmental factors were significantly associated with place where care was sought when sick. More than half of those who had their water within their residences (52.6%) and slightly more than one-fifth of those who had their water outside their residences (21.6%) sought care in a health facility when they were sick. While about 4 out of 10 of the female porters who had their toilet within their residences (47.1%) sought care in a health facility when sick, about 2 out of 10 of those who had their toilet outside their residences (22.4%) sought care in a health facility when sick.

Further, slightly more than 40% of those who had their waste collection within their residences and 22.3% of those who had their waste collection outside their residences sought care from a health facility.

Table 6.4: Percentage Distribution of Environmental Factors by Place Health Care was sought from

	Place sought health care			
Characteristics	In a health facility	Not in a health facility	N	X^2
Availability of water in residence				9.002**
Within residence	52.6	47.4	17	
Outside residence	21.6	78.4	196	
Availability of toilet in house				5.134*
Within residence	47.1	52.9	17	
Outside residence	22.4	77.6	196	
Availability of waste collection bin in house				4.320*
Within residence	40.7	59.3	27	
Outside residence	22.3	77.7	184	

Source: Field Survey, 2014

** P < 0.01, * P<0.05

The respondents reported that having water and toilet facilities at their place of residence is an indication that they were within the average income group, and also those who enjoyed these facilities had had some kind of education. It was also revealed that some of those with these facilities at their homes were those who lived with their masters

(mistresses) and that their first point of call when sick is the hospital as directed by their care takers. In an interview with Adisa, she reported the following:

> *"Where I live in Accra here, we have all the facilities, such as toilet, water, decent bath room and well ventilated place. I stay with my madam, the woman I help in the market in her shop. She is responsible for my upkeep and everything including my health. When I am sick she send me to the hospital for check-up and buy all the medication for me. I don't even bother myself to register for health insurance because she does everything for me".* Adisa, a 19 year old Kayayo at Tudu in the Accra Metropolis.

This shows what the respondent reported during the field survey at the various selected areas. This is most common with the master *Kayayei* and those who work as shop assistants at the various markets, as reported by Adisa in the interview above. Sanitation has long been recognised as an important factor that accounts for morbidity among populations, particularly people living in dense environments who are vulnerable to diarrhoea, cholera, malaria and lung infections (WHO, 2006). Migration scholars have also found that migrants are among the most vulnerable populations for reasons including poor sanitation in their destination. Migrants in the developing world, particularly those in urban zones, usually inhabit unplanned and poorly drained areas with poor or no waste collection services, a situation which exposes them to a variety of ill health conditions and diseases (IOM, 2005; De- Haan, 2010).

6.7 Economic factors and Health-Seeking behaviour

Table 6.5 shows the association between factors that assisted female porters to access healthcare at their destination and place where heathcare was sought when sick. The Table shows that only NHIS status was statistically significant with the place where

health care was sought. However, savings and assistance from institutions/individuals were not significantly associated with place where health care was sought. Specifically, about 32% of the female porters who had NHIS cards sought care in a health facility when sick, compared to 18.8% of those without NHIS cards. The table shows that the use of health care when sick was higher among those who saved more, although this is not statistically significant. While 22.7% of those who saved less than GH100 sought care in a health facility when sick, about 24% of those who saved GH100-GH200 and 41.4% of those who saved GH201 and above did so. Also, 29.4% of those who received assistance from institutions/individuals and about 25% of those who did not receive such assistance sought care in a health facility when sick.

> *"I always go to the hospital when I am sick because of the health insurance card. It was given and paid for us by the Ministry of Gender and Social Protection. Almost every year they come to renew it. With this opportunity even if I will walk 3 km to the facility for a proper health care I prefer doing that to dying".* Amatu, a 21 year old Kayayo from Gymsi in the West Mamprusi District.

Another Kayayo at the Tema station reported differently.

She said she contributed three Ghana cedis every week towards any eventualities. She reported as follows*:*

> *"My brother! The nature of our work is that you have to be very strong and healthy before you can carry the load. I know my strength is my wealth and my physical body is my wealth as well. As I am healthy and working I make saving towards any unforeseen circumstances such as sickness or accident. I contribute GHC 3 every week towards my health and that of my child. Last month my child was sick and when I sent her to the hospital I spent GHC 70 but I did not feel it because I made provision towards that".* Salima, 23 year old Kayayo at Tema lorry station in the Accra Metropolis.

This finding did not support that of Bemah (2010) that *Kayayei* did not make any provision towards their health care needs and that they were more particular about their

cooking utensils and capital to start businesses when they return to their origin in the north.

> **"***I always buy my medication at the chemist shop because I was not fortunate to be among those who were registered for the National Health Insurance Scheme. At the time they were doing the free registration for the vulnerable including the Kayayei I was in the queue but when it got to me it was late and they never came again. Considering the cost of assessing modern health care here in Accra I prefer to buy my drugs at the chemist shops and be free. I will only go to the hospital if I am able to get the health insurance card".* Sakina, 17 year old Kayayo from Sandu in the Savelegu-Nanton District.

The statement of Sakina supports the finding of Apanga (2012) that most of the poor seek health care from the chemist shops and drug peddlers due to the financial constraints and that the National Health Insurance should target the core poor in the society.

Table 6.5: Percentage Distribution of Factors that Prevent Female Porters from Accessing Health Care by Place where Care was sought when sick

	Place sought care when sick			
Characteristics	In a health facility	Not in a health facility	N	X^2
Savings				4.276
Less than GH 100	22.7	77.3	75	
GH 100-GH200	23.5	76.5	81	
GH201 and above	41.4	58.6	29	
Receive assistance from institutions/individuals				0.31
Yes	29.4	70.6	34	
No	24.9	75.1	173	
Do you have NHIS card				4.825*
Yes	31.9	68.1	94	
No	18.8	81.2	117	

Source: Field survey, 2014.

** P < 0.01, * P<0.**05**

6.8 Predictors of Health-Seeking Behaviour among Female Porters

Whether or not a female migrant porter will access health care in a health facility or not depends on a number of factors, which have been discussed at both the uni-variate and bi-variate analysis section. This section tests the robustness of some of the statistically significant associations that were established between some of the independent and control variables and the dependent variable.

Table 6.6 presents the logistic regression model of the effects of female migrant porters' socio-demographic and environmental factors on their health-seeking behaviour. The model R-squared indicates that about 21% of the variation in the health-seeking behaviour of female migrant porters in the study is explained by the socio-demographic and the environmental characteristics of the study population. In all, the age, level of education and mode of waste collection are significant predictors of health seeking behaviour among female migrant porters. The age and level of education of female migrant porters have a positive effect on their health-seeking behaviour while mode of waste collection had a negative effect.

Table 6.6: Logistic Regression Model of the Effects of Female Migrant Porters' Socio-Demographic and Environmental Factors on their Heath Seeking Behaviour (N=216)

Model 1				
Variable	Coef.	Robust Std. Err.	Odds ratio	
Age Group (RC is 10-14)				
15-19	1.470	0.983	4.349	
20-24	2.146	1.120	8.555	**
Marital status (RC is Never married)				
Married	1.114	0.897	3.047	
Divorced/widowed	2.414	1.651	11.184	
Number of living children	-0.323	0.437	0.724	
Level of education (Primary)				
Middle/JHS	1.657	0.974	5.242	*
Vocational/Technical/Secondary	2.267	1.156	9.646	**
Water (RC is Within residence)				
Outside residence	0.937	1.451	2.552	
Toilet (RC is within residence)				
Outside residence	-1.381	1.405	0.251	
Waste collection (RC is within residence)				
Outside residence	-2.026	0.992	0.132	**
Constant	-2.280	1.741	0.102	
Model R^2		0.208		

** P < 0.05, * P<0.10

Source: Field survey, 2014

Table 26 shows that female migrant porters aged 20-24 years are 8.555 times more likely to seek health care in a health facility when they are sick than those aged 10-14 years.

This may be because female porters aged 20-24 years are involved in activities that earn them more income as compared to those who are younger. It is expected that with higher income, when they are sick they will visit health facilities for treatment. Also, female migrant porters with Middle/Junior High School education are 5.242 times likely to seek care in a health facility when they are sick than their counterparts with primary education. In addition, female porters with Vocational/Technical/Secondary education are 9.646 times likely to seek health care in a health facility than those with primary education. Education gives an individual a wider opportunity in life and also accept more objective and scientific explanation about disease. Female porters with higher education are more likely to get better offers due to their ability to speak English, their higher level of confidence and bargaining power, so that they earn more, save more, and are therefore able to go to a health facility to seek care when they are sick.

Those with lower education may not be in the position to afford the fees in health facilities and may also lack knowledge about the benefit of going to a health facility to seek care. Also, educated porters find it relatively easier to navigate hospital procedures and therefore feel comfortable at health facilities compared to non-educated ones who can hardly speak English, read or write. This finding corroborates those of Wilson et al (2005) and Jeppesen (1993), who note that education is positively related to the health of rural-urban migrants as it enables them break the language barrier with health officials.

In terms of the mode of disposing waste by female porters in their homes, those whose waste was collected outside their homes were less likely to seek health care in a health facility as compared to those whose waste was collected in their residences. Waste

collection within residences in the neighbourhoods where the female migrant porters are located is not usually frequent. This brings about disease transmission in homes because waste is left within the residences for weeks before it is collected by waste management companies. Probably due to frequent illnesses associated with uncollected waste within the homes, this category of people may be faced by financial constraints to access health care. Thus they may rather easily resort to seeking health care in other avenues than health facilities.

In Model 2, table 6.7, other variables that affect health-seeking behaviour were controlled to see if the variables that were significant in model 2 were still robust. The R-square in Model 2 is 0.342. This implies that 34% of the variations in health-seeking behaviour of female migrant porters are explained by socio-demographic characteristics, environmental factors and other control variables. The Model also shows that age, marital status and mode of waste collection in homes were significant predictors of health-seeking behaviour of female porters.

Age and marital status have a positive effect on health seeking behaviour while mode of waste collection has a negative effect. Older female porters are more likely to seek health care in a health facility compared to those in the younger age group of 15-19 years. Also, female porters who were widowed were more likely to seek health care from a health facility than their counterparts who have never married. With regards to mode of waste collection, female porters who had their waste collected outside the house were less likely

to seek health care in a health facility compared with those who had their waste collected within their residence.

Table 6.7: Logistic Regression Model on Determinants of Health Seeking Behaviour

Model 2				
Variables	Coef.	Robust Std. Err.	Odds ratio	
Age Group (RC is 10-14)				
15-19	1.688	0.994	5.407	*
20-24	1.634	1.911	5.125	
Marital status (RC is Never married)				
Married	0.163	1.319	1.177	
Divorced/widowed	3.755	1.928	42.739	**
Number of living children	-0.629	0.540	0.533	
Level of education (Primary)				
Middle/JHS	2.613	1.905	13.635	
Vocational/Technical/Secondary	2.694	1.943	14.785	
Water (RC is Within residence)				
Outside residence	0.171	1.761	1.186	
Toilet (RC is within residence)				
Outside residence	0.088	2.093	1.092	
Waste collection (RC is within residence)				
Outside residence	-2.733	1.530	0.065	*
Savings (RC is less than GH 100)				
GH 100-GH200	1.317	1.575	3.733	
GH201 and above	0.700	1.443	2.013	
Receive Assistance from institution (RC is Yes)				
No	-4.385	2.712	0.012	
Have NHIS card (RC is yes)				
No	-0.822	1.706	0.440	
Constant	1.685	3.147	5.391	
Model R2		0.342		

** P < 0.05, * P<0.10 Source: Field survey, 2014

6.9 Chapter Conclusion

This chapter has examined the health seeking behaviour of the female migrant porters. Most of the female porters sought health care in avenues other than health facilities. These avenues included drug peddlers, local herbalists and Chemists' shops. Those who used traditional medicines mostly brought them along from their points of origin. Three factors assisted female porters to access health care. These are their own savings, assistance from institutions and NHIS status. Of these, the most important is own savings. It is obvious that without financial muscle sick people cannot pay for health services by themselves. The literature on health seeking behaviour acknowledges this notion quite clearly; that those who earned more income were more likely to attend a health facility (Jeppesen, 1993; Darj and Lindmark, 2002; IOM, 2005).

Also, proximity of the health facilities and availability of doctors at the destination facilitate the health behaviour of seeking assistance at the health facilities when sick. It is often thought that by migrating, people have little or no chance of accessing health care (Vu Thi et al 2003; Van Landingham, 2005; WHO, 2007; IOM, 2005), but some studies such as those of the Institute of Social Studies (ISS) (1997) and Nguyen Duc Vinh (1998) show also that migration can be a blessing to people's health in some regard, as in the case of the migrant head porters. Several factors including better health policies at the destination, availability of qualified medical personnel and higher income earned could make health care more accessible to migrants (Nguyen, 1998; Foresight, 2011).

For internal migration, as in the case of migrant porters, the most important factors seem to be the availability and proximity of health facilities and qualified medical staff, higher income and less influence from cultural norms that enhance the use of traditional medicines. Of the range of factors discussed in the chapter, age and marital status were generally found to have a positive effect on health seeking behaviour. Older porters were more likely to seek health care in a health facility compared to those in the younger age group of 15-19 years, and married females were also more likely to seek health care in a health facility compared to unmarried ones.

Also the study found that female porters who have their waste collected outside the house were less likely to seek health care in a health facility compared with those who have their waste collected within their residence. This indicates that the mode of waste collection could be used as a predicator of health-seeking behaviour among migrants. The mode of waste collection is a reflection of the poverty status of migrants. The poorer ones are those that mostly have their waste collected outside the home. Those who dumped their waste outside their home are those who cannot afford the service of Zoom Lion, a refuse collection agency in the country, and such residents throw their waste anyhow in the vicinity. Waste collection has a relationship with their health-seeking behaviour of the respondents because those who are able to pay for their waste are the same people who visit the health facility when sick. A relationship thus exists between sanitation and health-seeking behaviour of migrant female porters at their destination.

In summary, the predictors of health-seeking behaviour among female migrant porters are age, marital status and mode of waste collection in homes. Age, for instance, is a critical predictor that requires the attention of policy makers. The analysis showed that older female porters were more likely to seek health care in a health facility than younger ones. It is suspected that this has been so because of the kind of activities that porters in various age groups are engaged in and the amount of money they are able to make in a day. The patronage of health services outside health facilities by younger female porters has implications for their general health in the future since they could be introduced to wrong medication without any diagnosis.

CHAPTER SEVEN: CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

This thesis aimed at contributing to the emerging body of knowledge about migration and health linkages. It explored the multiple ties between human mobility and human morbidity in Ghana with a focus on migrant female porters (*Kayayei*) in Accra, the capital city of Ghana. Several studies (for example, Awumbilla, 2007; Anarfi, 2003, Abdullai, 2010) have so far given attention primarily to the livelihood of the migrant female porters, with only cursory remarks on the health of these migrants. This study fills this gap by examining migration and health in Ghana with a special focus on female porters who migrated from the northern part of Ghana to Accra to work as head porters. It has provided both empirical depth and theoretical clarification on the migration dynamics, the health seeking behaviours, and the multiple factors that hinder access to health with spin-off effects on the achievements of migrants.

7.1 The Migration Process and Dynamics of the Migrant Female Porters

Migration is seen by the female porters as a means to gain autonomy in their lives, a means of livelihood diversification or as an alternative livelihood source. Migration has always been an alternative or additional source of livelihood for rural people, especially in times of crisis (Ellis, 2000). Structural adjustment policies have shaped the economic opportunities in Ghana, compelling young people, especially the young girls and women from rural northern Ghana, to migrate to Accra to work as head porters. The reasons for migration are related to the declining importance of agriculture and the non-availability

of urban jobs which can be blamed on the liberalization of the Ghanaian economy. The rapid urbanization of Ghana, with Accra playing a primate role, accounts for its magnetic attraction. This finding is in line with those of several other researchers who argue that structural and economic reform policies have great effects on livelihoods of the people, thereby contributing to rural-urban migration, especially of females to cities as head porters (Adepoju, 2002, 2004, 2005; Anarfi et al, 2003; Konadu, 2000).

The migration process of female porters is enabled by their mothers and social network including boy lovers, friends and family in the origin, along the way and at the destination. While en route to Accra, social networks provide safety nets for female porters and the urban poor residents as it increases their social asset base. For the migrant female porters, social capital plays a role in providing information about Accra, housing needs at the destination, jobs and on other vital issues that may help the potential migrant to migrate. The migrant female porters derive their social networks through their communal living. Such communal activities, though informal and based on familial, ethnic and village or home town affiliations, go a long way in providing support for migrant female porters. The study revealed that female porters in Accra contributed financially and in kind to support their friends who were sick. Living communally and engaging in communal activities are the main processes by which traditional societies and women's productive activities have been recognized in African societies (McCusker, 2006; Steady, 1987).

Findings from the study support African feminist argument that communalism is an instrument that women have used to gain autonomy and leverage in African societies.

Cultural and structural conditions in the origin of the migrant female porters shape their strategies. The porters migrated from traditional societies characterized by patriarchal tendencies and power relations that put men in a relatively better position than their female counterparts. It is evident that the local context in the north dictates and structures the options available to women in their strategies. This culture of dominance of men and of gender roles is perpetuated even at the destination. The social organization of the migrants at the destination is composed of a hierarchy of leadership with a man at the apex representing migrants from specific villages and similar to power relations at the origin. Even sub-groups representing various origin villages have men as heads while a female or even another man acts as a deputy.

The male leader is responsible for resolving conflicts and mobilizing support for village members. The maintenance of the cultural traits of the origin in Accra thus ensures the preservation of their culture, which also affects the power dynamics between men and women, and the preservation of gender roles. Females perform jobs related to their traditional roles (such as cooking, hawking of food and water, head pottering) while men restrict their services and business to those activities similar to what men do at the origin (such as gardening, truck pushing, manual work, masonry and carpentry). The findings of this study provide empirical evidence for African feminism which stresses on the importance of culture and the local context in which women operate (Steady, 2003).

The organisation of migrants according to villages of origin as an important mediator of vulnerability has generally received little attention in the *Kayayei* migration literature. In fact, some earlier studies of the female porters assumed that the *Kayayei* were largely

unorganized and thus very vulnerable (IOM, 1995). It is crucial to recognize that their vulnerability to risks and contingencies including theft and rape are mediated and reduced by the social organization they replicate according to cultural norms at the origin. This finding calls for focused studies on the social-political life of migrants and how this influences their livelihoods and vulnerability at the destination.

7.2 The Living and the Working Environment and Health of Migrant Female Porters

The poor living environment is the major cause of diseases such as malaria, typhoid and cholera. Sleeping in the open in front of shops exposes them to mosquitoes and rapists, while the lack of decent bathrooms, water, toilets and hygiene in general exposes them to skin infections and water related diseases. Just as Apanga (2012) noted, the living environment of the migrant female porters is a source of vulnerability, as the majority of them are exposed to malaria and other environmental diseases. The nature of their work also exposes them to waist, neck and bodily pains. Several of them have been raped as a result of sleeping in the open, while others suffer from extortion from their landlords/ladies due to their lack of dwelling units. The working and living environments of the kayayei exposes them to several health risks, including communicable diseases, drudgery and reproductive health risks. This is in line with the arguments of the socio-ecological approach which recognises that health is a product of cultural and social conditions. Sickness or ill health is believed be a result of poor social conditions (Marshall & Altpeter, 2005; McCarthy et al., 2004; Swanson & Wonjar, 2004)

The informal nature of the urban economy within which these women work constitutes a major source of vulnerability. This vulnerability is due to the lack of proper and effective regulatory processes (ILO, 2002; Chen, 2004). There is lack of security, no legal protection and no union for the *Kayayei*. The situation of the *Kayayei* is even more serious because it concerns a less privileged group of people. The precarious nature of their activity and the continuous influx of migrants into the *Kayayei* trade lead to high levels of exploitation, which affect the income and wellbeing of the Kayayei. This is in line with Maxwell's (2000) argumentation that workers such as the *Kayayei* have no job security, no legal representation and no union representation. Clients take advantage of this situation and pay *Kayayei* less for their services as they realize that these porters lack institutionalized mechanisms to demand what is due them.

The ILO (2002) considers the lack of institutionalization of some workers and job types as a pertinent issue in addressing labour exploitation. This is in line with the IOM's proposition that migrant labour rights be properly ensured both for internal and international spaces of movement so that migrants can make the most out of their migration in a dignifying and deserving manner. This proposition, however, seemed to have received little attention in the case of internal migration in many developing countries (IOM, 2010). This may be due to the general failure of governments of developing countries to make and/or enforce labour laws.

7.3 Health Seeking Behaviour of the Female Migrant Porters

The majority of the female porters sought health care from elsewhere other than health facilities. These included drug peddlers, local herbalists and Chemists' shops. Those who used traditional medicines mostly brought them along from the origins in the north. They only visit modern health facilities when their condition is serious. Three main factors assisted female porters to access health care. These are their own savings, assistance from institutions like the Ministry of Gender and Social Protection and some Non-Governmental Organizations (NGOs), and the National Health Insurance Scheme. Of all these, their own savings is the most important. It is obvious that without any financial muscle sick people cannot pay for health services, particularly those that do not fall under the National Health Insurance Scheme. The literature on health-seeking behaviour acknowledges this notion quiet clearly: that those who earn more income are more likely to attend a health facility (Jeppesen, 1993; Darj and Lindmark, 2002; IOM, 2005). Also, proximity of the health facilities and availability of doctors at the destination facilitate the health-seeking behaviour of migrants. Beyond access to health facilities, a range of other factors influenced their health seeking behaviour. These factors include the age, marital status, religion, education, level of savings and insurance cover.

.Longer exposure to urban life seems to enlighten migrants and to enable them accept modern ways of dealing with illnesses compared to new migrants from villages who are used to traditional medicine and traditional belief systems. This is mainly because the older migrants have spent more time in the trade and earned higher positions in the hierarchy even as managers of a group of *Kayayei,* which entitles them to more income. Migrants who earned more income were more likely to seek medical care from a health

facility than poorer ones. Also, generally, younger female porters assumed they were physically stronger and could cope naturally with illness with less attention, while the older ones who were frail needed special care from health facilities. This way of reasoning is a major cause of future serious health conditions for *Kayayei* as they grow older, because they task their biological systems at a younger age without the medical care needed to maintain longer and healthy lives.

Also, married female porters were more likely to seek health care in a health facility compared to unmarried ones, as they were supported by their husbands in financing their health needs. The poor patronage of health services outside health facilities by younger female porters has serious implications for their general health, as the use of un-prescribed medicine could generally result in complications. The study also found that female porters who had their household waste located outside their residence were less likely to seek health care in a health facility compared with those who have their waste within their residence. While this is not a factor that influences decisions of the migrants to seek health assistance, it is important as an indicator of vulnerability to health risks. The literature on health and migration has long recognized the important link between sanitation and health of migrants, but such studies, including IOM (2005) and De Haan (2010), have given less attention to it as a possible predictor of health behaviour.

The factors promoting 'good' health-seeking behaviour are not rooted solely in the individual (as opposed to the theory *of planned behaviour*) but have a more dynamic, collective, interactive element.

The findings refine Shaikh & Hatcher's (2005) theorization on factors responsible for poor access to health in Ghana, and therefore contribute to knowledge by interrogating rational socio-cultural and environmental considerations in the decisions arrived at by the *Kayayei*. Migrants' age, levels of education and marital status were generally found to have a positive effect on health-seeking behaviour. These define the lifestyles of people. Longer exposure to urban life seems to enlighten migrants and to enable them accept modern ways of dealing with illnesses compared to new migrants from villages who are used to traditional medicine and traditional belief systems.

These findings buttress the behavioural approach which argues that lifestyle issues and behavioural factors influence people's health (Kaplan, 1985;; Stefansdottir & Vilhjalmsson, 2007).

Health promotion programmes targeted at the poor and other vulnerable people in developing countries including Ghana have long been premised on the idea that providing knowledge about causes of ill health and choices available will go a long way to promote change towards more beneficial health seeking behaviour. However, there is growing recognition, in the study of the health seeking behaviour of the *Kayayei*, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour. An abundance of descriptive studies on health seeking behaviour, highlighting similar and unique factors, demonstrates the complexity of influences on an individual's behaviour at a given time and place. However, such studies focus almost exclusively on the individual as a purposive and decisive agent, whereas elsewhere there is a growing concern that factors promoting 'good' health-seeking behaviour are not

rooted solely in the individual but have a more dynamic, collective, interactive element. Thus the main conclusion is that combinations of individual and local dynamics of the *Kayayei* communities at their destination in Accra have a great influence on their well-being, which translates into influences on their health and health-seeking behaviour.

The relationship between migration and health is complex and multidimensional in nature, requiring an integrated approach, policy-wise, that seeks to address the migrants' economic, social, cultural, and environmental vulnerabilities. An integrated approach aimed at addressing these complex and multidimensional problems requires national and local policies that are multidimensional in nature and seek to capture the different aspects of vulnerabilities that affect the health of migrant female porters at their destination. On the contrary, some policy development and dialogue focus on an individual's decision-making ability and the availability of health facilities as an important indicator on migration. However, while they focus almost exclusively on the individual as a purposive and decisive agent, this study proposes that promoting good health-seeking behaviour among migrants should not be targeted solely at the individual; the approach must have a more dynamic, collective, interactive element.

Further research is needed to address the issues not fully dealt with in this study and also to address emerging questions on female migration and maternal and child health, which was one of the biggest health related challenges faced by the migrant female porters at their destination. Also, female migrants and their nutritional status, as well as that of their children, was another important thematic topic worthy of future investigation. These

issues have received cursory attention in this study but represent important aspects of migrants' health that seem to have received little attention in the migration literature.

7.4 Recommendations

The study makes the following recommendations in order to improve the usefulness of migration as a livelihood strategy without compromising the health of the female migrants. One reason for the low incomes and low wellbeing of the *Kayayei* is that they generally outnumber the available jobs. Among these migrants are those who migrated as result of the lack of basic amenities in their places of origin. This kind of situation leaves little room for choices among migrants in the destination due to their desperation, and therefore exposes them to unfavourable conditions of living and working, particularly under conditions of scarcity of jobs, with serious implications for their health. Bridging the gap of inequality between the north and the south of the country is an important means of ensuring that migrations for precarious jobs are minimized. Efforts in this direction by various governments have generally failed. One reason for this lack of success is that the strategies are usually badly conceived or poorly implemented. The Ghana Poverty Reduction Strategy (GPRS 1) is an example of such strategies. This strategy was directed towards the attainment of the anti-poverty objectives of the UN millennium goals, and it outlines a range of developmental policies towards the eradication of poverty in Ghana. GPRS 1 identifies the regional inequalities in Ghana and the lack of adequate development indicators in Northern Ghana.

However, it fails to set out a systematic plan of action to help develop the northern regions to eradicate poverty in that region, as noted by many scholars, including Yaro (2004). It is thus crucial that the government designs more practical strategies, and that, in collaboration with district assemblies and other stakeholders (NGOS and Bilateral Organisations) to ensures that a development balance is achieved between the north and south. Besides the structure of the economy of the north that should be enhanced, basic amenities such as electricity, water, and educational infrastructure should be provided. This could enhance the decision-making situations of prospective migrants and reduce forced migration which may result in economic and sexual exploitation, and consequently poor health outcomes.

The study also recommend that the government, through the Savanna Accelerated Development Authority (SADA), which seeks to bridge the gap between the north and the south, should make a fund available for the young girls in the north so as to engage them in some economic activities that will prevent them from migrating to the south to work as K*ayayei*. In particular, the policy of revamping the shea nut industry should target the young girls.

The government, through the Ministry of Health, the Ghana Health Service and the Ministry of Gender and Social Protection, should come out with a national health planning policy that will target the vulnerable in society including the *Kayayei,* to organise periodic health education programmes for the migrant female porters at their destination in Accra, especially on sexual and reproductive health. The Ghana Health

Service should also intensify education on the effects of drug abuse, as the study revealed that the majority of the migrant female porters (*Kayayei*) resort to drugs as a stimulant to enable them carry heavy loads without feeling any pain. Also, the National Standards Authority should liaise with the Ministry of Health and the Ghana Health Service to ensure that drug store operators and other drug peddlers do not prescribe or sell drugs without prescriptions from recognized health personnel. This is because the findings show that the majority of the *Kayayei* depend on drug peddlers and chemist shops for their medication.

With regards to the housing condition of the migrant female porters, the government, through the Ministry of Gender and Social Protection, can come out with a state-managed housing facility by putting up hostels for the poor in urban Ghana, particularly in Accra. These should be safe (from thieves and rapists), simple, low-cost structures, but with basic sanitary conditions that could prevent basic ill health. In doing this, the study further recommend that the state, through the Accra Metropolitan Assembly, as in the context of this study, should provide a management unit and see to it that all occupants are duly registered for allocation. The AMA, with the help of the Ministry of Gender and Social Protection, should see to it that the basic facilities such as water, toilet and electricity are provided so as to enhance good sanitation in the area. The management of the facility should see to it that occupants pay user and utility fees for maintenance and for the services provided. This, in a way, would help solve the problem of poor living conditions of the migrant female porters at their destination in Accra.

The interventions of some NGOS and government programmes have the unintended effect of motivating more young girls to migrate to Accra. Such interventions are usually tailored at enhancing the livelihoods of the *Kayayei* as vulnerable groups in society in various ways, including job training and health education. The economic interventions enable and enhance the standard of living among some migrants, and the demonstration effect of this upon their return or visits to the origin acts as a push factor for many girls to migrate. 'An example of such interventions is the Livelihood Empowerment and Social Development Programmes (LESDEP) which identifies the *Kayayei* as vulnerable and provides job training for them. But training at their destination influences more young girls to migrate to the cities to also benefit from such training and acquire the skills and equipment to return and establish themselves in the rural communities in the north.

The study therefore recommends that any institution, be it governmental or non-governmental, should encourage migrants enlisted to return home to receive such training and financial assistance at their origin rather than targeting those at the destination. Patriarchal gender norms in the origin limit livelihood opportunities of women with consequences for female migration to the south of Ghana. It is therefore crucial to navigate such limitations in the patriarchal system to increase women's access to resources, particularly land. This will contribute towards reducing distress female migration to the south of Ghana, and hence reduce the number of desperate migrants who are vulnerable to exploitation. One way of approaching change in the patriarchal system is by giving a voice to women in the decision making process, both at the village and the local authority level.

Parent in the northern part of the country should be educated on the importance of girl child education so as to enable them send their girls to schools as they do to the boys.

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APPENDICES

APPENDIX A

QUESTIONNAIRE FOR FEMALE PORTERS (KAYAYEI)

MIGRATION AND HEALTH AMONG FEMALE POTERS (KAYAYEI) IN ACCRA.

Introduction

I am a student from the Centre for Migration Studies, University of Ghana, and Legon, conducting a study on Migration and Health among female porters *Kayayei* in Accra, Ghana. This study is part of my Doctor of Philosophy Degree hence I would be most grateful if you could assist me by answering the following questions. All information given would be confidentially treated.

SECTION A: Socio-Demographic Characteristics of Respondents

1. How old are you...
2. What is your current marital status?

   a. Never married b. Married c. Co- habitation d. Divorced/ Widow

3. Number of living children:
4. Level of Education:

a. No formal education b. Primary c. Middle/JHS

d. Vocational/Technical/SHS/O'level/ A'level e. Tertiary.

5 What is your religious affiliation?

6 Name of town/ Village of origin ……. Region ……

7 Ethnicity? ……...

8 What type of house do you live in?

a. House/ Apartment in residential area. b. House/ Apartment in slum c. Kiosks d. Open space e. in front of shops

SECTION B: Migration Process:

9. Which town or village did you migrate from? Town/village …….. Region …….

10. Did you stop somewhere before coming to this place? Yes…… [1] No…… [2]

11. If yes where did you stop……....

12. How long have you been living in Accra? ……..

13. State your main occupation/ economic activities before moving to Accra ……

14. What was the most important reasons for migrating to Accra?

(*Up to two reasons allowed, but if more than one factor is stated, they must be rank in order of importance 1 most important).*

……

1. ……

15. Do you have an intention to stay in Accra permanently?

1. Yes (explain why) ……

2. No (explain why)

16. Who was involved in your decision to migrate to your present destination?

a. Myself b. Mother, c Siblings, d Aunt/Uncle e. Friends/Boy Friend, f. Recruitment agent.

17. Who was the most influential person in your decision to migrate to Accra? ……

18. How did you finance your trip/ migration to Accra?

a. No cost b. savings c. Sales of Assets d. Loan from friends e. Borrowing from family members, f. Others, specify.

19. Who did you live with when you first arrived in Accra?

a. Alone b. Parents c. Recruitment agent, d. Partner, e. friends, f. others, specify……..

20. How long did you stay with that person? ……

21. If you had known about these difficulties before you moved here, would you still have decided to move? 1. Yes 2. No

22. Has your situation change compare to when you were at your place of origin?

1 Yes 2. No

23. If yes, explain the change (is it good or bad)? ……

24. Have you regretted for coming here 1 Yes 2 No

25. If yes why? ……

SECTION C: Housing and Sleeping Arrangement of Respondents

26. Where do you sleep in Accra?

a. Rented room, b. Kiosk, c. Open space, d. rented room, e. Others, specify

27. Who owns the house?

a. Own house, b. Relative c. Partner, d. Rented, e. Others, specify

28. If rented how much do you pay for a room monthly? GHc……

29. Give the total number of people living in your room? No……

30. **Using the table below, state whether the following facilities/ services are available for use within your residence? State also the amount you spend on this facility each month**

Facility/ service	**Within residence**	**Not available in residence**	**Expenditure (GHC)**
Water			
Bathhouse			
Toilet			
Electricity			
Waste collection			

31. Indicate how the following problems affect your wellbeing in this neighborhood.

Rank: 1 = not severe 2= severe 3 = extremely severe.

Problems/ Challenges	**Rank**
Health	
Sanitation	
Harassment by city officials	
Harassment by rapist	
Crime	

SECTION D: Economic and Related Activities of Respondents

32. How long have you been working as a Kayayo? ……

33. What category of *Kayayei* are you? 1. Street 2. Master 3. Kayayo and Store Assistance 4. Others please specify

34. What is your average earning per day carrying goods? ……

35. How many hours do you work in a day? ……..

36. Do you have any savings? ……..…….

37. How much is your monthly savings? ……..

38. For what purpose are you saving?

1. Build capital to start business
2. Support family members
3. Preparing towards marriage
4. Children education
5. Other, specify.

39. Where do you save?

a. Bank, b. Susu collector, c. I keep it myself, d. give it to a friend to keep, e. use to buy assts.

40. Do you sometimes get assistance from any institution or individuals?

1. Yes 2. No

41. If yes, what type of assistance?

a. Financial, b. In kind c. both financial and in kind

42. Do you send remittance to your family back home? 1. Yes 2. No

43. If yes how much do you send in a month? GHC……..

44. What are the channels of sending money you use .....

45. For what purposes do you send the money? List as many as possible

.....……

SECTION E: Migration and Health

46. What are the disease that you often suffer from?

……

47. Where do you normally go for treatment when you are sick?

a. Hospital……. B. Clinic…….c. Herbalist…….d. Drug seller …….

e. Others please, specify…

48. What factors influence the choice of the above facility?

1. Cheaper, 2. Proximity, 3. Belief in efficiency, 4. Convenience

49. Do you have the National Health Insurance card? Yes…..[1] No……[2]

50. If yes how did you acquire it? ……..

51. If No why? ……

52. Have you gone for any health check during the last three months?

Yes …..[1] No……. [2]

53. The last time you were sick did you work? 1. Yes 2. No

54. Who takes you for treatment when you are sick? Friends…….[1] Relatives……[2] boyfriend……[3] Others, please specify……..……[5]

55. Who pays for the bill for your treatment? Friends……[1] Relatives……[2] Boyfriend Others, please Specify……[4]

56. Have you ever been hospitalized before? Yes …….[1] No ……[2]

57. If Yes; when? And for what ailment? ……..... and for how long……

58. Have you heard of the following diseases?

Gonorrhea: 1. Yes 2. No

Syphilis: 1. Yes 2. No

HIV/AIDS: 1. Yes 2. No

1. Hepatitis B Yes 2. No

59. Do you know how the above diseases are contracted?

Having sex with multiple partners…….. [1]

Having sex with infected person without using condom…… [2]

Common use of tooth brush…… [3]

Unhygienic genitals…….. [4]

Others, please specify…….. [5]

60. Have you heard of HIV/AIDS before or after you moving here?

Before……[1] After ……..[2] Don't know……[3]

61. From which source of information have you heard of HIV/AIDS?

Radio……..[1] Television……[2] Community meetings…..[3]

Friends…. [4] Work place…….. [5] Health workers…….. [6] Others please,

Specify…… [7]

62. Use of contraceptives - Origin / Destination – indicate yes or no

Current use of contraceptives	**Ever used of Contraceptives**	**Origin**	**Current Destination**

63. If yes, what type of contraceptives do you use?

Pill…… [1] Condoms…….. [2] Periodic abstinence…… [3] Injection ……..[4] Others please specify……[5]

64. Do you have any knowledge on the use of contraceptives? Yes……. [1] No…….. [2]

65. If yes where did you acquire the knowledge on contraceptives use and practice? ……

66. Have you been pregnant before? 1. Yes 2. No

67. A. If yes, where did this happen? Place of origin…….1. Place of destination….[2]

68. Have you been raped before? 1. Yes 2. No

69. If yes, can you please share with me how it happened……

70. Please do you have anything to say about your activity as a Kayayo and how it affects your health? ……

THANK YOU.

APPENDIX B

MIGRATION AND HEALTH AMONG FEMALE POTERS (KAYAYEI) IN ACCRA

FOCUS GROUP DISCUSSION GUIDE

1. Can you explain the reasons for most Kayayo migrating to Accra?
2. Can you describe the living conditions under which most Kayayo live here?
3. How do the living conditions affect your health – with emphasis on experiences from group members?
4. What are the common diseases that relate to living conditions here?
5. Can you describe the nature of your work?
6. Are there any hazards associated with head porting – lists and explain, eg accidents, dangerous goods etc
7. What are the health problems associated with your work? – pick up descriptions from individuals present or about others.
8. What are the main sources of treatment for illnesses of most Kayayei?
9. Can you explain the preference for these sources of treatment – why the choice?
10. Which of these sources provide good reliable services and why?
11. Are there any of these sources of treatment that sometimes worsen the cases reported?
12. Are there any groupings among you that serve to support members in need?

13. What is the role of friendships and family in your daily lives – are these effective
14. What kinds of support do you give each other when a member is sick? Detail different assistance patterns
15. What are the major problems you face in accessing health from different sources – as mentioned previously?
16. How do you think these can be solved – what are your recommendation

APPENDIX C.

MIGRATION AND HEALTH AMONG FEMALE POTERS (KAYAYEI) IN ACCRA.

INDIVIDUAL INTERVIEW GUIDE FOR KAYAYO

1. What are some of the reasons for your coming to Accra?
2. Who assisted you to get here – did you first stop somewhere or you came directly to Accra?
3. How far have you achieved what you set out to?
4. What are some of the challenges you face in achieving these aspirations
5. What strategies do you put in place to deal with some of these challenges
6. Who are those who assist you when you have problems and who do you help in turn? Friends, relations etc.
7. Can you describe the place you live in/sleep?
8. What challenges does the sleeping environment pose to you? (Enquire about rape if not mentioned) And how do these challenges affect your health
9. Please describe the nature of your work – tell me about your typical day.
10. Have you ever been cheated or robbed by your clients and other miscreants?
11. Are you often stressed up as a result of your work?
12. Can you describe the nature of goods you often carry? Are some of these dangerous? How do carrying these affect your health?
13. Have you ever encounter any road accident whiles doing your work us a Kayayo?
14. Do you take some stimulants or drugs or special foods that improve your stamina in working?

15. What contraceptives are you aware of and which ones do you use and why
16. Where and how did you learn about the contraceptives
17. What is the first thing you do when you feel sick
18. Do you often buy your own drugs
19. Do you visit the hospital when sick, at what point of your illness do you go to the hospital
20. Do you feel discriminated against when you go to the hospital or clinic? If yes what has been your response or strategy? Eg avoidance of these facilities
21. Do you use traditional medicines, how do you access these?
22. Could you tell us more about the kind of illnesses linked to your work and living conditions
23. Do you help each other when sick, and do you get help from other friends and family, other sources such as organisations.