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Suffering in the Hands of a Loved One: The Endemic to Intimate Partner Violence and Consequences on Migrant Female Head-Load Carriers in Ghana

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Abstract

The study contributed to filling a knowledge gap in the area of intimate partner violence (IPV). Previous studies conducted in Ghana have investigated the causes and types of IPV, leaving a gap on the consequences the violence had on the victims. Using a population of local economic migrants (hereafter, head-load carriers), a qualitative design with emphasis on phenomenology was employed to investigate the effects of IPV on 20 head-load carriers in two major cities in Ghana (Kumasi and Accra). The analysis performed on the data, using interpretive phenomenological analysis, revealed that IPV affected the head-load carriers' health, employment, and human relationships. Each of the participants spoke of one or more health complications, which they attributed to IPV. Among the health-related effects reported by the head-load carriers were body pains, wounds, depression, suicide ideation, headache, and abdominal pains that resulted from the termination of an unwanted pregnancy.

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All the head-load carriers recounted the detrimental outcomes of IPV on their job and human relationships. After they had experienced IPV, some of the victims could not go to work due to fear of stigmatization and those who were able to could not work as they usually do due to severe pain. At their workplace, some of the IPV victims became aggressive toward customers and coworkers, whereas others remained isolated. These negatively impacted on their human relationship skills and earnings. Based on the findings, there is the need for policies that seek to address IPV to consider the effects on victims' employment, earning, and behavior.

Keywords
battered women, domestic violence, anything related to sexual assault, sexual assault, mental health and violence

Introduction

Intimate partner violence (IPV) is an abusive act that is perpetrated against a person in a past or current romantic relationship and may take the form of (or result in) physical, mental, and reproductive harms. Although IPV has been identified as a worldwide social and health crisis (Weber & Bouman, 2020), the situation in most African countries is worse and increasing (Olayanju et al., 2013). For example, the prevalence of IPV in sub-Saharan Africa (36%; Garcia-Moreno et al., 2013) surpasses the global prevalence rate of 30% (Garcia-Moreno, Jansen, et al., 2006). In addition, IPV is one of the leading causes of HIV/AIDS in sub-Saharan Africa (McClintock et al., 2021).

To be able to address IPV, scholars (Abrahams et al., 2014; Durevall & Lindskog, 2015; Issahaku, 2017) and international organizations (United Nations Department of Economic and Social Affairs Statistics Division, 2014) have suggested the need for attention to be directed at finding the causes, prevalence, and consequences on women. In response, over the last 5 years, there has been a revolution in studies of IPV in the Ghanaian context. For example, data from quantitative studies by Issahaku (2017) and Tenkorang et al. (2018) reported the endemic to IPV in Ghanaian communities. A qualitative study by Adjei (2016) on masculinity and IPV revealed that males are mostly the perpetrators of violence against intimate partners. Data collected from 2,000 Ghanaians by Ogum et al. (2018) maintained that women with low education and income who are in a male-controlling relationship are at high risk of IPV.

Although the above risk factors have been reported among a population of local economic migrants (head-load carriers; Otieku et al., 2017), little data

are available regarding their IPV experiences and consequences. Head-load carrying (locally known as Kayayei) is a term that describes a female who transports goods on the head from one point to another for a fee. Although head-load carriers have existed in Ghana since the late 1960s (Kwankye et al., 2009), their number is not known due to the lack of nationwide statistical data. However, a study conducted by Baah-Ennumh et al. (2012) estimated their number at 40,000 in the cities of Accra and Kumasi.

To date, there is limited knowledge on the consequences of IPV on women in the Ghanaian context (Issahaku, 2015; Sedziafa et al., 2018). Sedziafa et al.'s (2018) qualitative study focused on 15 IPV survivors from a patrilineal lineage who suffered suicidal ideation and body pains as a result of partner abuse. Issahaku's (2015) study among 443 women in Northern Ghana indicated that seven out of 10 women experienced IPV and there was a high rate of suicide ideation among those who had experienced it. It is worth noting that Issahaku's (2015) research was a quantitative study and targeted all women, whereas Sedziafa et al. (2018) focused on women from patrilineal kinship systems. Although IPV exists among head-load carriers (Ghana Statistical Service [GSS], 2014; Ziblim, 2013), almost no studies in Ghana have investigated the consequences it has on the women.

To date, questions regarding the consequences of IPV on survivors' health, employment, and human relationships are yet to be answered. Using data from a population of head-load carriers, we build on prior research conducted in Ghana by investigating the health, employment, and human relationship consequences of IPV among the population of head-load carriers. The study findings provide invaluable information that can inform policies on IPV in Ghana and serve as a guide to other nongovernmental organizations who are interested in IPV and the wellbeing of head-load carriers. Given that head-lad carrying is a phenomenon peculiar to Ghana and other sub-Saharan African countries, we have first discussed their working and living conditions and how these can increase their risk of IPV. The literature on the consequences of IPV was then reviewed.

The State of Head-Load Carrying in Ghana and IPV Risk

In Ghana, the Upper East, Upper West, and Northern regions are the regions with high rates of poverty and inequality (Diao & Sarpong, 2011). A lot of children and youths from these regions migrate to the Ashanti and Greater Accra regions to engage in head-load carrying business with the aim of improving their living conditions (Agyei et al., 2016). In the destination cities, head-load carriers

find themselves in more disadvantageous circumstances, given their poor background, homelessness, and migrant and ethnic minority status (GSS, 2014; Tran et al., 2016). These children and youths engage in head-load carrying on the streets and in the markets which poses a danger to their health and psychosocial wellbeing due to the physical nature and homelessness associated with the job (Kwankye et al., 2009). The majority of the head-load carriers live and work on the streets, exposing them to malaria, cholera, and other communicable diseases (Otieku et al., 2017).

Previous studies have reported a deplorable state of living and working conditions among the head-load carriers (Agyei et al., 2016; Kwankye et al., 2009). A recent qualitative study by Nyarko and Tahiru (2018) on head-load carriers underscores their deplorable working environment, poor eating habits, lack of proper accommodation, and poor health-seeking behavior due to financial constraints. The majority of head-load carriers spend the nights sleeping in front of street stores exposing them to violent attacks, rape, defilement, and other health complications (Agyei et al., 2016; Nyarko & Tahiru, 2018; Ziblim, 2013). A report by the United Nations Population Fund (2012) reflected that a majority of the head-load carriers experienced abuse from strangers and nonstrangers due to the vulnerability posed by their living and working conditions.

The working conditions of the head-load carriers have been described by scholars as hazardous (Baah-Ennumh et al., 2012; Owusu & Yeboah, 2018). This is because the amount of money they can make depends on the weight of load carried and the distance covered. In a productive day, an estimated load for a single trip weighs 50 kg or above, to a distance of approximately 1 km or more (Adams, 2012). Owusu and Yeboah (2018) reported that the weight of the load carried, coupled with poor eating habits and age, affected head-load carriers' health: Many developed spinal problems, headaches, and body pains. A majority of the head-load carrying workers are children below the constitutional mandated working age (18) of Ghana (Baah-Ennumh et al., 2012).

Apart from the harsh working and living conditions, head-load carriers encounter all forms of abuses and exploitations (Lattof et al., 2018; Opare, 2003). Scholarly explanations regarding why female head-load carriers are more likely to experience abuse and exploitation include loneliness in executing their jobs and low earnings (Owusu & Yeboah, 2018). These have left many women homeless and forced some to seek protection from males at their workplaces or live in shelters owned by men (Yeboah, 2010). The few that live in their own shelters do not have bathroom and toilet facilities; they take their bath or excrete in either the public facility or a friend's place (Nyarko & Tahiru, 2018).

In Ghana, studies on street children including head-load carriers have reported risky sexual behaviors that increase the likelihood of violence (Asante et al., 2014; Oduro, 2012). Asante et al. (2014) reported that the streets in which the head-load carriers work are male dominated and controlled. Females working and living in these streets are powerless, poor, and lack security (Agyei et al., 2016; Ziblim, 2013). As a result, in order for them to feel secured and satisfy other basic needs, head-load carriers are more likely to engage in survival sex or relationship with older and strong men who are controlling and abusive. This then increases the likelihood of IPV (Asante et al., 2014). Oduro (2012) concluded that street children such as head-load carriers are at a greater risk of ending up in abusive intimate relationships due to their low income and education status mixed with social insecurity and patriarchy. A study conducted by Chirwa et al. (2018) in Ghana reported that transactional sex (or sex for basic needs) is an antecedent to IPV perpetrated against women in Ghana.

Effects of IPV on Women

IPV affects the overall health of women, globally. In sub-Saharan Africa, recent studies on IPV have reported that survivors experienced physical, mental, and reproductive problems (Chikhungu et al., 2021; McClintock et al., 2021). Furthermore, IPV affects victims' self-confidence, leading victims to withdraw from families and friends as well as community activities (Erez et al., 2009). From the above, it is therefore evidenced that IPV disempowers and reduces victims' capacity to build social networks that could enhance their development (Gibbs et al., 2018).

IPV implants fear in victims by making them more vulnerable to nervousness and other mental health complications compared with the average person who has not been exposed to it (Wolford-Clevenger et al., 2019). Indeed, the above conclusion has been supported by findings from previous studies (Crandall et al., 2005; White & Satyen, 2015). For example, Symes et al. (2014) found that women who have experienced IPV are more anxious and emotionally traumatized, which affects their relationship with others and exposes them to suicidal ideation. These findings are supported by a recent study in South Africa by Gibbs et al. (2018), which reported that victims of IPV were more likely to attempt suicide compared with those who have never experienced it.

Apart from mental health and suicide, survivors of IPV have reported other fatal consequences based on their reproductive health (Stockl et al., 2012). Results from a quantitative study conducted in Zimbabwe by Shamu et al. (2018) showed that IPV victims experienced abuse-induced miscarriage

and stillbirth. Similar findings have been reported in developed countries such as New Zealand (Fanslow, 2017), Europe (Citernesi et al., 2015), and the United States (Karakurt et al., 2017). Other consequences of IPV on reproductive health have been reported to include unwanted pregnancy and induced abortion (Kuhlmann et al., 2019), preterm birth and low birth weight (Sigalla et al., 2017), and infant mortality (Emenike et al., 2008).

In addition to the recorded deaths, many more women suffer a lifetime of health problems as a result of IPV (Dicola & Spaar, 2016; Garcia & Hurwitz, 2007; Sedziafa et al., 2018). These health problems include, but are not limited to, chronic body pains, traumatic brain injuries and chronic mental health problems (Wong & Mellor, 2014), and sexually transmitted infections (Dhakal et al., 2014). Some IPV survivors are battling joint pains and lifetime physical injuries (Tiwari et al., 2013). Despite the cost associated with IPV, in terms of health and social isolation, there is scant literature in this area in sub-Saharan Africa (Abrahams et al., 2014). In Ghana, although the effects of IPV on some population of women have attracted researchers' attention over the past decade (Spangenberg et al., 2016), vulnerable population such as head-load carriers has not been looked at, hence the need for this study.

Method

Study Context and Population

The study was conducted in Ghana, West Africa (see Figure 1). Ghana faces the Gulf of Guinea on the South and shares boundaries with three countries: Burkina Faso (North), Cote d'Ivoire (West), and Togo (East). Ghana is divided into 10 administrative provinces (Greater Accra, Ashanti, Eastern, Central, Volta, Western, Northern, Brong Ahafo, Upper East, and Upper West regions). The last population census of Ghana conducted in 2010 reported a total population of 24,658,823. According to the census, 4,780,280 and 4,010,054 were living in the Ashanti and Greater Accra regions, respectively, making the two regions the most populous in the country (GSS, 2014). This study was conducted in the capital cities of Ashanti (Kumasi) and Greater Accra regions (Accra).

Apart from Accra and Kumasi being the two major cities in Ghana, earlier studies have reported that they host the majority of head-load carriers in the country (GSS, 2014). Kumasi and Accra have big markets with footpaths, which makes it difficult for vehicles to operate. For example, the Agbogbloshie and Makola Markets in Accra and the Central Market in Kumasi have no major links to the main roads. As a result, the head-load carriers contribute to helping traders or market women transport their loads to transport stations (Agyei et al., 2016). The majority of the girls and women that trade in the

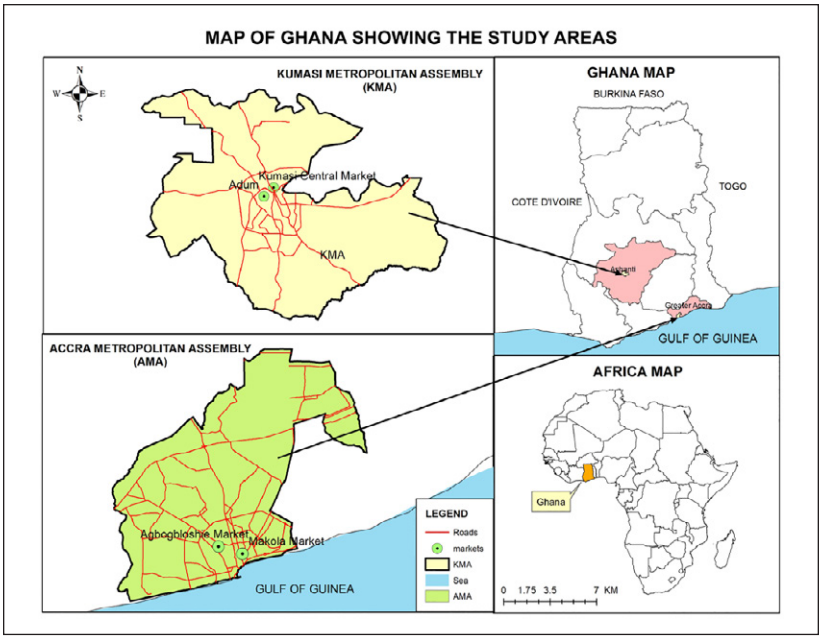

Figure 1. Map of Ghana showing the study sites.

head-load carrying business migrated from the Northern, Upper West, and East regions (Opare, 2003), making them an ethnic minority; Akan and Ga ethnic groups dominate the cities of Kumasi and Accra.

Study Design

This is a qualitative study based on phenomenology. Among the approaches to qualitative research, phenomenology has been considered appropriate when investigating the lived-through experiences of participants (van Manen, 2017). This allowed the study to ask questions that reflected participants' experiences of IPV and resulting consequences. Due to the researchers' prior knowledge about the population under study, the hermeneutic phenomenology (Heidegger, 2010) was employed over the descriptive one (Husserl, 1970) to allow the researchers to go into the field with presuppositions. However, the researchers were guided by the principle of reflexivity, as they acknowledged their biases and approached the study in a way that ensured participants' lived experiences were presented rather than those of the researchers (Reid et al., 2018).

Purposive sampling, a nonprobability sampling technique, was employed to sample 20 participants (10 from each of the study sites). The study design and purposive sampling technique helped the researchers select not only participants who were knowledgeable and had lived the problem under study (Creswell & Plano Clark, 2011), but, at the same time, those who were more willing to share information about their lived experiences (Bernard, 2002). This helped the researchers gather in-depth data on IPV which is sensitive and underreported (Dicola & Spaar, 2016). Given the vulnerability of the study population, the researchers did not publicize or advertise recruitment. What we did was approached the head-load carriers and explained to them the purpose and benefits of the study and provided assurance that their participation in the study would be kept confidential. In the process of the face-to-face recruitment, participants were assured of informed consent and the flexibility to move out of the study during data collection if they wished to.

Data Collection

The study collected data from 20 head-load carriers at the Agbogbloshie and Makola Markets (Accra), and the Central Market and Adum business district (Kumasi). All interviews were audiotaped after participants' consent had been sought. The researchers conducted individual in-depth interviews with participants using semi-structured interviews (Online Appendix). The interviews consisted of five questions, in which the researchers probed participants' responses when there was the need to do so. Examples of the questions included the following: How the abuse affects your employment and how does the abuse affect your self-image and everyday life? Interviews were conducted in Akan or Twi (a dominant local language) and were interpreted to the English language during transcription. Interviews with participants lasted for 50 to 60 min. Interviews were held in the afternoon (12:00 p.m. to 3:00 p.m.). The head-load carriers indicated that this time was appropriate to engage in other activities because they mostly take a rest or have lunch.

The researchers had lunch with some of the participants during the interviews, and those who were at work but stopped purposely for the interviews were compensated. This was important because during the interviews some were approached by clients, but to allow the interviews to continue we agreed to pay money in exchange for the time they spent with us. To minimize participants' fear and to let them fully narrate stories as they experienced them, the researchers, after approaching and having participants' consent, visited the participants three to five times at their workplace before the actual interviews took place. Participants who were too busy to grant interviews during weekdays, as well as those who expressed their displeasure that interviews

were to be conducted at the market's premises, were interviewed at their residence or other convenient place on Sundays.

Insider Positioning

As qualitative researchers, our position for conducting this study cannot be neutral and without impact (Creswell, 2017). Our interest in this topic was prompted by the experience we had with head-load carriers during our undergraduate social work field placement. Our encounters with survivors of IPV who were working as head-load carriers kept us asking questions regarding how best we can help to address partner violence against this vulnerable population. During data collection, we made our position clear to the study participants. Throughout the study, we were mindful of our compassion toward the study participants and constantly conducted ourselves in a way that minimized our biases. Continuous conscious reflections of our beliefs and values that have been shaped by previous encounters with head-load carriers increased our awareness to present and interpret meanings in a way that reflects participants' experiences rather than that of the authors (Online Diversity Statement).

We ensured trustworthiness and credibility of data through investigator triangulation. Both researchers conducted separate analysis and interpretation of the transcribed data at different locations and times. Afterward, a meeting was held to discuss the themes and the final report was produced after a rigorous discussion of the individual themes. In addition, the findings of the study were debriefed by a faculty member before conclusions were drawn. After transcription of the data, a language school teacher who was articulate in the interviewed language (Twi) and transcribed language (English) was assigned to listen to the interviews and compare the transcription for appropriateness and genuineness.

Data Analysis

The language used for the data collection was Akan (Twi) (Online Apendix). This meant that the researchers translated the original interviews from Akan to English language. Accordingly, interviews were listened to with attentiveness and transcribed in the English language using Microsoft Word 2016 version. The interpretive phenomenology was adopted to analyze the transcribed data. The interpretive phenomenology analysis allowed for the identification and utilization of unexpected themes that emerged from the transcribed data (Smith et al., 2009). It also helped the researchers establish a link between participants' lived experience of IPV and their current or previous health and psychosocial complications.

Table 1. Selected Sample of the Analysis Process.

Original Transcript	Analytic Process
Interview: How do your experiences of intimate partner violence affect your work as a head-load carrier?	
Participant's response: Anytime my boyfriend beats me, the following day I get pain all over my body. This has affected my health so as a result I am unable to go to work.	Beating by boyfriend Physical pains as a result of being beaten Inability to go to work the next day
Emerging themes for the interview extract above	Physical abuse Physical pains Attributing absence at work to being beaten by boyfriend
Relationship and clustering themes	Effects of intimate partner violence on head-load carriers Health effects Physical injuries Effects on employment

Note. An example of the analytic process from an interview with Abiba (a head-load carrier).

The researchers followed the four stages (multiple readings and making notes, transforming notes into emergent themes, seeking relationships and clustering themes, and writing up the final result) of interpretive phenomenology to analyze data for the study (Pietkiewicz & Smith, 2012). An example of the analysis process has been displayed (see Table 1). At the first stage, the researchers thoroughly read and re-read the transcribed data separately on several counts, made meanings out of the data, and notes were taken from the transcribed data. At the second stage, the researchers focused more on the notes that were taken from the transcribed data and 34 emerging themes were listed after combing each researcher's analysis of the data. At the third stage, themes that were consistent or similar were grouped into clusters. We identified three major themes and three subthemes from the cluster of themes. The written work was produced at the final stage.

Respondents

Table 2 presents the demographic information of respondents. The ages of the study participants ranged from 14 to 23 years. Out of the 20 participants, 13 were below 18 years. All the participants established that they dropped out from school at the basic level and as a result could not complete Year 9. Eight

Table 2. Demographic Characteristics of Participants.

Total = 20 females	
Age range	14-23 years
No. of participants aged below 18	13
No. of participants aged 18 or above	7
Education status	
Basic school dropout	20
Years in the head-load carrying business	2-7
Marital status	
Married	6
Cohabiting	9
Separated	1
Divorced	4
Living with a husband or partner	13
Living with a friend	3
Living alone	4
Number of children	
At least one child	17
No child	3
Region migrated from	
Upper West	8
Upper East	5
Northern	7
Accommodation status in the first month of migration	
Worked and slept on the street	16
Lived in a friend's room	4
Monthly income range	200 GHC (US$50)-400 GHC (US$100)

of the participants migrated from the Upper West region, seven of them were from the Northern region, and the remaining five of the head-load carriers migrated from the Upper East region with the aim of improving their living conditions. Most of the participants had at least one child with the exception of three who revealed that they had no children at the time of data collection.

Participants had been in the head-load carrying business for at least 2 years and at most 7 years. Six of the participants were married and the remaining 14 were either cohabiting, separated, or divorced at the time of data collection. Thirteen of the participants were living with either a husband or partner, four were living alone, and the remaining three were living with friends. Most of the participants had lived on the streets for at least 1 month after they migrated

before they moved to live with their husbands, partners, or friends. In addition, the monthly income of participants ranged from 200 Ghana Cedis (US$50) to 400 Ghana Cedis (US$100). All the participants had experienced abuse (verbal, physical, sexual, psychological, or emotional) from an intimate male partner (current or former) including those below 18 years.

Results

Effects of IPV on Migrant Female Head-Load Carriers

Results of this study were grouped under three major themes: health effects, human relationship effects, and effects on employment. Health effects underpinned IPV experiences that affect participants' physical and mental wellbeing including physical injuries, mental health complications, and reproductive or sexual health complications. We refer to human relationship effects of IPV as victims' behaviors toward friends, coworkers, and customers after experiencing IPV. Employment effects explain the impact that IPV had on victims' jobs and earnings.

Health Effects

Physical Injuries

In trying to describe the severity of IPV experiences, some of the head-load carriers (participants) showed the injuries sustained to the researchers. From the participants' narrations and physical evidence observed by the researchers, some of the head-load carriers had sustained wounds, blood clots, bruises, and several marks from previous intimate partner abuse:

> Let me show you so you will believe in everything I tell you . . . See the marks on my left ear and face [show], I sustained them as a result of my ex-husband's beatings. (Blaba)

Another participant had this to say:

> My ex-husband could do anything to you when he was angry . . . it took little things for him to be angry . . . this big scar on my left hand was sustained when he pushed me, and I fell on the gas stove. (Atimpali)

Aside from the marks sustained by some of the participants, other participants had sustained blood clots on the eyes: "My partner slapped me one night and for one week my eyes turned to red" (Abena). In support of Abena's experience was a statement by Fati:

> I had to remain indoors for some days because I had blood clots on my eyes after my husband had beaten me. I suffered injuries on my face with my eyes being the most affected.

In addition to the marks and blood clots, participants experienced severe body pains as a result of the injuries suffered from IPV:

> My boyfriend beat me to the point that I had a cut on my mouth and was unable to open it to eat. I had a swollen face with a lot of pains all over my body. I struggled to go out or eat due to my physical condition. (Amina)

Physical injuries that resulted from IPV were common among the participants. Head-load carriers reported severe body pains, with some attributing their chronic headaches and back pains to abuses they have experienced from an intimate partner: "Before I got myself in to this mess I had never fell pains at my back, but since my ex-partner pushed me to fall on my back I have never regained my strength" (Blaba). Blaba's narration gives evidence to the danger that IPV can pose to the physical health of the head-load carriers.

Husbands or cohabitants were not the only perpetrators of IPV against the head-load carriers. Three of the participants revealed that, sometimes, abuse was perpetrated by other wives or female partners of their husbands or partners: "I had a fight with my husband's second wife, she flogged me in the head with a pot and my head has been aching ever since" (Ada). Most sub-Saharan African country traditions encourage polygyny; as a result, some of the participants revealed that their husbands or partners were married to, or dating, more than one woman:

> I have engaged in a lot of fights with other partners of my man . . . if not that, by now, I will not still be there with him . . . some get to beat me up and I beat some as well. (Esi)

Although Esi's narration may sound like she did not suffer any injury from her fight with the other women she believed to be in a relationship with her partner, Aku's experience was different:

> I have a very big scar at my back! If you don't mind, I can show to you . . . it was my husband's second wife who bit me.

Reproductive and Sexual Health Issues

Head-load carriers were abused sexually. Partners of head-load carriers resisted the use of contraceptives during sex. Head-load carriers were made

to compromise to have sex without contraception or family planning methods to prevent abuse from their partners.

> My husband resisted that I use family planning methods because it will hurt his manhood . . . when I tried to explain to him, it turned to an argument and he threatened to beat me and divorce me if I go on to do it . . . because I do not want my marriage to collapse I had no option other than to do what he wants. (Nunu)

The misconceptions held by some husbands and male partners about family planning methods made them react violently toward it whenever the issue of contraception was discussed. As a result, some of the head-load carriers were unable to initiate family planning discussions (birth spacing) or insist on it before sexual intercourse:

> My ex-husband used to have sex with me at least five times in a week but I was in no position to tell him to protect himself with a condom and I could not use one either. His abusive behaviour prevented me from using contraceptives and he almost killed me one day when I brought in the idea of using contraceptives. (Hajia)

Participants' inability to participate in sexual and reproductive decisions affected their birth spacing and control, leading to unpreparedness and unwanted pregnancies. Consequently, some of the head-load carriers engaged in self-induced and unsafe abortions without the knowledge of their partners. It was revealed that the head porters who became pregnant due to sexual violence aborted them by self means:

> I have aborted three times, but I still have four children at this age (23) . . . since my last abortion I have never conceived, and it worries me if there is something wrong with me. (Efua)

Another participant gave her life account to explain how she got pregnant three times within 4.5 years:

> All my three children with my husband were delivered through caesarean section . . . sometimes he starts sleeping with me in just a month after delivery. Even during pregnancy, he was forcing me because he was always drunk . . . my first child was four months old when I got pregnant again. As a result, I experienced a lot of abdominal pains, which let to me spending many weeks at the hospital. The nurses advised me not to get pregnant again after the third one because I may lose my life, but I could not tell them my story . . . it is a very big problem I am facing. (Alaba)

Mental Health Complications

Participants' experience of IPV and the resulting physical, sexual, and reproductive health consequences affected their mental wellbeing:

> As I speak with you I am not feeling well, there are pains all over my body, but there is no money to go to the hospital and the person who caused this does not care about me—this makes me think and feels sad all the time. (Afi)

Ramat gave her life account to illustrate a mental health problem she developed as a result of thinking about her experiences of IPV:

> At a point, my friends realised I was not thinking well; I mean as normal as I should, so they sent me back home to the north. My parents took me to a traditional healer in our village and thanks to God that I am better and back to normal again.

Aside from the severe mental health complications were sleepless nights that came as a result of participants feeling worried about their situations, leading them to feel depressed and traumatized: "At a point in my life, I was struggling to sleep in the nights . . . any little noise I heard frightened me and I was thinking too much" (Atimpali). In addition to their sleepless nights, participants whose partners were controlling and had ordered them not to visit friends or use or talk about contraception during sex expressed the feeling of fear for their lives:

> At a point my ex threatened to kill me if he sees me talking to one guy at the market . . . this is a guy I could not do without because he is from my hometown and protects us in the market . . . each day, after work and I am on my way home I think and talked to myself; what if he saw me with him? What will happen? Will he kill me as he said? These questions were all over my thought and I will not be myself till the next morning. (Nunu)

According to Hajia, she has transferred her feeling of fear from her ex-husband to her current relationship:

> My ex—husband warned me not to think about using contraception or deny him sex when he needs it—whenever I resisted he will beat me and lock me up in the room, at a point his presence was intimidating and will be shivering whenever he tried to get close to me . . . it has even affected me in my current relationship and I am struggling to overcome it.

In addition, in more extreme cases, one of the participants was having suicidal ideation:

> I thought of killing myself at some point because I did not know what to do . . . I was not happy at home neither was I happy at the workplace . . . I had become so useless to the person who used to make me feel very important. (Nafiz)

IPV affected participants' confidence and made them feel unvalued. Head-load carriers became more concerned about the abuses they experienced, thereby negatively affecting other aspects of their lives such as their jobs and interpersonal relationships.

Effects on Human Relationships

Experiences of abuse by the head-load carriers affected their human relations skills. Some male partners vetoed their female head-load carrier partners from attending social gatherings or associating with colleagues and friends. In addition, some of the participants had lost self-confidence and were ashamed by their situation. To prevent colleagues and other people from suspecting that they had been abused by the partners, they opted to stay indoors:

> When I get beaten by my partner, I do not feel like eating or stepping out from the room . . . I feel about what other people in the neighbourhood will say if they see me with those wounds . . . I become reserved and do not feel like talking to anyone including my partner. (Alima)

Another participant explained,

> If people get to know that your husband beats you up all the time, it is a shame . . . to prevent yourself from any embarrassment you stay away from friends and others in the neighbourhood. (Afi)

Apart from the personal decision victims of IPV made to remain isolated from neighbors and friends, some of the participants were forced by their partners not to engage in social networking. Abena explained,

> The kiosk I and my friends were living in was owned by my partner . . . and he was dating other women in the next kiosks . . . now, in order for him to prevent us from finding out, he banned me from talking to them and insisted that under no circumstance should he see me with them together.

In addition, a statement from the oldest participant was in support of the above assertions:

> I was prevented from visiting my friends or attending any public event . . . my husband would beat me if I disregard his instructions . . . I remember one day going for a funeral and my husband came to the funeral grounds to beat me for attending it. (Bawa)

IPV negatively impacted participants' human relations, leading to social isolation. Some of the head-load carriers lost the desire to be with other people due to the fear of stigmatization. Others harbored the fear of attracting abuse from their partners if they attended social gatherings or continued social networking with friends. These practices affected the head-load carriers' human relationship skills, which, for some, transferred to their workplaces.

Effects on Employment

Sometimes, in their workplaces, head-load carriers transferred their poor human relationship skills, which resulted from partner abuse, to clients and coworkers. Some established that they got angry at small incidents with their clients and before they knew it the client had left them to use a more accommodating head-load carrier. Ada noted,

> I did not know what has come over me . . . I was screaming at everybody who approaches me . . . I was speaking to my clients very harshly and those who could not stand it either fought me or leave to hire a friend.

Furthermore, social isolation resulted from IPV affected victims' relationships with other head-load carriers. This had a negative impact on their job because the nature of the head-load carrying business is such that, sometimes, customer referral by a coworker is the only means to get a job. This is what Nunu had to say about this:

> At first, I was the most lively in this market, but now I am not that same person . . . I used to have time and patience for customers and friends, but now things are not the same . . . I am going through a lot at home . . . sometimes I come to work and do not feel like talking to anyone . . . in this job, some days, you have to rely on your co-workers to give you job and if you do not behave to them nicely, they will not recommend you to customers.

Furthermore, head-load carrying is a very physical job that requires a depth of strength for one to be able to engage in. The physical injuries and emotional trauma the head-load carriers experienced from their partners affected their work performances. Some remained indoors because of the physical injuries which affected their work:

> Anytime my boyfriend beats me, the following day I get pain all over my body. This has affected my health so as a result I am unable to go to work. (Abiba)

Another explanation was given by Rabi to justify why she does not work for days after an IPV episode:

> How do you expect me to go to work with bruises all over my body, the moment I come here in that state, it will be all over in my village . . . most of the workers in this market are from my village and they will tell my parents . . . my mother is not feeling well and the moment she gets to know, her condition may get worse.

Although some of the participants stayed home after experiencing IPV, some, due to financial constraints, explained that they had to go to work at all cost. However, due to the physical pains and the physically demanding nature of the head-load carrying business, they felt weak throughout the day and it affected their daily earnings:

> Even when I am beaten and in pains, I have no other option than to come to work . . . if I do not come, myself and the children will starve . . . there will be no food at home for the children . . . the problem is if I come, I struggle on the job and it affects the money I take home. (Alaba)

Atimpali, another participant, explained why she always goes to work after experiencing violence but struggles:

> You have seen for yourself the load we carry . . . they are very heavy and most times heavier than what you have seen as carrying . . . you cannot work while in pain, but you still need to come to the market—a friend may get a lot of work that day and may give you chop money . . . I do to others when they are not feeling well and cannot carry.

From the researchers' observation, the weight carried by the average head-load carrier ranged from 15 to 30 kg or more. Therefore, it would be difficult for a woman (or a child) to be efficient or successful in the head-load carrying business if she is physically, mentally, or emotionally weak. Most of the participants that were interviewed complained about how IPV has affected their strength, which has negatively affected their earnings:

> At first, I used to make a lot of money, but due to the nature of the job and my back pain I get tired early—I sometimes earn just GHC4 . . . this is when my back pains. (Abiba)

Aku's narration supports Abiba's:

> Before I got myself to this (abuse), I was very strong, I could carry very heavy loads, but now, it is not the case, I struggle with a very lighter loads and it is affecting my income.

Discussion

This study has reported findings on the effects of IPV on a locally economic migrant group (head-load carriers) at two major cities in Ghana (Kumasi and Accra). All the head-load carriers migrated from the Northern part (Northern, Upper East, and Upper West regions) of Ghana to seek better living conditions in the destination cities. However, the situation seems to have turned from bad to worse immediately after they arrived in the destination cities. First, they struggled to find decent shelter and a job. Second, they had to rely on a physically demanding job (head-load carrying) to survive. Third, after finding themselves relatively decent accommodation through their husbands and partners, their hardships intensified when they became chronically abused by these intimate partners.

The study has reported three overarching themes. These are health effects, human relationship effects, and employment effects. Almost all of the participants interviewed had experienced a trinity of IPV (physical, mental, and sexual abuse). Husbands and cohabitant male partners were the perpetrators of the abuses against the female head-load carriers who participated in this study. Our finding that men were the perpetrators of IPV against the head-load carriers who participated in this study is consistent with the tenet of the feminist theory (Dobash & Dobash, 1979) and previous studies conducted on IPV in Ghana (Diao & Sarpong, 2011) and other sub-Saharan African countries (Gage & Thomas, 2017).

However, although the above cited theory and studies have identified patriarchy and societal norms as antecedents to IPV, findings from this study have reported divergent factors. Our findings suggest that, for the head-load carriers that participated in this study, it is the idea of transactional relationships and perceived controlled behaviors exhibited by the husbands and partners that underpinned the IPV. In a study conducted in Ghana, Chirwa et al. (2018) found that women who entered into relations with the primary motive of bettering their lives were more likely to be abused by partners. In this study, most of the female head-load carriers had entered relationships in exchange for shelter. There are implications for policy and future research.

Head-load carriers, after experiencing abuse from their intimate partners, incurred physical injuries (wounds, bruises, severe body pains, headaches,

and joint pains), mental health complications (depression, trauma, and suicidal ideation), and sexual and reproductive health complications (severe pains during labor and self-induced abortions or pregnancy termination). Similar findings by previous studies conducted in Ghana on IPV have been reported (Issahaku, 2015). Furthermore, head-load carriers, in an attempt to prevent abuse from their partners, succumbed to unprotected sex which resulted in unwanted pregnancies that warranted induced abortion; most of these happened without the knowledge of their partners. In Tanzania, Stockl et al. (2012) recorded cases of induced abortions that were spearheaded by IPV. The marks, wounds, chronic body pains, and reproductive health complications that participants experienced as a result of IPV had become indelible in the head-load carriers' memories, which have affected their jobs and relationships with others.

Although health impacts of IPV have been well documented in both Ghana (Ziblim, 2013) and other sub-Saharan African countries (Durevall & Lindskog, 2015), the effects of IPV on victims' employment and human relationships are underreported. The novel contribution to knowledge represented by this study is the consequences of IPV on victims' employment and human relationships. Specific to the head-load carrying population, this is the first study that has investigated the health, employment, and human relationship effects that IPV poses. Contrary to previous studies that focused on identifying the existence and types of IPV against women (Ogum et al., 2018; Sedziafa et al., 2018) and its health consequences (Issahaku, 2015), our findings moved from just identifying health effects of IPV to throwing light on the effects these health consequences had on victims' employment and relationships with friends, customers, and coworkers. This is important because the study's population (head-load carriers) relies solely on their job for survival. As a result, any condition that may prevent them from effectively doing their jobs is a major concern which needs to be addressed.

The findings of the study regarding the effects of IPV on head-load carriers' employment and human relationships are explained by a study conducted in North America that has linked victims of IPV to future aggressive behaviors (Taylor et al., 2009). After having gone through IPV perpetrated by male partners, female head-load carriers became aggressive toward their clients and coworkers, which negatively affected their employment and earnings. Their interpersonal relationship with clients was affected and they were no longer attracting more customers as they usually did. This implies that IPV directly affected victims' jobs.

Furthermore, victims' interpersonal relationships with friends and colleagues became awkward as their husbands and partners banned them from social networking with friends and participating in social gatherings. Although

previous studies conducted in other jurisdictions on migrants found friends and coworkers to be helpful to victims of IPV (Kyriakakis, 2014), our findings on informal networking are divergent. This could be as a result of the interplay of fear instilled in victims by perpetrators, culture, stigma attached to IPV, and the ethnic minority nature of our study population. Our findings are confirmed by a study conducted by Hellemans et al. (2015) on a sample of Moroccan and Turkish ethnic minority migrants, which reported fear of stigma and causing harm to their family as reasons for their poor human relationships after experiencing IPV. These are important implications for future research.

Limitations and Future Research

Despite the insightful findings discussed above, it is important to pinpoint some methodological limitations of the study. First and foremost, we encourage transferability of the findings over generalization due to the methodological choice and sample size of the study. Second, translating interviews from Twi to the English language led to lost data. This happened because some terminologies in the Twi language were difficult to translate to their direct meaning in the English language. Nevertheless, the authors made sure that the choices of the English language used reflected the meaning of participants' accounts.

Despite the limitations, this study has made a significant contribution to the body of literature in the area of IPV, taking into consideration the effects it has on head-load carriers in Ghana. Our findings have provided information that goes beyond the identification of types of IPV to highlighting the health, employment, and human relationship effects of IPV among head-load carriers. These have implications for research and policies on survivors of IPV.

Based on the findings, future research should conduct a nationwide investigation on the indirect effects of IPV on children's health and education. Such a study should collect data on victim–child pairs to provide data that reflects the experiences of victims and children. The study has reported that head-load carriers, after experiencing abuse resulting in various health consequences, went on with their routine job activities. Future research should investigate their coping and health-seeking strategies. Finally, to date, most studies conducted on the causes of IPV in sub-Saharan Africa have limited participation to females. Given the fact that males have been identified as the perpetrators of most IPV incidents, there is the need for future studies to include males. Such a study will know from the perspective of the perpetrators why they commit IPV—leading to a more accurate conclusion on the causes of IPV.

Conclusion and Implications

IPV affects every aspect of the victim's life. It affects the complete physical and mental wellbeing of the individual who is abused. We argue that the experiences of IPV by migrant females such as the head-load carriers in this study are more severe than for the average person. Head-load carriers migrated from their families (in the Northern part of Ghana) to relatively new cities in the South (Kumasi and Accra). Aside from their migration status, most of them are children who may find themselves in abusive relationships. In addition, they are poor, uneducated, and unskilled, making it difficult to find themselves a decent job. They rely heavily on their physical strength to survive in their new cities and most often have to rely on their male partners for decent accommodation. This implies that any intervention designed to address IPV among head-load carriers must be target oriented to be able to directly address IPV against head-load carriers.

Ghana is a patriarchal community where intimate partner abuse has been culturally normalized (Issahaku, 2017). To change this social order, there is the need for the Ghana Ministry of Gender, Children, and Social Protection and the police division on Domestic Violence and Victim Support Unite to enforce the existing domestic violence policies of Ghana. Currently, the Domestic Violence Act of Ghana is broad and does not specifically target IPV. There is the need for a specialized intimate partner court that will swiftly adjudicate cases on violence perpetrated against an intimate partner. This will serve as a deterrent and mitigate the occurrences of IPV in Ghana. Furthermore, there is a need for IPV posts to be established in market centers. The center should be tasked with the responsibility of periodically educating head-load carriers about the legislation on IPV and the need to report perpetrators to the appropriate authorities.

To encourage swift reporting of IPV cases, there is the need for head-load carriers to be empowered to do so. In reporting perpetrators of IPV, victims, most often, find themselves in a dilemma: the dilemma of reporting a husband or father of their children, and survival after reporting a breadwinner. This dilemma and fear for their security have been the major reasons that prevent victims from reporting perpetrators. We recommend that head-load carriers should be provided with trade skills by the local government. This will empower the head-load carriers by building their capacity to cater for themselves, as well as their children. Also, strict and responsive measures should be put in place to protect victims, who find the courage to report perpetrators to authorities from future victimization. Doing this could encourage other victims to report abuse and deter other males from abusing their partners.

In an effort to prevent incidents of IPV perpetrated against head-load carriers, there is an urgent need for the National Migration Policy for Ghana to be revised to prohibit the migration of unaccompanied children. In this study, the majority of the participants were below 18 years and had traveled by themselves to engage in the head-load carrying business. The policymakers should ensure that children in the three Northern regions are enrolled in school or apprenticeships. Doing this will have short- and long-term implications. In the short term, the children will be occupied with school or apprenticeships, which may prevent them from migrating to the South. In the long term, the children will be equipped with knowledge and skills needed to develop themselves and their communities at large.

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References

Abrahams, N., Devries, K., Watts, C., Pallitto, C., Petzold, M., Shamu, S., & García-Moreno, C. (2014). Worldwide prevalence of non-partner sexual violence: A systematic review. *Lancet*, *383*(9929), 1648–1654. https://doi.org/10.1016/S0140-6736(13)62243-6

Adams, F. (2012). *Analysis of public health issues (including that of climate change) facing female internal migrants workers (Kayayei) in Ghana*. Ministry of Health.

Adjei, S. B. (2016). Masculinity and spousal violence: Discursive accounts of husbands who abuse their wives in Ghana. *Journal of Family Violence*, *31*(4), 411–422.

Agyei, Y. A., Kumi, E., & Yeboah, T. (2016). Is better to be a kayayei than to be unemployed: Reflecting on the role of head portering in Ghana's informal economy. *Geojournal*, *81*(2), 293–318. https://doi.org/10.1007/s10708-015-9620-z

Asante, K. O., Meyer-Weitz, A., & Petersen, I. (2014). Substance use and risky sexual behaviours among street connected children and youth in Accra, Ghana. *Substance Abuse Treatment, Prevention, and Policy*, *9*, 1–9. http://dx.doi.org/10.1186/1747-597X

Baah-Ennumh, T. Y., Amponsah, O., & Adoma, M. O. (2012). The living conditions of female head porters in the Kumasi Metropolis, Ghana. *Journal of Social and Development Sciences*, *3*(7), 229–244.

Bernard, H. R. (2002). *Research methods in anthropology: Qualitative and quantitative approaches* (3rd ed.). Alta Mira Press.

Chikhungu, L. C., Amos, M., Kandala, N., & Palikadavath, S. (2021). Married women's experience of domestic violence in Malawi: New evidence from a cluster and multinominal logistic regression analysis. *Journal of Interpersonal Violence*, *36*(17-18), 8693-8714. https://doi.org/10.1177/0886260519851782

Chirwa, E. D., Sikweyiya, Y., Addo-Lartey, A. A., Ogum Alangea, D., Coker-Appiah, D., Adanu, R. M. K., & Jewkes, R. (2018). Prevalence and risk factors of physical or sexual intimate violence perpetration amongst men in four districts in the central region of Ghana: Baseline findings from a cluster randomised controlled trial. *PLOS ONE*, *13*(3), 1–18. https://doi.org/10.1371/journal.pone.0191663

Citernesi, A., Dubini, V., Uglietti, A., Ricci, E., Cipriani, S., Parazzini, F., & Italian Aogoi Study Group on Violence on Women. (2015). Intimate partner violence and repeat induced abortion in Italy: A cross sectional study. *The European Journal of Contraception & Reproductive Health Care*, *20*(5), 344–349. https://doi.org/10.3109/13625187.2014.992516

Crandall, M., Senturia, K., Sullivan, M., & Shiu-Thornton, S. (2005). "No way out": Russian-speaking women's experiences with domestic violence. *Journal of Interpersonal Violence*, *20*(8), 941–958. https://doi.org/10.1177/0886260505277679

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed method research* (2nd ed.). Sage.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Sage.

Dhakal, L., Berg-Beckhoff, G., & Aro, A. R. (2014). Intimate partner violence (physical and sexual) and sexual transmitted infection: Result from Nepal Demographic Health Survey 2011. *International Journal of Women's Health*, *6*(1), 75–82.

Diao, X., & Sarpong, D. B. (2011). Poverty implications of agricultural land degradation in Ghana: An economy-wide, multimarket model assessment. *African Development Review*, *23*(3), 263–275.

Dicola, D., & Spaar, E. (2016). Intimate partner violence. *American Family Physician*, *94*(8), 646–651.

Dobash, R. P., & Dobash, R. E. (1979). *Violence against wives: A case against the patriarchy*. Free Press.

Durevall, D., & Lindskog, A. (2015). Intimate partner violence and HIV in ten Sub-Saharan African countries: What do the demographic and health surveys tells us? *Lancet Global Health*, *3*(1), 34–43.

Emenike, E., Lawoko, S., & Dalal, K. (2008). Intimate partner violence and reproductive health of women in Kenya. *International Nursing Review*, *55*(1), 97–102.

Erez, E., Adelman, M., & Gregory, C. (2009). Intersections of immigration and domestic violence: Voices of battered immigrant women. *Journal of Feminist Criminology*, *4*(1), 32–56. https://doi.org/10.1177/1557085108325413

Fanslow, J. (2017). Intimate partner violence and women's reproductive health. *Obstetrics, Gynaecology & Reproductive Medicine*, *27*(5), 148–157.

Gage, A. J., & Thomas, N. J. (2017). Women's work, gender roles, and intimate partner violence in Nigeria. *Archives of Sexual Behavior*, *46*(7), 1923–1938.

Garcia, L., & Hurwitz, C. (2007). Homicide and intimate partner violence: A literature review. *Trauma, Violence & Abuse*, *8*(4), 370–383.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, *368*(9543), 1260–1269.

Garcia-Moreno, C., Pallitto, C., Devries, K., Stockl, H., Watts, C. H., & Abrahams, N. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.

Ghana Statistical Service. (2014). *2010 population and housing census report: Migration in Ghana*.

Gibbs, A., Dunkle, K., & Jewkes, R. (2018). Emotional and economic intimate partner violence as key drivers of depression and suicidal ideation: A cross-sectional study among young women in informal settlements in South Africa. *PLOS ONE*, *13*(4), 1–18. https://doi.org/10.1371/journal.pone.0194885

Heidegger, M. (2010). *Being and time*. State University Press.

Hellemans, S., Loeys, T., Buysse, A., & De Smet, O. (2015). Prevalence and impact of intimate partner violence (IPV) among an ethnic minority population. *Journal of Interpersonal Violence*, *30*(9), 3389–3418.

Husserl, E. (1970). *The idea of phenomenology*. Martinus Nijhoff.

Issahaku, P. A. (2015). Health implications of partner violence against women in Ghana. *Violence and Victims*, *30*(2), 250–264.

Issahaku, P. A. (2017). Correlates of intimate partner violence in Ghana. *Sage Open*, *7*(2), 1–14.

Karakurt, G., Patel, V., Whiting, K., & Koyuturk, M. (2017). Mining electronic health records data: Domestic violence and adverse health effects. *Journal of Family Violence*, *32*(1), 79–87.

Kuhlmann, A. S., Shato, T., Fu, Q., & Sierra, M. (2019). Intimate partner violence, pregnancy intention and contraceptive use in Honduras. *Contraceptive*, *100*, 137–141.

Kwankye, S. O., Anarfi, J. K., Tagoe, C. A., & Castaldo, A. (2009). *Coping strategies for independent child migrants from northern Ghana to southern cities*. Development Research Centre on Migration, Globalization and Poverty.

Kyriakakis, S. (2014). Mexican immigrant women reaching out: The role of informal networks in the process of seeking help for intimate partner violence. *Violence against Women*, *20*(9), 1097–1116.

Lattof, S. R., Coast, E., & Leone, T. (2018). Priority and challenges accessing health care among female migrants. *Health Service Insights*, *11*, 1–5.

McClintock, H. F., Trego, M. L., & Wang, E. M. (2021). Controlling behaviour and lifetime physical, sexual, and emotional violence in Sub-Saharan Africa. *Journal of Interpersonal Violence*, *36*(15-16), 7776-7801. https://doi.org/10.1177/0886260519835878

Nyarko, S. H., & Tahiru, A. M. (2018). Harsh working conditions and poor eating habits: Health related concerns of female head porters (kayayei) in the Mallam Atta Market, Accra, Ghana. *Biomed Research International*, *2018*, Article 6201837. https://doi.org/10.1155/2018/6201837

Oduro, G. Y. (2012). "Children of the street": Sexual citizenship and the unprotected lives of Ghanaian street youth. *Comparative Education*, *48*(1), 41–56.

Ogum, A. D., Addo-Lartey, A. A., Sikweyiya, Y., Chirwa, E. D., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. K. (2018). Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: Baseline findings from a cluster randomised controlled trial. *PLOS ONE*, *13*(7), 1–19.

Olayanju, L., Naguib, R. N. G., Nguyen, Q. T., Bali, R. K., & Vung, N. D. (2013). Combating intimate partner violence in Africa: Opportunities and challenges in five African countries. *Aggression and Violent Behavior*, *18*(1), 101–112.

Opare, J. A. (2003). Kayayei: The women head porters of southern Ghana. *Journal of Social Development in Africa*, *18*(2), 33–48.

Otieku, E., Ackah, C. G., & Forkuor, D. (2017). Motivations, income determinants and livelihood vulnerability of teenage head porters in Kasoa, Ghana. *International Journal of Social Economic*, *44*(12), 2396–2408.

Owusu, L., & Yeboah, T. (2018). Living conditions and social determinants of health inequities affecting female migrants in Ghana. *Geojournal*, *83*, 1005–1017.

Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using interpretive phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne*, *18*(2), 361–369.

Reid, A., Brown, J. M., Smith, J. M., Cope, A., & Jamieson, S. (2018). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education*, *7*(2), 69–75.

Sedziafa, A. P., Tenkorang, E. Y., & Owusu, A. Y. (2018). Kinship and intimate partner violence against married women in Ghana: A qualitative exploration. *Journal of Interpersonal Violence*, *33*(14), 2197–2224.

Shamu, S., Munjanja, S., Zarowsky, C., Shamu, P., Temmerman, M., & Abrahams, N. (2018). Intimate partner violence, forced first sex and adverse pregnancy outcomes in a sample of Zimbabwean women accessing maternal and child health care. *BMC Public Health*, *18*, 1–10.

Sigalla, G. N., Mushi, D., Meyrowitsch, D. W., Manongi, R., Rogathi, J. J., Gammeltoft, T., & Rasch, V. (2017). Intimate partner violence during pregnancy and its association with preterm birth and low birth weight in Tanzania: A prospective cohort study. *PLOS ONE*, *12*(2), 1–14, e0172540. https://doi.org/10.1371/journal.pone.0172540

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method, research*. Sage.

Spangenberg, K., Wobil, P., Betts, C. L., Wiesner, T. F., & Gold, K. J. (2016). Intimate partner violence among mothers of sick newborns in Ghana. *Health Care for Women International*, *37*(5), 586–594. https://doi.org/10.1080/07399332.2015.1037444

Stockl, H., Filippi, V., Watts, C., & Mbwambo, J. K. K. (2012). Induced abortion, pregnancy loss and intimate partner violence in Tanzania: A population based study. *BMC Pregnancy and Childbirth*, *12*(12), 1–8.

Symes, L., Maddoux, J., McFarlane, J., Nava, A., & Gilroy, H. (2014). Physical and sexual intimate partner violence, women's health and children's behavioural functioning: Entry analysis of a seven-year prospective study. *Journal of Clinical Nursing*, *23*, 2909–2918.

Taylor, C. A., Guterman, N. B., Lee, S. J., & Raphouz, P. J. (2009). Intimate partner violence, maternal stress, nativity, and risk for maternal maltreatment of young children. *American Journal of Public Health*, *99*(1), 175–183.

Tenkorang, E. Y., Owusu, A. Y., & Kundhi, G. (2018). Help-seeking behavior of female victims of intimate partner violence in Ghana: The role of trust and perceived risk of injury. *Journal of Family Violence*, *33*(5), 341–353.

Tiwari, A., Fong, D. W. T., Chen, C., & Ho, P. (2013). Factors mediating the relationship between intimate partner violence and chronic pain in Chinese women. *Journal of Interpersonal Violence*, *28*(5), 1067–1087.

Tran, T. D., Nguyen, H., & Fisher, J. (2016). Attitude towards intimate partner violence against women among women and men in 39 low-and middle-income countries. *PLOS ONE*, *11*(11), 1–14. https://doi.org/10.1371/journal.pone.0167438

United Nations Department of Economic and Social Affairs Statistics Division. (2014). *Guidelines for producing statistics on violence against women-statistical surveys*. https://unstats.un.org/unsd/gender/docs/Guidelines_Statistics_VAW.pdf

United Nations Population Fund. (2012, April, 23). *Kayayee/female head porters: Improving sexual and reproductive health (SRH) knowledge and legal literacy*. Good practices, Ghana country office 5th country program (CP5) 2006-2011. https://ghana.unfpa.org/sites/default/files/pub-pdf/KAYAYEE.pdf

van Manen, M. (2017). Phenomenology in its original sense. *Qualitative Health Research*, *27*(6), 810–825.

Weber, T., & Bouman, Y. H. A. (2020). Intimate partner violence: Variations in perpetrators and treatment allocation. *Journal of Interpersonal Violence*, 35(3-4), 1012-1034. https://doi.org/10.1177/0886260517692994

White, M. E., & Satyen, L. (2015). Cross-cultural differences in intimate partner violence and depression: A systematic review. *Aggression and Violent Behavior*, *24*, 120–130.

Wolford-Clevenger, C., Smith, P. N., Kuhlman, S., & D'Amato, D. (2019). A preliminary test of the interpersonal psychological theory of suicide in women seeking shelter from intimate partner violence. *Journal of Interpersonal Violence*, *34*(12), 2476–2497. https://doi.org/10.1177/0886260516660974

Wong, J., & Mellor, D. (2014). Intimate partner violence and women's health and wellbeing: Impacts, risk factors and responses. *Contemporary Nursing: A Journal for the Australian Nursing Profession*, *46*(2), 170–179.

Yeboah, M. A. (2010). Urban poverty, livelihood, and gender: Perceptions and experiences of porters in Accra, Ghana. *Africa Today*, *56*(3), 42–60.

Ziblim, S. D. (2013). Travelling without goodbye: Coping strategies nexus of female independent migrants in Ghana. *Research on Human and Social Sciences*, *3*(3), 103–109.

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