Journal of Health, Medicine and Nursing- An Open Access International Journal
Vol.3 2014

Accessibility of Maternal Healthcare by Migrant Female Headporters in Accra

Gloria-Sheila A. Yiran[1], Joseph K. Teye[2], Gerald A.B. Yiran[3*]
1. Centre for Migration Studies, University of Ghana, PO box LG 25, Legon-Accra, Ghana
2. Department of Geography and Resource Development/Centre for Migration Studies, University of Ghana, PO box LG 25, Legon-Accra, Ghana
3. Department of Geography and Resource Development, University of Ghana, PO box LG 25 Legon-Accra, Ghana
* E-mail of the corresponding author: yiranab@gmail.com

Abstract
Accessibility to basic services such as healthcare across Socio-economic groups such as the migrant female head porters (kayayei) in the Greater Accra Region has remained an issue of concern, as public policy on health has not addressed the maternal health of the kayayei. This study was therefore done so as, to unveil the challenges that the kayayei encounter in the process of trying to seek maternal healthcare. Mixed methods were employed in the study in order to cross validate the information on the questionnaire and in-depth interviews. The research found that factors affecting accessibility of Maternal Health services by the Kayayei are geographical accessibility, financial accessibility, acceptability, constant shortage of medicines in the hospitals and many others. The results show that though there is general awareness, the above factors limited the maternal kayayei from accessing healthcare services. It was therefore suggested that government should increase the number of health facilities as well as strengthen the National Health Insurance Scheme so as to increase access to healthcare by this vulnerable and poor group of people.
Keywords: Maternal Healthcare; Migrant female head porters; Accessibility; Living conditions

1.0 Introduction

All over the world, it has been shown that migrants, especially migrant women, suffer from several problems which affect their health (Machado et al., 2009). The world Health Organisation stressed the need to give priority to healthcare of women in all migration related situations (Carballo et al., 1996). This is particularly important because the numbers of women in the migration flows are increasing and the health risk, especially those associated with maternal mortality and reproductive health, are higher for migrants (Machado et al., 2009).

As women move to other places, their reproductive and maternal health may be affected by changes in their socio-economic status, sexual behaviour and other factors related to the new environment, including access to healthcare (Carballo and Nerukar, 2001). These changes affect migrant women and make them more likely to have low income, low social support and even poor healthcare (Sword et al., 2006). Several studies in countries such as Ethiopia, Nigeria, Uganda and many others, have suggested that migrant women do not have access and knowledge on family planning services and also no information on adequate contraception methods (Carballo, 2006; Dias and Quintal, 2008; Tong et al., 1999). This leads to the under utilisation of contraceptives, making migrant women to have a lower control on pregnancy which results in a higher proportion of unintended pregnancies and possibly abortions (Puigros et al., 2008).

Globally, over five hundred and eighty thousand (580,000) women of reproductive age die from pregnancy and childbirth related complications each year (WHO, 2011). Majority of these preventable deaths occur in Sub-Saharan Africa, where poverty and other socio-economic factors affect the accessibility and maternal health services by certain groups of women.

As in many parts of Africa, Ghana has a relatively high maternal mortality rate. The Ghana Statistical Service (2007) indicated that the maternal mortality ratio was 451 per 100,000 live births. The high maternal mortality rate in Ghana has been attributed to many factors such as distance to health facilities, waiting time in the hospital and poverty (Carballo and Nerukar, 2001). The government of Ghana, in her quest to minimize the burden of health financing, introduced the National Health Insurance Scheme (NHIS) in 2001. Although this scheme improved access to healthcare, there is no evidence to suggest that it has helped to reduce the problems associated with inequalities and maternal healthcare delivery (Collins, 2003). In recent years, it has been acknowledged that the maternal mortality level in Ghana can only be reduced, if certain vulnerable groups are considered (Litchfield and Waddington, 2003). One such vulnerable group of women is poor migrant female head porters (locally referred to as Kayayei), who have moved mostly from northern Ghana to work in the cities in the south.

One factor which makes migrant female head porters (*Kayayei*) a vulnerable group regarding maternal health issues is poverty. The incomes generated from the head porting business is not enough to rent good accommodation, since their income is largely based on the generosity of their clients and not a negotiated price between the porters and their clients (Awumbila and Ardayfio- Schandorf, 2008). Therefore, some of the

Kayayei have no option than to sleep in makeshift houses such as kiosks and in front of stores and transport stations (Kwankye et al., 2007). This situation exposes them to all forms of abuses (Kwankye et al., 2007). In addition to the accommodation problem, the *Kayayei* face other problems, such as inadequate/poor sanitary facilities which predispose them to diseases such as typhoid, cholera and dysentery (Quaicoe, 2005). Antenatal and postnatal issues add more social and financial burden to their already impoverished situation. As most of them sleep outside, they are prone to sexual abuses and sexually transmitted diseases. These adversities make them susceptible to becoming pregnant and with its attendant effects. Indeed, it has been reported that about 50% of children born to the *Kayayei* at the Korle-Bu Teaching Hospital in Accra have been abandoned by their mothers (Opare, 2003). These show clear cases of high incidence of unwanted pregnancies.

Given these problems, understanding the accessibility of maternal health services by these poor women will go a long way to address their problems. It will also help in informing policy as Ghana strives to achieve the millenium development goals on maternal and child health by 2015. However, most studies on the female head porters (*Kayayei*) were largely limited to their socio-economic challenges (see Opare, 2003; Quaicoe, 2005; Yeboah and Appiah-Yeboah, 2009). This study therefore examines the livelihoods conditions of Kayayei and the extent to which they have access to maternal health services in Accra.

2. Conceptual issues

Recent studies show a changing trend of actors in the migration process. The feminization of migration is illustrated in studies on both internal and international migration of Ghanaians. In contemporary times, women move independently within and without the country for economic as well as other reasons through network of friends and other relations. This is evident in the movement of females from northern Ghana into southern Ghana to take up jobs as head porters (Anarfi, 1989; Abrefi-Gyan, 2002; Awumbila et al., 2011). Most often than not, they are usually located at market centers and lorry stations (Awumbila and Ardayfio-Schandorf, 2008). Some studies try to associate the north-south pattern of migration to the spatial inequalities in the levels of development brought about by a combination of colonial and post-independence economic policies as well as environmental factors, among other factors (Awumbila, 1997).

In the global frontiers and in fact in Ghana also, migration has transformed due to advancement in technology, social networks and easy access to information, cheap transportation costs and many other factors. These socio-economic indications are usually reflected in the pattern of migration which is in essence very important in the development agenda. Since migration occurs in and across social, economic, and political space with particular reasons and particular outcomes in the process of integration in the destination areas, as acknowledged by Sahn et al. (2002), these outcomes could either be negative or positive of which migration of the female head porters (*kayayei*) and the attendant accessibilty to maternal healthcare is not an exception. Migration, though a strategy that aims at reducing life's risks, also often creates vulnerabilities, especially for women and children which may constrain their wellbeing.

Accessibility to health services by migrants has become a contemporary issue in Ghana which many researchers have taken keen interest in. This is not just for fun, but in a bid to highlight on the serious dimension that the issue of health and migration has assumed. Some studies have investigated the maternal and child healthcare for immigrant population (Machado et al., 2009). In this research, the International Orgamisation for Migration tries to look at the needs associated with increasing migration for women as they consider access to quality healthcare as an important aspect of social exclusion and thus caring for the health needs of migrants as a human right as well as the maternal and newborn health of migrants. Other studies have also focused on equity, access to healthcare services and expenditure on health in Nicaragua (Angel-Urdinola, et al., 2008).

The term accessibility is being used ambiguously in health, and as such the definition of the term can be said to be vague since it varies across space and time (Savedoff, 2009). Some researches argue that, physical and social resources are influential when it comes to accessibility to healthcare (La Vela et al., 2004). Accessibility, according to Miller (2005), can be determined or prevented by availability, traditional medicine use and perception of quality, affordability and socio-cultural factors. The expensive nature of health, long waiting time, transportation difficulties and a host of other variables, determine accessibility to healthcare services. A review of related literature revealed that, the issue of accessibility to healthcare in general and maternal health in particular is a multi-dimensional concept in that accessibility could be measured in terms of distance otherwise being the geographical accessibility, financial accessibility which in effect looks at the income of the expectant mother. Acceptability could also be looked at in terms of the expectant mothers' own belief systems that restrict her from accessing maternal healthcare services. All these factors are captured in the conceptual framework (Fig. 1).

Fig 1: Conceptual Framework

Healthcare, in most instances, varies in space and therefore the provision, distribution and Organisation always have a spatial component. Even the population characteristic such as age, sex, income, occupation and many others are not uniform in space (Onokerhoraye, 1999). Accessibility of healthcare in every nation, to an extent, is dependent on the presence or availability of healthcare facilities. However, it must be noted that, most

countries are yet to have a definite theory that highlights how health facility distribution and location for every public health facility should be done (Barnett, 1984).

As indicated in the framework (Fig. 1), the policy and macro environment can cause deprivation which will have a trickledown effect on ill health thereby leading to greater exposure to vulnerabilities (Peters et al. 2008). This means that, since the policy and macro environment can either induce poverty or propel riches, they will have an impact on the individual's way of life and health style for that matter. Additionally, where the user of the health need is residentially located as well as the service or facility location generally have an impact on the geographical accessibility. This is because, it has been realised that, when people migrate, they do through social networks and social capital and for this reason, end up concentrating themselves at one location that they are more comfortable living since there will not be an issue of language barrier. One characteristic as pertaining to the *Kayayei* is that they are predominantly poor and as such are located in slum areas as part of their coping strategies that tend not to be favoured when it comes to the geographical distribution of health facilities even though such locations have greater populations. For instance Sodom and Gomorra in Accra is densely populated but is not privileged to have a health facility within that locality (Dugbazah, 2007). According to Mayor (2001), slum areas all over the world are geographically disadvantaged when it comes to the distribution of resources of which health resource is not an exception. This however impacts on the accessibility of maternal healthcare by the people who need the care.

The cost element in the framework is an important element when assessing accessibility of healthcare in that it has to be determined whether the patient can afford, and/or is willing to pay for the drugs that have been prescribed, as well as the services offered by the facility. These aspects of health, according to Miller (2005), has the potential of dissuading people from accessing health and resorting to other options of healthcare such as traditional medicines, which are readily found in the forests near them without any payment. Peters et al. (2008) also stressed that, it is not uncommon in countries to see the rich paying more attention to modern healthcare than the poor because in all social spaces the rich can afford much better than the poor thereby changing things to suit them considering that the poor outnumber the rich all over the world and most especially in developing countries. There is 'affordability gap' as Collins (2003) puts it. According to him, when those who need healthcare are unable to pay for, or do so due to lack of resources, then accessibility does not come into play. A study in Nigeria by Onokerhoraye (1999:20) asserts that "Private Out-Of-Pocket Expenditure (POOPE) account for over 70% of the estimated $10 per capita expenditure on health in Nigeria". This therefore causes a hindrance to healthcare accessibility.

Another variable in the framework is the availability of the resource. In most cases, the underlying factor is equitable distribution of the health resource. This was revealed in the study by Onokerhoraye (1999:16) that "the main healthcare facilities in Bayelsa State are not only poor compared to other parts of Nigeria, but there is inequity in their distribution within the state". It is one thing having the facility and another having the right type of service available to those who need it. For example, operations time, having the appropriate type of service, consultation time and a host of other factors to actually meet the growing demand of those that need the care are said to influence accessibility (Peters et al., 2008). Penchansky and Thomas (1981) found that, availability of the health resource has to do with the supply being equivalent to the demand, considering the population that desire the health. For instance, accessibility to healthcare will be incomplete, if there is the provision of the health facility but the health professionals at post are unable or lack the skill to provide the needed care.

Quality at the centre of the diagram is a diffusion of all the other variables discussed above which will either amount to an achievement or a failure of accessibility when the overall ability of the community or residents who need the care to use or despise it (The Health of Washington State, 2002). Ultimately, accessibility becomes complete when quality is achieved not only in the fields of health but also in all spheres of life as argued by Joshi (1994). However, some aspects of the conceptual frame work such as individuals and household characteristics, illness, vulnerability and others were not the focus of this research and therefore have not been explained

3. Methodology

Choosing an appropriate research strategy is one of the most difficult stages of research process. As a result of the strengths and weaknesses of both quantitative and qualitative research approaches (see Tashakkori & Teddlie, 2010; Teye, 2012), the mixed methods research design (also known as triangulation method) was used for this research. It is instructive to mention that both quantitative and qualitative research strategies were of interest to the study, so as to capture the existing social realities of accessibility of maternal healthcare services by the '*Kayayei'*.

The quantifiable data was collected by means of a questionnaire survey that allowed the generation of data that were analysed statistically to describe the level of access of maternal health services. The target population for the questionnaire survey was pregnant '*kayayei'* and nursing mothers at the Agbogbloshie market and the Madina market (Fig. 2). Theese markets are chosen because they are locations where the head porting

business thrives and also have greater proportion *Kayayei*.

Fig. 2: The study markets

Additionally, these *Kayayei* operations are based on social networks as well as ethnicity, thus the Dagombas are located at Agbogbloshie, Tema station made up of the Mamprusi whilst Madina has a mixture of all ethnic groups as depicted by some earlier studies (Awumbila et al., 2008). This is because, the Madina and Agbogbloshie areas are the places in the city with very vibrant and major markets where trading activities are brisk and people from all over the city and beyond converge to do business. Thus, when the buyers finish buying their ware, they hire the services of these head porters to cart their goods to the lorry parks for a fee, depending on the weight of the goods (Awumbila and Ardayfio-Schandorf, 2008).

For the sample size, the total population of the *kayayei* in the Greater Accra Region of Ghana is not exactly known. This is because, they come in to the region day in and day out, while others also leave, thereby making it difficult to quantify the exact number. This hinders using statistical formula to determine a sample size for the work. Consequently, a sample of seventy (70) was chosen. This was large enough for any statistical study (see Bryman, 2001), and also considering peculiar nature of the study population and the time available for the collection and analysis of data. The seventy (70) questionnaires were however further divided into two, Agbogbloshie took market forty (40) because that area was much more densely populated, as it is located at the Central Business District and had more of the *Kayayei* than any area in Accra. Thirty respondents were selected from the Madina Market located in the Ga East District of the Greater Accra Region. In view of the low level of education among the *kayayei*, the questionnaires were administered directly in the local languages by research assistants who could speak the northern languages. As the *Kayayei* were busy going about their business, a random sampling technique was used to select the participants for the questionnaire survey. The method used is consistent with previous studies (see Kwankye et al, 2007).

Regarding the qualitative methods, in-depth interviews were used to obtain data from some health practitioners and on experiences of some of the *kayayei* as well as their motivations for choice of various maternal health services. Thus, the combination of methods was done to enhance the findings, and also to examine the various dimensions of the research problem. This is in line with Devine and Heath's (1999:49) observation that "triangulation can be used effectively to explore the dynamics of complex social phenomena highlighting the multi-layered and often contradictory nature of social life". Also according to Patton (2002), triangulation is an opportunity for unveiling deeper meaning in the data. For this reason, the analysis was done based on both quantitative and qualitative data that was collected on the field.

The quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) using descriptive statistics to generate frequency tables and charts. Some cross-tabulations were done to establish the relationship between some of the variables that were considered. Qualitatively, the in-depth interviews were analysed together with the results of the semi-structured questionnaire. In some cases, direct quotations were provided to place emphasis and also to clarify assertions. Pseudonyms or nicknames were used in such quotations to protect the identity of the respondents.

4. Results and discussions

This section presents the results and discusses them. However, it starts by looking at the living conditions of the *Kayayei* as studies have shown that their living conditions have a bearing on them getting pregnant due sexual abuses of men taking advantage of them () as well as the poor conditions make them susceptible sicknesses such as cholera, diarrhea and malaria.

The study shows that, the *kayayei* live in very poor neighbourhoods which expose them to several vulnerabilities. As shown in Table 1, more than 94% of them sleep in wooden structures. They explained that their inability to raise the high rent advances charged by landlords compelled them to sleep in the wooden structures. However, each of them pay as much as GHS 2.00 a night which is equivalent to GHS 60 a month far higher than what some landlords are charging but because they pay on daily basis, they find it more cheaper than the one-time payment of two or more year advance.

Table 1 Distribution of respondents by type of living place

The respondents also added that they are crowded in these wooden structures and therefore do not sleep comfortably. Some of the kiosks accommodate as many as 10 people. The inadequate/uncomfortable rest in the night has an implication for their health, especially the pregnant or nursing mothers who have to spend the whole day toiling in the sun. They also have to overwork in order to make sufficient money for the day. Some respondents also complained of chronic body pains which could be linked to the heavy load they carry and insufficient sleep. The over-crowded wooden structures do not have places of convenience for the inhabitants. So, they either queue for the few public toilets or ease themselves in their rooms and dump the excreta wrapped in black polythene bags at any available open space or in the drains. Observations of the environment within which the *kayayei* live also revealed more sanitation problems in the areas. Some of them sit close to refuse and eat. The common sicknesses reported, that are associated with poor sanitation in their neighbourhoods are cholera, diarrhoea and malaria.

Also, their homes, especially those at Agbogboloshie, are sited in low lying areas and are often flooded when it rains. The areas also lack proper drainage systems and the few drains that are available are choked with refuse. The area therefore has some unpleasant odour. The pools of water left after rains together with the poor sanitation and chocked gutters breed mosquitoes that carry the malaria vectors. Therefore, their environment and their daily activities as well as other factors make the maternal *kayayei* vulnerable to a host of diseases and sicknesses. Although there was a general awareness of the use of treated mosquito nets, they said the crowding in the rooms make their use difficult.

The findings of this study are consistent with other studies of female head porters. It has been shown elsewhere that the female head porters get poor wages for their services and therefore have low incomes (Kwankye et al., 2007). Due to the meagre amount of money the porters make a day, they are unable to afford decent accommodation and meals (Yeboah and Appiah-Yeboah, 2009). Their poor accommodation or sleeping arrangements and environmental conditions expose them to illness and diseases such as malaria, cholera and other diseases (Yeboah and Appiah-Yeboah, 2009). Their sleeping arrangements also expose them to sexual abuses and reproductive health risk in the city. For instance, Kwankye et al. (2007) reported of some cases of rape whiles some are being lured or coerced into sexual acts for exchange of favours. These sexual activities make some of them get pregnant at some point in time.

It is obvious that the people living in these areas especially the pregnant and nursing mothers who are considered vulnerable have a lot of health problems and therefore need healthcare. Therefore their awareness of the existence of health facilities and the type of services available was assess so as to pave way for determining the accessibility of healthcare by this migrant vulnerable group of women. Awareness of the health services in one's locality as argued by Angel-Urdinola, et al. (2008) is a requirement for its consequent usage. All the 70 respondents indicated that they knew at least one hospital or clinic or pharmacy/drugstore where they could go to for maternal health services. They were further asked if they knew about the free *maternal services introduced by the government of Ghana a few years ago. As shown in Table 2, as many as 57 (81.4%) of the respondents stated that they were aware of the 'free materna'l health services available in the hospitals and clinics in the area.*

Table 2: Awareness of free maternal health services

About 18.6% of the respondents were, however, not aware of the 'free maternal' services introduced by the government. This confirms assertions by state officials that the service is popular among nursing mothers and pregnant women in the country (see Global Press Institute, 2011). An attempt was also made to find out how those kayayei *who reported knowing about the free maternal health services first got such information. To the question on how they got to know of the free maternal health services, nearly 73% reported that they got the information from hospital staff during their first antenatal visit. A few of the respondents also got to know about the existence of these services through news/advert/poster or an NHIS officials. This is an indication that the Nurses at the facilities where these people went for their antenatal are doing a lot of counseling, which is very useful to the first time mothers. It can be deduced from here that the migrant women are also aware of the existence of antennal and postnatal services at the various health facilities.*

In response to a question that sought to find out about the antenatal attendance of the kayayei, about 87% of respondents stated that they have used antenatal services at a health facility (see Table 3). In specific terms, 42 (60%) utilised antenatal services at a *hospital*. Another 24% utilised the antenatal services at a *clinic*. About 5.7% of the respondents did not attend antenatal clinics, and the 4.2% sought help somewhere. Those who had the antenatal with TBA delivered at their place of origin before coming to Accra.

Table 3: Place of antenatal attendance

Those who provided the antenatal services were largely Midwives/Nurses. In fact, about 73% of the respondents received antenatal services from Midwives/Nurses, while about 14% received it from a Doctor. Those who never attended antenatal clinic delivered at home with assistance from friends or relatives. It was also revealed that some of the Kayayei *went to the hospital/clinics occasionally. The place of delivery even shows that most of them did not use the health facilities adequately. The results of the data analysis show that, a little more than a third (34.3%, 24) of the respondents delivered their last child at home.*

Given that the hospitals and the Clinics were the safest places to receive antenatal and postnatal care, the Kayayei *who reportedly did not go to those facilities were asked to explain why they sought help from elsewhere. Here, the long hours of waiting at such places prevented the kayayei from using these facilities. In fact, even those* Kayayei *who reported that they have been seeking maternal care from the hospitals and clinics stated that the long hours of waiting is a challenge to their use of such services. It also came out that, as a result of the long hours of waiting, some of the* Kayayei *did not start antenatal attendance till they were in their eight month, when they could not work again as evidenced in a statement by Rashida:*

"I wanted to go there [hospital] when my pregnancy was just three months old, but I later changed my mind because I didn't get time. I know ehhh…. at the hospital I would be required to wait for a long time and sometimes I may have to spend the whole day before seeing the doctor. …As I needed to work to save some money so that I could use it after giving birth, I only went to the hospital when my pregnancy was in the eight

month. The Nurses insulted me for staying home so long before coming to the hospital but I took it in good faith knowing my predicament" (Rashida, 11 May, 2012).

It needs to be mentioned that, this problem of long delays at the hospitals has been with Ghana for some years now, but the situation has worsen in recent years. Indeed, the continuous deterioration of the health sector has created a situation whereby one could spend the whole day at the maternity unit queuing for antenatal service (Akabzaa et al., 2010). It has been reported elsewhere in Nigeria that there were cases when people stood in long queues for hours at antenatal clinics only to be told that the medication prescribed by the doctor is not available (Onokerhoraye, 1999). Under such circumstances these pregnant women can lose confidence in the modern health practices and therefore resort to giving birth at home.

Apart from the waiting time at the hospital, some of the Kayayei also stated that, they used other services other than the hospital/clinics because of lack of money to pay for the hospital services. Again, some of the respondents preferred traditional medicine to the hospital and this explained why they did not go to the hospitals when they were pregnant. This finding resonates with the position of the health belief model that the belief in the effectiveness of the proposed health seeking behaviour will predict the likelihood of adopting that behaviour (Rosenstock et al., 1988). Stated differently, some women believed that they could rely on herbs to protect themselves and their babies.

It is also in consonance with cultural practice in areas where these migrant women are coming from. In most of these communities, there are no health facilities and therefore maternal mothers do not attend clinics. *Kayayei,* in their places of origin, have witnessed their mothers through antenatal and postnatal periods or have gone through it using traditional methods without going to hospital and therefore finds it normal for not attending clinics. Ayishetu who deliver in her village and came to Accra a month after delivery to do head porting business said:

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

Thus, the socio-cultural practices of the people also influence their health seeking behaviour. According to World Health Organisation (1998), culture in the African continent is not woman friendly. Decision making concerning the woman, is mostly left in the hands of the man. Even though it is the woman who carries the pregnancy, decisions on her health seeking behaviour is determined by the husband or boyfriend as he is the one paying for the service. The tendency therefore to accept modern healthcare services is determined by the cultural setting of the woman and the perception of the ailment. In the setting where these women are coming from where child bearing is prestigious, pregnancy for example is not seen as a health problem or sickness. Thus they do not see the need to go to hospital/clinic unless there is a disturbance in their system. This partly explain why they only go to hospital/clinic when they feel they are sick as explained earlier and also carrying heavy load even in pregnancy. Thus, the cultural background of the people affects their health seeking behaviour as stated by Penchansky and Thomas (1981). This research confirmed that, culture plays a role in the educational level of the respondents thereby having an adverse effect on their maternal healthcare seeking behaviour. This is seen in the fact that majority of respondents were not educated because educating the girl child is not so important as compared to their male counterparts in the societies they are coming from. Though there is awareness of the health services, there is a mix of behaviour in seeking or accessing these services. Some of the factors that contribute this mixed behaviour such as financing and geographic accessibility are examined.

As discussed in the Literature review section, financing healthcare can be a constraint on the accessibility to quality healthcare service (Miller 2005). As hinted already, even though there is free maternal healthcare policy, it does not cover all the health needs of the people. Most of the drugs are not provided in the health facility but are prescribed and therefore have to be bought from pharmacies or drugstores with cash. This means that it is necessary to know the mode of financing maternal health services. The distribution of respondents according to mode of health financing is shown in Figure 3. As shown in the figure, majority (55.7%) of the women receive money from their spouses to pay for the maternal health services.

Fig. 3: Mode of Healthcare financing by respondents

Only 27.2% of the respondents use the national health insurance scheme to finance their maternal health services. The main reason why a significant proportion of the women did not register under the National Health Insurance Scheme was lack of money for the premium. The expensiveness of the premium is not because it is so high but by the time they accumulate money to the tune of the premium (GHS 40 or so), other pressing needs come and money is used for that. Thus, it is bordering on priorities. However, although the premium of the insurance scheme is seen as being expensive, the money spent on healthcare eventually will far exceed the premium. It was also revealed that some of those who initially registered with the scheme were not using it again, since they did not have enough money to renew the scheme. Another reason was that during the period they registered, they never felt sick, so their money went wasted, thus the low priority place on renewing. Others stated that most of

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

An in-depth interview with a health official in charge of maternal healthcare at the Legon Hospital, a facility that also serves the Madina community where some of the *Kayayei* reside and operate, revealed that maternal health is rarely accessed by the *Kayayei* considering the cost involved: "*I do not see how maternal health will be accessible to the kayayei in this hospital considering the kind of job they do and the expected income and that the hospital is located outside of the community and therefore some may not know of it and come for the services"* (Health Official, May 20, 2012). According to her, Legon had also suspended the use of National Health insurance and therefore healthcare services at Legon were cash and carry. Responding to questions on how much a prospective mother needed to be able to access delivery service, she said that for delivery, an initial deposit of GH¢ 200.00 is required before the commencement of service. The total cost however depends on the complexity of the delivery but is usually more than the deposit charged. They also have to provide other things like enema pumps, gloves, cloths, sanitary materials, etc which increases the cost. The cost of delivery is therefore too high for the *Kayayei* considering the fact that they and their husbands are in the low income bracket. As stated already, about 34% of the respondents were delivered at home, and they cited the high cost of delivery at a health facility as the major reason for choosing to deliver at home. This means that even some of those who went to the hospital for antenatal services ended up delivering at home. Thus, majority of the respondents finance their healthcare from their pocket, relying heavily on the pockets of their partners. Although more than 57% of respondents admitted that their husbands/boyfriends take full care of their health finances, the women reported that their partners were sometimes unable to bear the full cost of healthcare. The findings here therefore lend much credence to the assertion of Peters et al. (2008) that financial constraints is one of the factors that prevent women using maternal health services.

As indicated earlier, finance is another factor that determines one's accessibility to healthcare since healthcare comes with some cost. This assertion is in line with those of Wyss (2003) and Miller (2005). The results gathered from the research show that, one's income determines the kind of healthcare facility to patronize. One of the respondents in the in-depth interview had this to say when answering the question on how income determines the kind of healthcare she seeks:

> "*if the money I have can only afford for the drugs and cannot pay for consultation, the best place is to go to the drug store and describe what is wrong with you"* (Mariam, May 19, 2012).

Most of the respondents also argue that, even though the *free maternal* health services was introduced by the government of Ghana, technically, maternal health service is not completely free of charge because, they still needed money to access health since most of the drugs and some laboratory tests and other charges are paid for by them and also for transportation to the health facility. On this, Mariam lamented that:

> *"It is said that maternal health is free, but when I went to deliver, I was made to provide examination gloves and many other items before they process me for delivery and when I was discharged these items were included in my bill and I had to pay. This therefore doubled the cost of delivery"* (Field work, 2012).

This supports the argument made by some researchers that the informal fees that are paid in the hospitals influence the health seeking behaviour of people (Gertler and Van der Gaag, 1998). Due to the fact that, the kayayei are low income earners, some of them are unable to finance the premium of their national health insurance which also helps in reducing the cost of healthcare. Even some of those who are able to pay the premium the first time have problems renewing because of low income and other equally competing demands such as food, rent and taking care of the health and educational needs of their children among other needs. According to the respondents, financing the premium of the health insurance is also dependent on the income that one is able to make. This brings about the issue of inequality in access to healthcare since women with higher socio-economic background are more likely to frequently seek maternal healthcare than their counterparts in the lower socio economic groups even in global situations (Ghana Statistical Service, 2007).

On the part of geographic accessibility, indicators such as availability and waiting time were used. Although the availability of the facilities was not measured directly, it can be deduced from the responses that the health facilities particularly hospitals and clinic were not actually accessible. As indicated earlier, the long queues and times spent in the hospitals discouraged the respondents from going to the health facilities. This means that the facilities were not enough and the fact that they had to move to other communities indicates that the services were not available to them in their communities. Those who delivered in their place of origin were from communities with no health facility and the distance to the nearest health facility coupled with lack of appropriate transport made it difficult for them too access antennal and postnatal services. The results gathered shows that most of the health facilities were geographically inaccessible to these poor women. Only 11.4% of respondents stated that they lived close to a health facility, implying that most respondents travel long distances to attend antennal and postnatal services. In fact, 60% of the respondents complained of the distance to a health facility as a challenge to their use of maternal health services. Some of the women who delivered at home also

explained that the distance to a health facility was one of the reasons why they delivered at home, instead of going to the hospital. According to the respondents in Accra central (Agbogboloshie), for instance, there is only one health facility in James-Town where they attend clinical service and this facility is more than 2 km away from them. They therefore have to take a car and sit in traffic or walk that long distance to get to the facility. Given the fact that these are very poor people, who cannot hire a taxi cab, the long distance to health facilities is a serious challenge to their use of the facilities. These findings support what has been noted in the literature that long distance is one of the factors that affect accessibility to healthcare service in many developing countries (Ramachandran 1989; Shan et al., 2002). Most of the respondents also live in slums which do not have health facilities. For example, all the respondents at the Accra business area live in Sodom and Gomorrah (a slum) which according to Dugbazah (2007) is not privileged with a health facility. This confirms what Mayor (2001) stated that slum communities all over the world are disadvantaged when it comes to the distribution of health facilities. Thus health facilities are not present at the user's location which affected their accessibility.

5. Conclusion

The migrant female head porters and their husbands are mostly not skilled and find themselves doing menial jobs and do not generate enough income to take care of their basic needs. Thus, their living conditions left much more to be desired as they lived mostly in slum areas at the destination with poor housing and sanitation. Most of them live in wooden structures which are overcrowded and located in low lying areas that are prone to flood. Due to lack of planning in these slums, the sanitary conditions are so bad that some of these people usually sit close to refuse dumps and public toilets whilst eating with flies hovering around them which have health implications. This is related to the individual and household characteristics of the health belief model of peters et al. (2008). Their work also entailed carrying heavy load and walking all day and this also pose health risk to them especially the pregnant women. These living conditions make them especially the maternal mother prone to diseases and illnesses (Fig. 1) and therefore need to have access to healthcare. However, their location and economic situation of the *Kayayei* make it difficult for them to have access to quality healthcare. This is because these migrant women live in slums which do not have health facilities. Dugbadza (2007) saw this as a characteristic of slum dwellings. The migrant porters therefore have to travel more than 2km either on foot or by car to the nearest facility. The lack of health facilities in the slums where these people find themselves is an indication of non-availability of the facilities and services at the user's location which limits their geographic accessibility as elucidated in the conceptual framework (Fig. 1). Some also delivered in their places of origin which do not have healthcare services.

Another and perhaps the most important factors seen in this study is finance. The economic situation of these *Kayayei* make healthcare not affordable to them. The respondents complained of the expensive nature of health services in the country which they saw as a major hindrance to their accessibility of healthcare. This is related to the costs and prices component of financial accessibility (Fig. 1). Long queues and waiting time also limited the accessibility to healthcare services.

Therefore policy makers and major players in the health sector should consider improving access to healthcare especially to slum dwellers if they are to move up the ladder of attaining the Millennium Development Goals by 2015. This can be done by making health facilities and services available and reducing the cost of health through strengthening the health insurance system. More educational/public health campaigns should be done to change the attitudes and negative cultural practices of the people that hinder accessibility healthcare. In this regard the campaigns should focus on the need to attend antenatal and postnatal services and to constantly renew the health insurance card whether the holder has used it or not and this should be nationwide so us to sensitise migrants and potential migrants.

References

Anarfi, J., Kwankye, S., Ofuso-Mensah, A. & Tiemoko, R. (2003) *Migration from and to Ghana: A background paper*. Working Paper C4. Brighton, U.K.: Development Research Centre on Migration, Globalisation and Poverty.

Angel-Urdinola, D., Cortez, R., and Tanabe, K. (2008) Equity, Access to Healthcare Services and Expenditure on Health in Nicaragua, HNP Discussion Paper.

Awumbila, M. (1997) Internal migration, Vulnerability and Female Porters in Accra, Ghana. Downloaded from http://paa2007. Princeton.edu/download.aspx? sumissionld=70865

Awumbila, M. & Ardayfio-Schandorf, E. (2008) Gendered poverty, migration and livelihood strategies of female porters in Accra, Ghana. *Norwegian Journal of Geography* 62 (3): 171–179

Awumbila, M., Alhassan, O., Badasu, D., Bosiakoh,T., & Dankyi, E. (2011) Socio-cultural dimensions of migration in Ghana . Center for migration studies, migration studies technical paper series, technical paper No. 3.

Awumbila, M., Manuh, T., Quartey, P., Tagoe, C.A. & Bosiakoh, T. A., (2008) "Migration Country Paper (Ghana)". Paper prepared as part of the African perspectives on human mobility programme, generously founded by the MacArthur Foundation.

Barnett, J. R. (1984) "Equity, Access and Resource Allocation: Planning Hospitals Services in New Zealand" *Social Science and Medicine,* Vol. 18, pp.981-989

Bryman, A. (2001) *Social research methods*. London, England: Oxford University Press.

Carballo, M. (2006) Female migrants, reproductive health, HIV/AIDS and rights of women. In UNFPA/IOM, *Female migrant: Bridging the gaps throughout the life cycle*. New Yrk. UNFPA

Carballo, M., Grocutt, M. & Hadzihasanovic, A. (1996) Women and Migration: A Public Health Issue. *World Health Stat Q*, 49(2): 158-164

Carballo, M. & Nerukar, A. (2001) Migration, refugees and health risks. *Emerging infectious diseases.* 7(3 Suppl.) 556-560

Colins, T. (2003) Globalization, global health, and access to healthcare. *International journal of health planning and management*. 18:97-104.

Dias, S. & Quintal, F. (2008) Cultural Dynamics in Mental and Reproductive Health of Immigrant women in Portugal. *European Journal of Public Health.* 18 (suppl. 1).

Devine, F., & Heath, S. (1999) *Sociological research methods in context*. Basingstoke, England: Palgrave Macmillan.

Dugbazah, J.E. (2007) Gender, Migration and Rural Livelihood in Ghana. A Case of the Ho District.

Ghana Statistical Service (2007) Ghana Maternal Health survey, Accra.

Gertler, P.J., Locay, L. and Sanderson, W. (1998) Are user fees regressive? The welfare implications of healthcare financing proposals in Peru. In P. Gertler, L. Locay, W. Sanderson, A. Dor, and J. van der Gaag, (eds.) *Healthcare financing and demand for medical care* LSMS working paper No. 37. Washington, D.C.: The World Bank48

Joshi, A. R. (1994) Maternal schooling and child health: preliminary analysis of the intervening mechanisms in rural Nepal. *Health Transition Review* 4:1-28.

Kwankye, S.O., Anarfi, J.K., Tagoe, C.A. and Castaldo A. (2007) Coping strategies of independent child migrants from Northern Ghana to Southern cities. Development Research Centre on Migration, Globalisation and Poverty. *Arts* C-226, University of Sussex Brighton BN1 9SJ

LaVela, S. L., Smith, B., Weaver, F.M., and Miskevics S. A (2004) Geographical Proximity and Healthcare Utilisation in Veterans with SCI and D in the USA. Social Science and Medicine, 59:2387-2399.

Litchfield, J., and Waddington, H. (2003) Migration and poverty in Ghana: Evidence from the Ghana Living Standards Survey. Sussex Migration Working Paper No.10, Brighton, U.K.: Sussex Centre for Migration Research.

Machado, M.C., Fernandes, A., Padilla B. Dias, S. Gomes, I. and Oliveira da Silva, M. (2009) Maternal and Child Healthcare for Immigrant Populations. International Organisation for Migration (IOM). A background paper. Developed within the framework of IOM project "Assisting Migrants and Communities (AMA):Analysis of Social Determinants of Health and Health inequalities".

Mayor, S. (2001) Poorest women 20 times more likely to die in childbirth. *British Medical Journal*, 323,

Miller, P. (2005). Barriers Preventing Access to Healthcare Services For Women in Rural Samoa, a Thesis Presented to the Faculty of the Centre for International Studies of Ohio University.

Onokerhoraye, A. G. (1999) Access and utilisation of modern Healthcare facilities in The Petroleum Producing Region of Nigeria: The case of Bayelsa State , A Research Paper no. 162, Takemi Program in international Health, Havard School of Public Health, 666 Huntington Avenue, Boston, MA02115 (617)4326686.

Opare, J.A. (2003) Kayayei: the women head porters of southern Ghana. *Journal of social development in Africa.* Vol. 18, No. 2

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publications.

Penchansky, R. and Thomas, W. (1981) The concept of Access to Medical Care, 19(2), 127-140.

Peters, D.H., Garg, A., Brieger, W.R., Bloom*, G.,* Walker, D.G and Rahman, M.H. (2008) Poverty and Access to Healthcare in Developing Countries. *Ann. N.Y. Acad. Sci*. 1136: 161–171 (2008).doi: 10.1196/annals.1425.011

Puigros, M., Volta, C., Eseverri, I., Colomer, J. and Barnusell, J. (2008) Immigrant Pregnancy and Neonatal Morbidity. *Anales des Pediatrias (Barcelona)*. 68(6):596-601.

Ramachandran, L. (1989) THE Effect of Antenatal and Natal Services on Pregnacy Outcome and Health of the mother and child. *Journal for Family Welfare* (35(5), 34-46.

Sahn, D. E., Younger, S. D., Genicot, G. (2002) The Demand for Healthcare Services in Rural Tanzania

Savedoff, W. D. (2009) A Moving Target: Universal Access to Healthcare Services in Latin America and the Caribbean, Inter American Development Bank, Banco Interamericano De Desarrolo (BID), Research Department, Department De Investigation,Working Paper #667.

Sword, W., Watt, S. and Krueger, P. (2006) Postpartum health services needs and access to care experience of immigrants and Canadian-born women. *Journal of Obstetric, Gynecology and Neonatal Nursing.* 35(6): 717-727.

Tashakkori, A., & Teddlie, C. (2010) Putting the human back in human research methodology: The researcher in mixed methods research. *Journal of Mixed Methods Research*, 4(4), 271-277.

Teye, J.K. (2012) Benefits, Challenges, and Dynamism of Positionalities Associated With Mixed Methods

Research in Developing Countries: Evidence From Ghana *Journal of Mixed Methods Research* XX(X) 1–13 http://www. sagepub.com/journalsPermissions.nav DOI: 10.1177/1558689812453332 http://jmmr.sagepub.com
The Health of Washington State(2002) *Access to Primary Healthcare Services*. Washington State Department of Health, USA.
Tong, C., Chen, J. and Cheng, L. (1999) Survey of causes of induced abortion in Shanghai. *Shanghai Medical Journal.* 22(6): 345-353.
WHO (2011) making pregnancy safer,
www.who.int/making_pregnancy_safer/topics/maternal_mortality
Wyss, K. (2003) Access of the Urban Poor and Vulnerable to Healthcare in Africa. Switzerland: Swiss Agency for Development and Cooperation.
Yeboah, M.A. and Appiah-Yeboah, K. (2009) An Examination of the Cultural and Socio-Economic Profiles of Porters in Accra, Ghana. *Nordic Journal of African Studies 18(1): 1–21 (2009)*

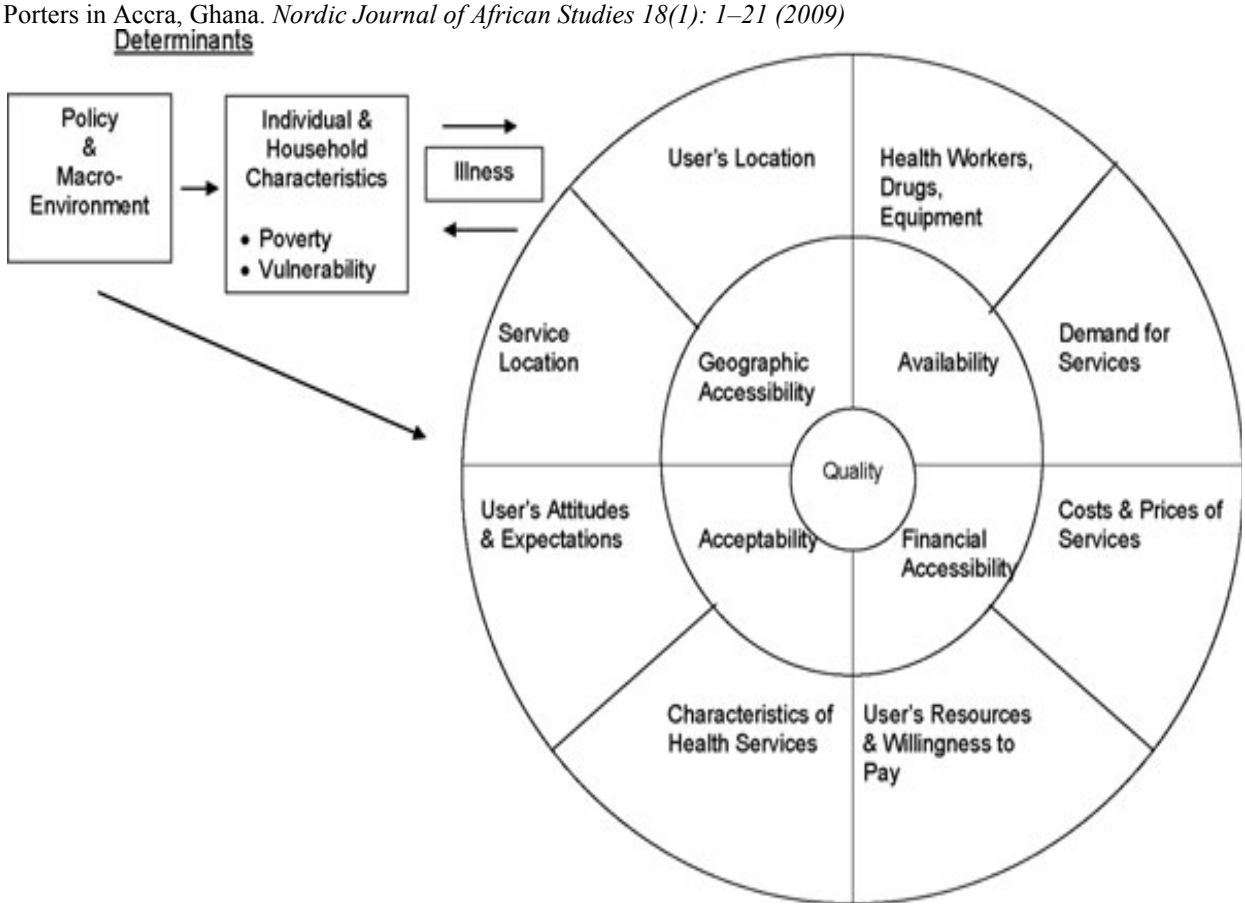

Fig. 2.1: Conceptul framework for assessing access to health services

Source: Adopted from Peters et al. 2008)

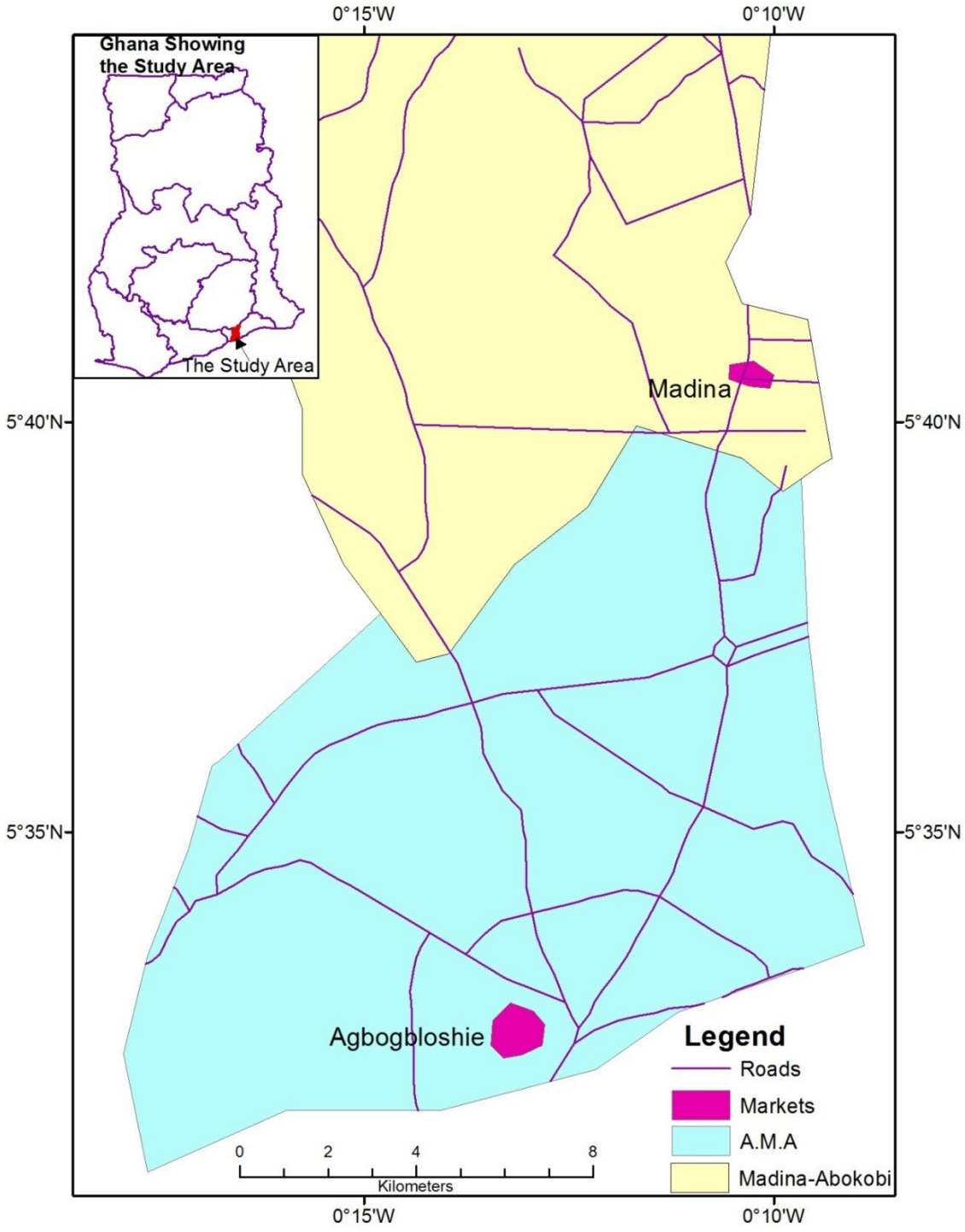

Fig. 3.1 Map of the Study Area

Source: Composed with data from Survey of Ghana

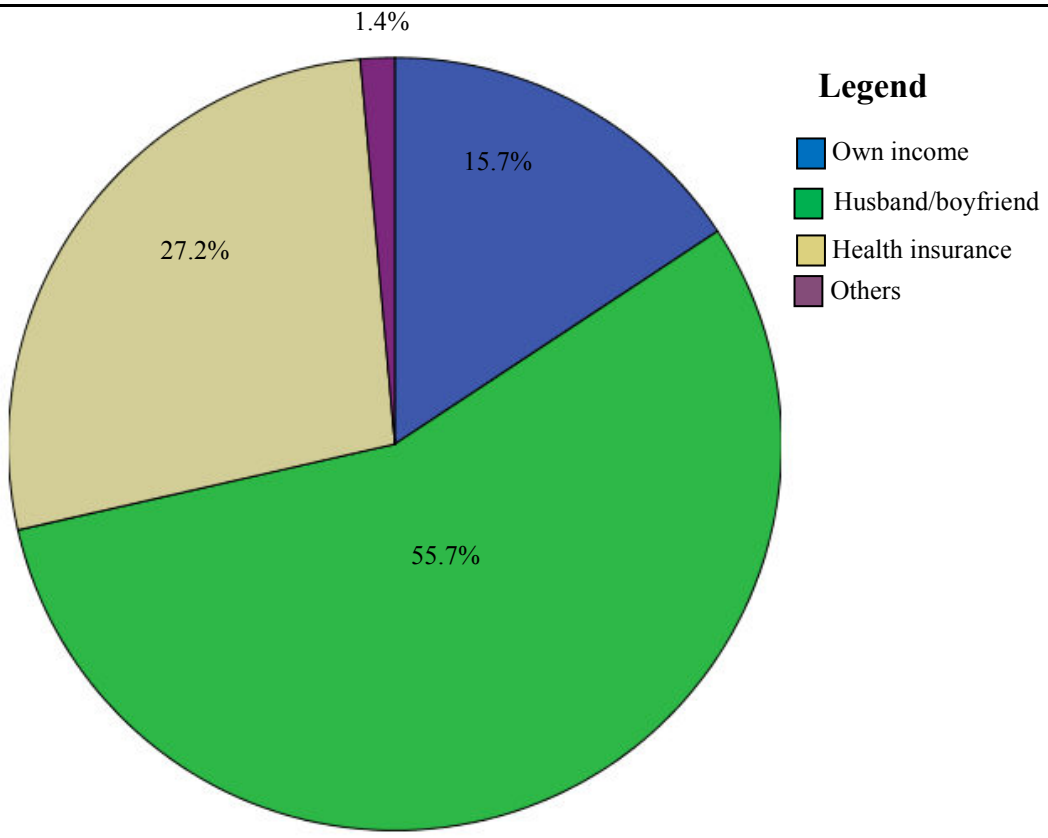

Fig. 3: Mode of Healthcare financing by respondents
Source (Fieldwork, 2012)

Table 1 Distribution of respondents by type of living place

Living place	No. of respondents	Percent
House	3	4.3
Wooden structure	66	94.3
Lorry Station	1	1.4
Total	70	100.0

Source (Fieldwork, 2012)

Table 2: Awareness of free maternal health services

Awareness of free maternal services	Number of Respondents	Percent
Yes	57	81.4
No	13	18.6
Total	70	100.0

Source (Fieldwork, 2012)

Table 3: Place of antenatal attendance

Place of antenatal attendance	No. of respondents	Percent
Hospital	42	60.0
Clinic	19	27.1
TBA	2	2.9
Other	3	4.2
Did not use any facility	4	5.7
Total	70	100.0

Source (Fieldwork, 2012)