

**MIGRANT HEALTH CARE PRACTICES: THE PERSPECTIVES OF WOMEN
HEAD PORTERS IN KUMASI, GHANA**

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Dedication

To the hardworking Northern Ghanaian migrant women porters,
for taking time off their busy schedules
to share their stories of migration and health seeking with me.

Abstract

This thesis seeks understanding of how gender, as a system of power, facilitates, constraints, determines, and impacts not only women's migration, but more significantly, women's access to health services post migration in contemporary Ghana. Drawing on the stories of women head porters, via the application of the principles of feminist standpoint theory, I explore women porters' experiences as deeply embedded in social and power struggles that women did not create, but yet find binding on their lives. Women porters discuss financial struggles, negative encounters with health staff, and the hurdles of dealing with the power that men exert over their decisions and actions as barriers that limit their access and utilization of health services. They also speak of strategies they adopt to challenge the barriers. The findings of this study indicate that the broader social struggles that disempower women persist in contemporary Ghana. Practical, sustainable suggestions for change are offered.

Acknowledgements

Wow, my journey of a thousand miles has finally ended. What a challenging, life-changing, yet gratifying and rewarding experience this has been for me. The lessons learned in this journey are for a lifetime, and for that, I reserve a special **Thank You** for the 12 women porters whose stories formed the bedrock of this scholarship. I share your stories and your struggles every single day.

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Chapter One:

Migration and Health Research

Migration from rural to urban Ghana is fundamental to broadening waged employment opportunities for less affluent Northern women. Even though migration is not unique to a particular group or gender nor to a class of people (Bonifacio, 2012), the most dominant, widely acknowledged, reproduced, and prevailing image of migration, over a century ago, was that of “the lone, rugged male” (Pessar & Mahler, 2003, p. 822). Women who were migrants in their own right were classified as followers of men (Abdul-Korah, 2003; Awumbila & Ardayfio-Schandorf, 2008). However, in the last two decades, the dominant image of migration is no longer that of the single male, but rather of the independent female (Awumbila & Ardayfio-Schandorf, 2008; Pessar & Mahler, 2003). In the twenty-first century, women account for approximately half of all migrants globally (Bonifacio, 2012). This phenomenon is identified as the “feminization of migration” (D’Ávila Neto, Durand-Delvigne, & Nazareth, 2012, p. 209).

In Ghana, feminized migration is also prominent, characterized by independent labour migratory flows of female youths from Northern rural to Southern urban cities such as Kumasi to escape poverty (Agyei, Kumi, & Yeboah, 2015) by engaging in waged work (Yeboah, Owusu, Arhin, & Kumi, 2015). The recent increase in the independent outmigration of women in Ghana has resulted in the feminization of certain categories of urban labour (Awumbila & Ardayfio-Schandorf, 2008). The most notable feminized labour category that has directly resulted from rural-to-urban feminized migration flows in Ghana has been female head portering (Opare, 2003; Yeboah et al., 2015).

Scholarly focus on this recent increase in the independent outmigration of women from rural to urban Ghana has allowed for an understanding of exactly how migration impacts women's lives and wellbeing. Understanding this dynamic is vital because the effects of migration on women, particularly on their health, are uniquely different from men. The intent of this thesis was, therefore, not to merely document or highlight the increasing feminization of migration within Ghana nor to "ask the same questions of immigrant women that are asked of immigrant men" (Hondagneu-Sotelo, 1994, p. 3).

Through the research for this thesis, I sought an in-depth understanding of how gender, as a system of power, facilitates, constrains, determines, and impacts not only women's migration, but also, more significantly, their access to health services post migration. Understanding the subtleties of gender's impact on women's migration and access to health services is imperative because Ghanaian women's migration and health seeking are not solely influenced by poverty and regional developmental differentials, as authors such as Opare (2003) have argued, but also by deep-rooted historical, cultural, and socially constructed gender norms that empower men and disempower women (Haar, 2009).

Northern Ghanaian men's disproportionate empowerment promotes inequalities that permeate several aspects of women's lives, including but not limited to their migration and health seeking (Haar, 2009). For instance, within rural communities in Northern Ghana, socially constructed gender norms impact, shape, and ultimately determine every facet of women's health-seeking decisions (Adongo, Phillips, & Binka, 1998; Ngom, Debpuur, Akweongo, Adongo, & Binka, 2003). As Adongo et al. (1998) observed, the cultural practices, social norms, and the gendered division of labour within

Northern Ghanaian communities have ensured that men are the heads of every household. In this privileged social position, Northern men regulate all aspects of women's migration and health-seeking decisions. As Adongo et al. further observed, the seriousness of an illness within a woman's body is consistently evaluated by the men within her household (e.g., father, husband, uncle, etc.). That is, male relatives, rather than the (sick) woman decide whether her illness warrants care seeking and, ultimately, the type of care that it merits (i.e., allopathic or traditional).

Employment and income, social norms, gender roles, and labour market conditions prevailing within Northern Ghana have also severely limited women's occupational opportunities in comparison to men (Harr, 2009). Women's limited waged employment opportunities result from the fact that they are expected to be responsible for almost all non-waged activities within and outside the household (Dejene, 2008; Haar, 2009). As a consequence, most rural Northern Ghanaian women are often bereft of any choices other than to be economically dependent on fathers and husbands. The impact of less affluent Northern Ghanaian women's dependence on their men is diverse and has been documented by several scholars.

For instance, Adongo et al. (1998) observed that Northern women's economic dependence on the benevolence of men had a tremendous impact on their health and wellbeing. The authors highlighted that rural Ghanaian women sought care less frequently than men. The authors reasoned that women's low patronage of health services was mainly due to their complete dependence on the financial, economical, and social resources (i.e., assets) of men. Similarly, Ngom et al. (2003) found that among the Kassena-Nankana of Northern Ghana, women (notably, less affluent, uneducated rural

women) possessed no authority in their health-seeking decisions. According to Ngom et al., Kassena-Nankana women's decisions to seek health care did not rest with the women themselves, but on "compound heads and husbands [who] impede women's prompt access to modern health care" services (p. 24). It is reasonable then to assume that Northern Ghanaian women, especially less affluent women in rural areas, are less empowered to make independent decisions relative to their male kin (Haar, 2009). The question that begs answering, however, is whether women migrants become empowered to make independent decisions in regards to their health and wellbeing when they migrate for labour independent of male relatives. Through this study, I have provided insights into this question.

Through this study, I aimed to evaluate Northern Ghanaian women's health-seeking behaviours, post-urban migration, to understand how women utilize available health services when the need arises. Understanding this dynamic is important because health gives value to women's lives (Sen, 1999). For Ghanaian women, especially Northern migrants who are less affluent, being healthy empowers them to strive for social and economic self-sufficiency. As one research participant, Sharon, reflected,

Being healthy is everything to me, my health is my everything. When I wake up in the morning, and I don't feel any pains, headache or tired, it means that I can go to work. I can make money for myself and my family.

Sharon's perspective demonstrated that good health enabled her to participate in the social and economic opportunities that the Ghanaian urban environment afforded. As well, in the rhetoric of the nation state, a healthy Ghanaian woman contributes significantly to the socio-economic wellbeing and development of her immediate family as well as the nation at large; thus investment in women's health might be seen as of

interest to Ghana at a national level. On this basis, migrant women's health, health-seeking behaviours, and access to health services warranted investigation from a combined perspective of histories and sociology of migration and health studies.

Indeed, over the past two decades, researchers and policy makers have recognizably attended to the health and wellbeing of women in modern society (Currie & Wiesenberg, 2003; Palmer, 2006; Roudi-Fahimi, 2003; World Health Organization [WHO], 2013). Less-privileged migrant women have been of particular scholarly interest (Abdul-Korah, 2011; Anarfi, 1993; Arango, 2000; Bonifacio, 2012; Hondagneu-Sotelo, 2000; Hong, 2009; Piper, 2010; Saunders, 2011; Van den Berg, 2007; Van der Geest, 2011). Through my study, I reviewed with earlier scholarship, and consequently, I argue that health research that informs public policy should not merely be cognizant of the recent paradigm shift in migratory trends, but that health research should also account for gender as a relation of power that impacts women's health choices and behaviours. As only a few gendered migration studies specific to Ghana currently exist, it was my hope that findings from my study would rekindle discussions and further research on the structural and gendered dynamics inherent in women's migration and health seeking behaviours.

Study Objectives and Rationale

Through the research for this thesis, I examined the healthseeking behaviours and health services utilization of less affluent Northern Ghanaian migrant women, working as head porters within the informal economy of Kumasi, a city in Southern Ghana. I also examined the factors behind the decision(s) of these women to migrate to become head porters. On the basis of these objectives, I developed questions that explored the

perceptions and lived experiences of women porters regarding their working and living conditions, their perceptions and understanding of health, their health-seeking behaviours, and their health service utilization within the urban space. Drawing on the principles of feminist standpoint theory (Harding, 1987, 2004; Hesse-Biber, 2014; Smith, 2005; Wolf & Deere, 1996), I adopted a position of inquiry that centred the experiences, hence voices, of women porters at the heart of this thesis. I employed a feminist standpoint theory because empirical research, exclusively grounded on the real lived experiences of marginalized groups such as women porters, had the potential to provide a much clearer picture of the gendered structural restraints that not only shape Northern Ghanaian women's migration experiences, but also hinder their ability to attend to their health. Engaging marginalized women as "knowers" (Balfour & Comack, 2014, p. 25) in this thesis helped produce an enhanced understanding of their lives, struggles, and successes regarding their migration and health-seeking behaviours.

Theoretical Framework

By using the principles of feminist standpoint theory (Harding, 1987, 2004; Hesse-Biber, 2014; Smith, 2005; Wolf & Deere, 1996), I situate the experiences of women at the centre of this research. Despite the potential value of including men (i.e., male porters) in my research, I decided to exclusively focus on the lived experiences of women porters. This stance was supported by Devine and Heath (as cited in Gatrell, 2006), who argued that feminist research must give "priority to the voices of the less powerful and the marginalized . . . women" (p. 240). Therefore, I began this research with a zeal to "understand[ing] the complex world of lived experience from the point of view of those who live in it [i.e., the women head porters]" (Baily, 2012, p. 68).

I quickly realized the most efficient way of truly understanding a socially constructed world is to examine it from within (Hesse-Biber, 2014) and, in this case, via women's lived experiences. More importantly, feminist theories demand that research for, rather than about, women must ask new questions in order to uncover social relations that deny the lived realities and experiences of women. This approach is also emancipatory, so as to enable women to be active agents in their own right. Feminist theoretical approaches pay attention to women's ways of knowing and grant presence to women's lived experiences via methods that promote access to the oft-neglected voices of women, which then help bring to the fore "voices that are often excluded from knowledge production and policy making" (Wambui, 2013, p. 2). My overall objective was to place less affluent Northern Ghanaian migrant women as *knowers* at the heart of this research, in order to produce an enhanced understanding of their lives, struggles, and successes (Balfour & Comack, 2014, p. 25).

In so doing, I concurred with Dorothy Smith, Sandra Harding, and other feminist scholars who emphatically stressed that feminist research must begin with women's lives (Harding, 2004; Rishani, 2014; Smith, 2005). Consequently, my research began with an interest in the lives and experiences of Northern Ghanaian migrant women, who have been described by several authors as the most marginalized in Ghana's urban sector (Agyei et al., 2015; Opare, 2003; Van den Berg, 2007). From their lives, I sought to uncover accounts of not just their marginalized social positions, but also the experiences of those who occupy more privileged positions (i.e., male relatives) within these social relations (Harding, 2004; Hesse-Biber, 2014). Like Hesse-Biber (2014), my argument finds roots in the notion that woman's material and lived experiences informs their

understanding of their social environment. For example, I believed migrant women's perspectives on migration, living and working conditions, and health seeking within the Ghanaian urban context would not only be insightful, but would also strengthen participants' objectivity because of their increased motivation to understand both their world and the world/perspectives of those in positions of power (Hesse-Biber, 2014). Uncovering the lived perspectives and experiences of the most marginalized within Ghana's urban sector (i.e., women porters) would bring into purview the nature, extent, and effects of such uneven power relations.

My research, in part, challenged the silences in mainstream research in relation to how women's issues are studied, how such studies are undertaken, and how women's stories are told and represented (Letherby, 2003). The following principles of feminist standpoint theory were most influential to my perspectives in this thesis (Bowell, as cited in Rishani, 2014):

1. Knowledge is socially situated;
2. Marginalized people or groups become socially embedded in social relations that make it more possible for them to be conscious of their surroundings and issues affecting them than non-marginalized groups;
3. Research focused on power and power relations must begin with the lives of the marginalized. (p. 91)

As noted by Harding (2004), these standpoint principles challenge the established and mainstream

androcentric, economically advantaged, racist, Eurocentric, and heterosexist conceptual frameworks [which] ensured systematic ignorance and error about not only the lives of the oppressed, but also about the lives of their oppressors and thus about how nature and social relations, in general, worked. (p. 5)

In so doing, this research aimed to "study up" (p. 6) by making central the *capture* and analysis of the lived experiences and voices of a small sample of less affluent

migrant Northern Ghanaian women. These women offered invaluable “critical insight” (p. 7) via one-on-one in-depth interviews, which served as my “point[s] of entry” (Smith, 2005, p. 10) into the lives of these women porters. Their perspectives revealed how women’s migration and health-seeking experiences are influenced by multiple social relations in both rural and urban Ghana. It was imperative for this study to highlight the impact of social relations because the lives of less affluent Northern Ghanaian women do not exist in a vacuum, but are indeed rooted in, influenced, and shaped by uneven social power relations present in their families and home regions as well as in urban settings. These women are embedded in unequal social relations with family, friends, customers, and health practitioners, among others. These relationships do not lie within their control, but remain influential in their daily choices and decisions.

Standpoint theory was relevant to this thesis because the voices of Northern Ghanaian women, particularly less affluent women, have been absent in scholarly research and the women are subordinate to the more dominant men in their lives (i.e., fathers, husbands, or other male kin). These male relations have consistently represented them, and spoken for them, on and about these women’s experiences (Ngom et al., 2003). As Ngom et al. (2003) and Yakong, Rush, Bassett-Smith, Bottorff, and Robinson (2010) observed, women from rural Ghana are rarely present in the Ghanaian research world because they are by custom prohibited from speaking to strangers or outsiders (i.e., researchers) without the consent of their husbands or compound heads. Furthermore, when women are permitted to speak on their own behalf, their husbands often censor their responses (Luppi, as cited in Kitts & Roberts, 1996).

In my community (Navrongo), men's desire to speak for women is embedded in a popular saying: "kaani ba jei buchojo ni," which is translated as a *woman is not supposed to sit outside the house*, because she is not supposed to interact with strangers without the permission of male relatives. This imperative, which privileges men and their right to represent women, actively silences women and limits their opportunities to interact with researchers, most of whom are considered strangers. For this reason, not surprisingly, Northern Ghanaian women have been underrepresented in migration and health studies since independence in 1957. Because the knowledge generated from such studies is dominated by a male perspective, such knowledge more often than not advanced the hegemonic interest of dominant groups, comprised of men (Harding, 2004). By utilizing feminist standpoint theory, I seek to give a voice to less affluent Northern Ghanaian migrant women who have been left out of mainstream research by recognizing their life stories as invaluable knowledge (Balfour & Comack, 2014; Hesse-Biber, 2014).

It was anticipated that this investigation into the health-seeking behaviours of less affluent migrant women, distinct from the mediation of male relatives, might yield a better understanding of the complexities of their social relations, which are power relations, within the family, in the Ghanaian health sector, and the urban environment as a whole. Therefore, by reinforcing women's ability to speak for themselves, this study unearthed some of the socially constructed "conceptual practices of power . . . through which [Northern Ghanaian} women's oppression [and subordinate social position were] designed, maintained, and made to seem natural and desirable" (Harding, 2004, p. 6). It may be argued that when less affluent Northern Ghanaian women migrate to Southern urban Ghana, they detach themselves from men who not only socially control them, but

who also find the opportunity to financially determine all facets of their daily lives, including health seeking. As such, it can be opined that migration has an emancipatory impact on less affluent Northern Ghanaian women's lives because it liberates and empowers them to be self-determining agents of their own health and economic status.

Outline of Thesis

Five chapters follow this introductory chapter. Chapter two reviews Ghana's health care system, including health reforms, as well as the health care system of the research area, Kumasi. Chapter three reviews relevant secondary literature, including, but not limited to, health-seeking behaviour and the determinants of women's health seeking as evidenced by past research in Ghana and the world. Chapter four details the methodological strategies that were employed in the study, the ethical considerations, as well as the data collection strategies I adopted during fieldwork. My findings are reported in the fifth chapter. The sixth chapter discusses my findings, but also offers concluding recommendations for governmental policies as well as for further research.

Chapter Two:

Ghana's National Health Care System

Ghana's three-tier allopathic health care system, which comprises a national health system, a regional health system, and a district health system (subdivided into semi-districts and community units) is ranked internationally as one of the most developed in West Africa (Canagarajah & Ye, 2001).¹ Structurally, the Ministry of Health is tasked with formulating effective and efficient national health policies as well as allocating resources for implementation by the individual offices of the Ghana Health Service (Canagarajah & Ye, 2001). The Ghana Health Service operating in the regions and districts is responsible for the implementation of health policies as well as the provision of health education and preventive and curative services via health facilities such as hospitals, health centres, and clinics. Ghana has approximately 1,819 publicly funded health facilities (e.g., hospitals, clinics, health centres). These governmental agencies are complemented by 205 non-profit (i.e., mission) and 1,315 for-profit, private hospitals, and clinics (Ghanahospitals.org).

These publicly funded and private health facilities are mostly located in urban areas, to the neglect of rural areas. For instance, the Ashanti Region currently has over 97 primary hospitals, while the Upper East Region has only six (Ghanahospitals.org). In addition, the hospitals in the Upper East Region are ill-equipped, lacking modern medical equipment and health specialists such as gynecologists and dermatologists

¹ Is this assertion reality or rhetoric? Current published literature does not elucidate. From personal experiences, however, this assertion is not reflected in the lives (health and wellbeing) of the poor, especially, those in rural and deprived areas in Ghana.

(Ghanahospitals.org). Hence, women with unusual or severe health conditions are usually, at the peril of their lives, transferred to the more modern and well-equipped hospitals, such as Tamale Teaching Hospital, Komfo Anokye Teaching Hospital, and Korle-Bu Teaching Hospital. These fully equipped facilities are 193 km, 568 km, and 780 km respectively from Navrongo². On the other hand, most mission health facilities are located in rural areas. Mission health facilities, such as the Saint Martin's clinic in Bui (one of the poorest villages in rural Northern Ghana) and Presbyterian Hospital in Bawku, are integral to the Ghanaian rural health care system, where they sometimes are the sole providers of health services (Couttolenc, 2012). Ghana's allopathic health care system is complemented by its traditional health care system³, which provides alternative health services in the form of herbal medicine and bone-setting services, among other service, to both urban and especially rural populations (Hill et al., 2014).

Health Reforms in Ghana (1957 to 2014)

Ghanaian governments since independence in 1957 and presently under the leadership of President John Mahama (elected 2012) continue to engage in several health sector reforms as a means of improving regional health, while addressing gender health inequities throughout the country (Buor, 2004). For instance, the immediate post-independence government led by Ghana's first elected President, Dr. Kwame Nkrumah, embarked on numerous health care reforms and developments. These reforms included

² I am merely using Navrongo as an example of the travel distance required from rural areas to urban centres.

³ Traditional health system "encompasses all health care practices . . . that incorporates plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises . . . applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing" (Aniah, 2015, p. 20).

the construction of modern health facilities, including Ghana's first school for the training of qualified medical personnel (Frimpong, 2013). As a result of the developments within the health sector, the number of health institutions in the country, increased from 1 to 41 between 1957 and 1963 (p. 258). Moreover, about 31% of the government's budget of £144 million set aside as public expenditure for the fiscal year 1963-1964 went towards the provision of social services, with a substantial portion of this expenditure invested in the health sector (p. 258). Additionally, health expenditure increased from 6.4% in 1965 to 8.2% in 1969 (p. 258). Most significantly during this period, Ghana implemented free universal health coverage for all of its citizens. As such, Ghanaian men and women of all classes gained access to all available health services free of charge.

Blanchet, Fink, and Osei-Akoto (2012) observed that free universal health coverage best served the health needs of poorer Ghanaian women, as they were no longer deterred from seeking health care at a price they usually could not afford. In fact, in response to high usage, the government of Ghana found it necessary to implement a low health facility user fee to deter Ghanaian men and women from the "unnecessary" use of health services on the basis that it was free (p. 76). Ghana's universal health care system of this era best served the interests of less affluent Ghanaian women, who, for lack of ownership of productive resources and waged income, would have needed financial assistance from men (i.e., fathers, husbands, or other male kin) to be able to access health care. Ghana's post-independence universal health coverage, therefore, not only empowered less affluent women to, at the very least, be financially independent of men in

health seeking; I believe some women may also have been emancipated to make their own health-seeking decisions.

While this era from the late 1950s to the early 1960s offered considerable health advancements, the quality of health service in Ghana begun to decline in the later part of the 1960s due to state coup d'états that occurred in 1966, 1972, 1978,1979, 1991. Political instability characterized the first three decades of the post-independence period, and severe economic crises ensued (Couttolenc, 2012). As a result, successive Ghanaian governments, both military and civilian, failed to sustain or re-invest in the country's health care sector (Osei-Boateng, 1992). In fact, the later 1970s and early 1980s were characterized by severe hardships for most African countries, Ghana included. Ghana's economic difficulties of the time are also attributed to high inflation rates, diminishing returns on export goods, and poor and unstable governance, which resulted in the incurring of monumental deficits by successive Ghanaian governments (Parsitau, 2008). These economic difficulties, coupled with extreme internal shocks due to increased population growth of about 2.5%, the drought of 1983, and the expulsion of more than one million Ghanaian men and women from Nigeria further exacerbated Ghana's socio-economic crisis (Manuh, 1994). These crises not only negatively impacted Ghanaian women and men's standard of living and health, but also constrained the national resources designated for the health sector (Canagarajah & Ye, 2001). To reverse the trend, a set of interventions was imposed by international financial institutions and implemented by Ghana in harmony with other African countries facing similar difficulties. The most notable intervention was the Structural Adjustment Programs (SAPs).

Structural Adjustment Programs in Ghana: The impact on Ghana's Health Care Sector and Ghanaian Women

SAPs consisted of a range of macroeconomic policy interventions promoted by the Bretton Wood Institutions, as guided by the World Bank and International Monetary Fund. These policy interventions aimed at increasing the economic efficiency and resilience of African countries in response to changes in the global financial market (Parsitau, 2008; Yeboah, 2008). Enabling the economies to re-develop and be free-market oriented was the basis for the adoption of SAPs by African nation-states, including Ghana. Ghana adopted SAPs as a means of reducing and preventing any further economic downturns as well as to help make its internal economy more efficient and productive (Yeboah, 2008).

Frimpong (2013) noted that about five billion dollars were allocated to Ghana under SAPs. The author further noted that this allocation notwithstanding, the Ghanaian health care system and the overall health status of Ghanaian women and men did not profit from this infusion of SAP funds. What the author failed to shed light on was who had control over the disbursement of this monetary allocation, and more importantly, why certain sectors of the Ghanaian economy were favoured over others like health. Research indicated that the Ghanaian government had no control over and very little input on the disbursement of the monetary allocation obtained under SAPs because SAPs operated under very strict externally regulated conditions imposed by the Bretton Woods Institutions (Frimpong, 2013). These regulatory conditions made it impossible for the Ghanaian government to invest any SAP monetary allocations in high priority sectors, such as health. This new financial landscape, controlled by external bodies of the

International Monetary Fund and the World Bank, deprived Ghana's health sector of the needed funds to maintain and improve the health needs of less affluent. SAPs further recommended the adjustment of exchange rates via the devaluation of the Ghanaian currency, the removal of domestic price mechanisms, as well as the collection of government revenue through an expansion of the tax base (Konadu-Agyemang, 2000; Yebaoh, 2008). Each of these policies, especially the expansion of the tax base, negatively impacted the already low financial standing of less affluent Ghanaians. Furthermore, state-owned enterprises were required to be privatized under SAPs. Privatization of state-owned enterprises had negative consequences, since it resulted in high prices of state services due to the removal of price cushions. Together, these policies negatively impacted the health-seeking decisions of the less affluent in Ghana. The government of Ghana was also required to significantly reduce its expenditure on health from an already meager 10% to 1.3% (Frimpong, 2013, p. 259). The above conditions, which were in fact preconditions for attracting loans, debt relief, and foreign investments needed to aid the stabilization and recovery process for the Ghanaian economy, had a monumental impact on the health and wellbeing of all Ghanaians, but particularly on less affluent Ghanaian women.

Some scholars believed that Ghana's economy improved considerably in the post-SAPs implementation era (Konadu-Agyemang, 2000). According to Konadu-Agyemang (2000), there was a 5% to 6% growth in Ghana's gross domestic product between 1984 and 1991 and a 5% growth in gross national product as well as a 2.4% increase in per capita income (Konadu-Agyemang, 2000). More so, the mining, banking, and agriculture institutions simultaneously experienced growth, with the national inflation rate also

dropping from a high 123% to 29% between 1980 and 1997 (Konadu-Agyemang, 2000; Yeboah, 2008). Despite these indicators, other scholars argued that the parameters for measuring the attainments above were conducted only at the macro level (Konadu-Agyemang, 2000; Manuh, 1994). Clearly, the impact of SAPs on vulnerable populations, especially on women in both rural and urban Ghana, was overwhelming. For instance, the adoption and subsequent implementation of SAPs by Ghana resulted in the retrenchment of about 300,000 workers in the public sector and 33,500 within the civil sector by 1989 (International Labor Organization, 1989). Additionally, 39,800 out of 320,000 workers in state-owned organizations were also retrenched. Recruitments into the public sector and state-owned organizations were frozen as per the conditions of SAPs. As a result, unemployment and underemployment became the order of the day in Ghana. In an analysis of the effects of SAPs in Ghana, Manuh (1994), Parsitau (2008), and Yeboah (2008) observed that Ghanaian women were the most affected in the SAPs retrenchment regime because most Ghanaian women in the immediate post-independence era were concentrated at the lower ranks of formal employment and, as such, were the first to be retrenched (Manuh, 1994; Parsitau, 2008; Yeboah, 2008).

As a result of these hardships that bedeviled the Ghanaian economy and in the face of the regulatory impositions by SAPs, the Ghanaian government reduced its expenditure on health care, abolished free universal health coverage, and introduced health facility user fees in 1971 (Badasu, 2004). In 1983, 1985, and 1991, health facility user fees rose significantly to help generate revenue for the health sector (Badasu, 2004). Health facility user fees meant that there was now a cost associated with health care for Ghanaian women, reversing earlier freedoms implemented by the universal health care

system. According to Canagarajah and Ye (2001), health facility user fees increased gender inequity because less affluent women, many of whom made less than a dollar a day, could not afford the price tag associated with seeking health care. Despite these initial worrying signs, the government of Ghana in 1992 replaced health facility user fees with the cash system popularly known as “Cash-and-Carry” or “Pay-As-You-Go” (Badasu, 2004). Ghana’s newly introduced cash-and-carry system meant that the full cost of health care was to be borne by individual Ghanaians rather than by the state; the individual was, therefore, made fully responsible for his/her own health, and women, particularly less affluent Northern women, suffered disproportionately. Because most Ghanaian women could not afford the requisite point-of-service user fees, they altogether avoided seeking care services from hospitals and health centres. Instead, they resorted to self-medication or the use of herbal medicine or traditional care as less expensive care options (Frimpong, 2013). Studies conducted in Zaire, Lesotho, and Switzerland also revealed a similar decline in the utilization of health services after the introduction of health facility user fees (Arhin-Tenkorang, 2001). The findings by Arhin-Tenkorang (2001) successfully captured my argument that conversion from one health system to another generates health inequities, particularly for less affluent women.

In its bid to remove the financial barriers that significantly impacted and shaped the health-seeking decisions and behaviours of Ghanaian women and their access to quality health care, in 2003 the Government of Ghana under the leadership of John Agyekum Kufuor initiated and passed the National Health Insurance Law. The National Health Insurance Law brought into effect the National Health Insurance Scheme (NHIS), which aimed to eliminate the cash-and-carry system as well as limit out-of-pocket

payments at health service delivery points (Frimpong, 2013). The NHIS hoped to reimplement the universal health coverage that Ghanaians enjoyed prior to the introduction of the health facility user fees, although the new system still required the payment of an enrollment fee. In other words, the NHIS replaced the cash-and-carry system, which proved to be an enormous task and further disincentive to the health-seeking behaviours of less affluent Ghanaian women, such as women porters in the informal urban economies, by providing a universal health coverage system for enrolled women and men. Enrollment became the new qualifying condition. Any Ghanaian woman who enrolls into the scheme has access to primary health care services, including emergency care, prenatal care, delivery and postnatal care, and access to prescribed drugs from the NHIS drug list.

Despite the good intentions behind the introduction of the NHIS, it has not been problem free. For this reason, a lot of work still needs to be done in the area of health equity for Ghanaian men and especially for less affluent Ghanaian women. First and foremost, the mere existence of a contentious health insurance scheme does not mean that all Ghanaians will enroll. I use the word contentious to describe the scheme, as there remains outstanding neglect of the traditional health care system, which serves over 70% of the Ghanaian population. Hence, those who utilize traditional medicines as a preference on cultural or economic grounds remain excluded from this supposed universal health coverage. More so, NHIS requires the payment of premiums to qualify for enrollment with the average premium in 2011, for instance, being GHC 11.20 (3.40 USD) (Gajate-Garrido & Owusua, 2013). The lack of affordability of this premium hinders access for Ghanaian women who make less than a dollar a day. Sulzbach,

Garshong, and Owusu-Benahene (2005) observed that about half of uninsured households that used to be insured in Nkoranza, a District in the Brong Ahafo region of Ghana, cited unaffordable cost of premiums as the main factor behind their disenrollment. Thus, certain citizens still do not qualify for state health care and cannot access it due to their economic disenfranchisement. In addition to this economic disqualification, several health conditions are excluded from the NHIS health insurance package. This implies that any Ghanaian with a health condition not covered under the NHIS such as heart and brain surgery⁴ must revert to the cash-and-carry system and pay before he/she receives the required medical attention (Baidoo, 2009).

Ultimately, enrollment in the NHIS health scheme does not guarantee that Ghanaian women will be able to access the services to which they are supposedly entitled. Contextual factors such as their geographic location (e.g., Northern or Southern Ghana), gender and gender roles, distance to health facility, pre-existing health conditions, attitudes of health personnel, gatekeepers, and other factors may still hinder enrolled women's utilization of public or private health services. That is, the mere existence of a health insurance scheme, in this instance, the Ghanaian NHIS, does not imply that the health-seeking behaviours of Ghanaian women will be enabled.

Kumasi's Health Care System

Administratively, Ghana is divided into 10 regions (see Figure 1).

⁴ These diseases are mainly excluded because they may be too expensive to treat.

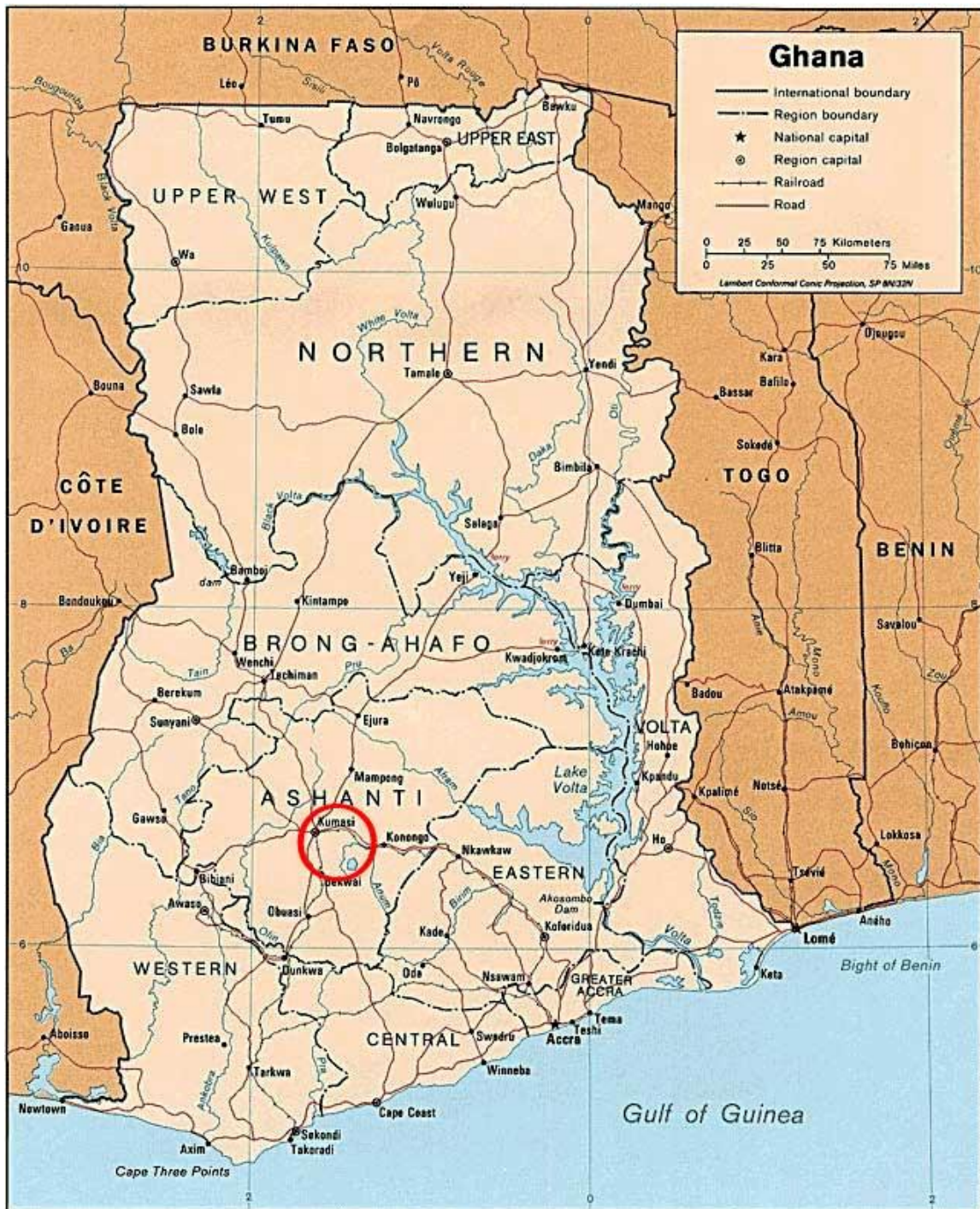


Figure 1. Map of Ghana showing Kumasi (circled), the site for this study.

Metropolitan Kumasi, the site of this research, is the regional capital of the Ashanti Region. A pluralistic form of health care provision exists in Kumasi, combining

modern allopathic and traditional health care. Kumasi's modern allopathic health sector, which operates under the auspices of the metropolitan health service, is organized around five sub-metropolitan health teams located in Bantama, Manhyia North, Subin, Manhyia South, and Asokwa. Kumasi boasts several health facilities serving both the public and private sectors. For instance, the Komfo Anokye Teaching Hospital is but one of two well-equipped hospitals in the metropolis. Kumasi also has six quasi-health⁵ institutions as well as five health centres and a medical training school. Furthermore, about 200 public health institutions, 13 general clinics, 54 traditional birth attendants autonomous from any health centre, 9 maternal and child health points of service, and 19 outreach sites⁶ are distributed throughout the region (Kumasi Metropolitan Assembly, 2006). Each of these publicly funded and private allopathic health care providers offer health education as well as preventive and curative health care services, such as immunization, disease control, out-patient and in-patient care, dental and eye care, surgery, gynecology, and obstetrics to all Ghanaian men and women and their children.

These allopathic facilities are complemented by numerous undocumented and NHIS uncredentialed traditional health care providers. These latter services, while not understood as credentialed in the state system, are patronized by a substantial portion of the Ghanaian population. Statistically, one traditional medical practitioner exists for every 400 Ghanaians, compared to one allopathic medical doctor for every 12,000

⁵ "Quasi-Health" institutions are health institutions that are supported by the government but managed privately.

⁶ Outreach sites are makeshift health posts, usually erected in remote areas/villages for the purposes of temporary health delivery like immunization or for health education.

Ghanaians (Yarney et al., 2013). As such, it is estimated that over 70% of Ghanaians patronize traditional health care in comparison to only 30% who utilize allopathic care (p. 4). The relative lack of access to credentialed public health care supported by Ghana's national government may be one reason so many Ghanaians still rely heavily on traditional health care providers. Yet, another reason may be that many allopathic providers are isolated from the culture of the communities within which they operate, and traditional health care providers remain more conscious and aware of local cultural beliefs and practices (Hill et al., 2014).

Some participants in the current study informed me that their continuous patronage of the services offered by traditional health providers is not merely motivated by their cost effectiveness relative to allopathic care services. Traditional health providers have the added attraction of proximity to those they serve and relatively easy access, with no long queues. In addition, traditional health providers offer the option of deferred payment, and this asset positively accommodates the economic restraints experienced by less affluent Ghanaian women. As my research participant, Cynthia, reflected,

There is one man beside us; he is just a traditional man (herbalist), and he is also from the north (Northern Ghana). So usually, those who are falling sick (sick porters), we usually send them there [to his house] for him to give us medicine. And after, if the money is there, we will pay him, and if the money is not there, we will come home and later, we will go and pay him. He is just the man for us, and he is just sitting beside us.

As can be deduced from Cynthia's reflection, a lot of factors influence her thought processes and her final decision on the type of health service to use when the need arises. While cost may and indeed is a compelling determinant of health service utilization,

proximity, preference among other tangible factors may have an equal bearing on less affluent women's utilization of available care services, whether allopathic or traditional.

Conclusion

Several factors, both internal and external, structural and contextual have shaped and continue to shape the availability, cost, and utilization of health services, particularly by the less affluent in both rural and urban Ghana. An in-depth investigation of the experiences of Northern migrant women in urban Ghana has the potential to bring into full view any factors that continue to mitigate women's efforts in regards to health seeking and utilization in 21st century Ghana. The literature on my research topic is reviewed in the next chapter.

Chapter Three:

Literature Review

Ghana is becoming increasingly more urbanized, like other countries worldwide. Globally, urban populations are projected to continue growing at an unparalleled pace (Saunders, 2011). Currently, approximately 3.5 billion people, more than half of the world's population, reside in cities (Meleis, Birch, & Wachter, 2011), and women account for over half of both the current internal and international migrant population (D'Ávila Neto et al., 2012). Several factors account for the increasing migration of women. In Ghana, for instance, women's increased migration from rural to urban cities like Accra and Kumasi has been attributed to their desire for improved socioeconomic opportunities, freedoms, and choices (Awumbila & Ardayfio-Schandorf, 2008). Under-resourced Northern Ghanaian women, in particular, believe that they can enhance their socioeconomic opportunities, social position, autonomy, and economic independence through migration. These motivating factors account for the feminization of Ghanaian migration in the 21st century (Awumbila & Ardayfio-Schandorf, 2008; Opare, 2003).

While migration is a reality for some Northern Ghanaian women, others are not as fortunate in the pursuance of their objectives, as several authors have shown (Awumbila & Ardayfio-Schandorf, 2008; Opare, 2003; Van den Berg, 2007). A continued increase in female migration, particularly the migration of less affluent women, is expected to contribute to the increasing number of urban poor living in migrant destination cities (Meleis et al., 2011). This extrapolation is already evident in Kumasi and Accra, two Ghanaian migrant destination cities that receive a majority of less affluent Northern women (Awumbila & Ardayfio-Schandorf, 2008). Less affluent as used in my study

refers to underprivileged rural women who are bereft of all choices other than migration to work within Ghana's informal economy.

A majority of less affluent Northern migrant women, as described by Van den Berg (2007), settle in cities that remain unequipped with resources needed to meet women's unique health and safety needs. The author reported that 80% of women porters lacked basic necessities such as accommodation and, as a result, were forced to sleep and bath and cook in the open while defecating in nearby open gutters. She also added that physical abuse, rape, and attacks by armed robbers became the everyday challenges of these women. As a result of these challenges of personal security and health, a fundamental human right essential for sustainable economic and social development eludes many migrant women in urban Ghana. For this reason, migrant women in cities such as Kumasi face several health risks caused by various factors including, but not limited to, substandard working and living conditions (Van den Berg, 2007). Hence, even though rural to urban migration in Ghana is undertaken by Northern women in anticipation of new socioeconomic opportunities, choices, and freedoms, migration can also be a perilous exercise for less affluent women (Meleis et al., 2011; Van den Berg, 2007).

Despite the fact that waged employment promises to empower migrant women financially and thus grant them independence from men, waged work in Ghana's cities is mostly within the informal sector; these positions often have negative consequences for women's health due to their below-average conditions (Van den Berg, 2007). In this chapter, I review relevant secondary literature concerned with women's health and health-seeking behaviours in urban and rural Ghana. Beginning with an overview of pre-

existing literature on health research in Ghana from 1957 to 2015, my analysis highlights the most significant social determinants of women's health in Ghana, including gender, educational status, marital status, occupation, and income.

Health Research and Health Inequality for Women in Rural and Urban Ghana

Historically, health research has been dominated by the biomedical model (Benoit et al., 2009; Knibb-Laouche, 2012; Radcliffe, 2002). This literature is limited because it focused primarily on the causes of diseases and the development of cures and treatments. While this literature is successful as reports on empirical knowledge, improved medicines, and improvements in health equipment, the weakness of the biomedical model as a central category of health and health care is now becoming more visible. According to Knibb-Lamouche (2012), a major weakness of the biomedical model, notwithstanding the aforementioned infrastructural, technological, and medicinal developments, is the lack of attention granted to the economics of health such as unaffordable price for the use services. Access to treatments and cures is often unaffordable to the majority. For example, in Ghana, only a small, more affluent portion of the population stands to benefit from advances in biomedical health research and technologies. Health inequity, therefore, persists for less affluent women, including informal wage workers such as women head porters who may earn as little as one dollar a day. These women can ill afford the expense associated with the usage of these types of health technologies and services (Yiran, Teye, & Yiran, 2014). Moreover, the biomedical model tends to focus solely on factors and diseases that can be observed, measured, and reproduced in a clinical setting, thus neglecting other contextual determinants of health. The latter is more relevant to the women in my study. From this perspective, research on the biomedical model has

contributed little to a consideration of less affluent women's health needs, expectations, or behaviours (Knibb-Lamouche, 2012). Current literature on women's health, therefore, calls for the incorporation of the social rather than biomedical model of health as a means to understanding how health care might improve for the less affluent and most vulnerable constituents in Ghana (Yiran et al., 2014).

Furthermore, women have consistently been excluded as subjects from biomedical-based research, with the justification that their hormonal fluctuations make them "too complicated to study; men had to be the norm" (Ratcliff, 2002, p. 11). This exclusion has resulted in "the exploration of women's health as an aberration of a health norm historically based on the experience of men" (Benoit et al., 2009, p. 5). Even in situations where women's biology is recognized as unique, the focus commonly centers on women as "reproductive beings, forever in a potentially pregnant state" (Radcliffe, 2002, p. 7), and as a result, women's specific health needs beyond their reproductive health needs have remained underreported and under analyzed. This implies that comprehensive research on women's health at all ages has been impeded by the preoccupation on women's reproductive capacities.

The fact, however, remains that women "are not just men with menstrual cycles" (Priest, as cited in Kitts & Roberts, 1996, p. 4), since women's health extends across their whole life span and cannot be limited solely to their reproductive bodies. Treating women as human beings with unique personalities, emotions, minds, and spirits is essential to social and structural health research (Adibi, 2014). The biomedical model, on the other hand, often resorts to the "denigration of systems or viewpoints that attempt to address these facets" (Knibb-Lamouche, 2012, p. 4). In reality, proponents of the

biomedical model look down upon treatments and technologies not developed through clinical methods. This predisposition often leads to the outright dismissal of, for instance, alternate forms of self-care that less affluent health clients may seek, including traditional medicines and treatments developed over generations. These types of treatments are often identified by those focused on biomedical models as mere superstition or quackery.

In sum, the conditions that influence women's health, reproductive or otherwise, and subsequently determine their health-seeking decisions and behaviours are not solely biological, but cultural, social, and structural (Senie, 2013). Thus, I suggest that much of the literature on women's health has struggled, failed, or perhaps even intentionally neglected a more in-depth social determinant approach to women's health. This lack of complexity has resulted in the neglect of both women's lived experiences and little analysis of the deeper meanings that women associate with their health. Recently, however, there has been growing recognition of the population health or health determinants approach, wherein health is viewed holistically as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1948, para. 1). The WHO perspective incorporates non-biomedical determinants of health, also referred to as *social determinants*, to create a faceted health analysis. This social emphasis allows for a more nuanced understanding of women's health by exploring women's unique perceptions, lived experiences, and personal narratives regarding their health, including their reflections on the inequities of service and the lack of access that they sometimes experience (Caronna, 2010). Exploring women's health from a social and structural perspective offers a clearer understanding of the reasons women behave the way they do with respect to health care and exposes the wider social

structures that impact their daily circumstances. It is my contention that an examination of the social, cultural, and structural determinants of women's health seeking and health service utilization broadens awareness of the underlying factors that impact the health and wellbeing of Northern Ghanaian migrant women.

The Impact of Social Cultural Determinants of Health on Less Affluent Rural Ghanaian Women

The socio-cultural environments in which women (and men) are born and live have a significant bearing on their health and wellbeing (Pendar, Murdaugh, & Parsons, 2015). Indeed, out of the four broad determinants of health; acquired health behaviours; health care accessibility; personal attributes; social determinants; and the social conditions under which women are born, grow, live, work, and age have the greatest impact on their health (Pender, Murdaugh, & Parsons, 2015; Reutter & Kushner, 2010). The findings of the WHO Commission on the Social Determinants of Health (CSDOH) acknowledge that social conditions such as poverty, lack of education, and poor working conditions are undeniably responsible for health inequities⁷ between women and men, between classes in all nations, and between nations (CSDOH, 2008). The Commission further recognized that inequities in the distribution of power, inclusive of the inequitable distribution of money and resources between women and men, are responsible for most health disparities (CSDOH, 2008). Health disparities caused by the combined effect of power, money, and resources are evident in rural Northern Ghana, particularly if the

⁷ Health inequities here refers to any “inequalities in health that are deemed to be unfair or stemming from some form of injustice” (Kawachi, Subramanian, & Almeida-Filho, as cited in Canadian Nurses Association, 2013, p. 2).

health of less affluent rural women, conventionally positioned on the bottom rung of the social ladder, is compared with the health of men who are conventionally positioned on the top rung of the social ladder irrespective of economic standing (Dixon, Luginaah, & Mkandawire, 2014; Ngom et al., 2003). While the health of women is directly, or indirectly, influenced by a range of social determinants, only those determinants seen to significantly induce health disparities and shape the health-seeking decisions of these women are examined in the following two sections: (a) socio-demographic and sociocultural factors and (b) factors relating to access to health services.

Socio-Demographic and Socio-Cultural Factors

Socio-demographic factors such as gender and gender inequity; class, income, and occupation; and education and sociocultural factors of cultural belief directly, or indirectly, shape the decisions of women whenever they need to seek and utilize available health services (Ahmed, 2005; Adongo et al., 1998; Macca et al., 2012; Zhang et al., 2010). Each of these factors is discussed in depth in this section.

Gender and inequity. Gender is a prevailing determinant that leads to disparities in health and shapes the health-seeking decisions of women and men. Benoit et al. (2009), among others, have called for gender to be recognized as a key determinant of health worldwide. Nonetheless, gender has often been and still continues to be conflated with sex and, as a result, remains underanalyzed or uninterrogated in health research (Benoit et al., 2009).

As feminist and gender analysis has shown over the past 40 years, gender and sex are distinct in meaning. *Sex* refers to the biological differences between male and female, while *gender* extends beyond biology to include socially constructed and expected roles

expressly enacted and imposed (Rubin, 1975) within a particular society or culture (Benoit et al., 2009; Oakley, 2000). My own use of the category of gender thus refers to the historically contingent identities, behaviours, social expectations, and roles that construct the categories of *women* and *men* in the first place, qualified by time and place. The distinction between gender and sex supports Simone deBeavoir's (1972) premise that one is not born, but rather becomes, a woman (or a man). Gender is dynamic, fluid, fragmented, unstable, and flexible, depending on the society into which one is born, lives, or migrates.

Given that gender is first and foremost a relation of power, it is unsurprising then that gender norms particular to Ghana profoundly impact, shape, and determine women's health and health-seeking behaviours. While the independent effects of sex and gender have been addressed in health scholarship in developed countries such as the United States (Senie, 2013), the same cannot be said of scholarship from developing countries like Ghana. In Ghana, gender norms and the resultant gender and power inequalities largely remain intact and, thus, continue to profoundly impact, shape, and determine women's health and health seeking.

Ghanaian women's health is not merely influenced by their biology, but also by socially constructed and expected gender roles, not only enacted but ascribed. For instance, within patriarchal rural communities in Northern Ghana, "androcentric assumptions, gendered power differences, and pervasive sexism" (Radcliffe, 2002, p. 7) profoundly influence women's health, health seeking, and health service utilization (Adongo et al., 1998; Dixon et al., 2014; Ngom et al., 2003). This influence is particularly true of rural Ghanaian communities where gender customary norms are not

only revered, but held in high esteem (Adongo et al., 1998; Dixon et al., 2014; Ngom et al., 2003). According to these Ghanaian scholars, gendered division of labour and socially constructed gender roles often deprive women of power, money, and resources, which are circumstances that impede women's inclination to independently seek, demand, or utilize available health services. Simply put, Northern Ghanaian women's health, health seeking, and health service utilization are not only constrained by their lack of access to resources, money, and power, but they are further restricted on the basis of the gendered constructions operative within their communities and family formations, hence by *patriarchy*. Lacking resources such as land and property means less affluent Northern women have little financial power; this situation marginalizes women socially compared to men of equal class standing (Dixon et al., 2014; Ngom et al., 2003). Social marginalization does not merely mean Northern women lack the capacity to access health services, it also means they are entirely dependent on the benevolence of those with money, resources, and power (i.e., fathers, husbands, or other male kin).

Adongo et al. (1998) observed that Northern Ghanaian men use their economic power as leverage to determine all facets of women's health-seeking decisions. The authors pointed out that the seriousness of a health issue faced by a woman is determined and assessed by the male kin (father, husband, uncle, or other male kin). It is male kin and not the woman who decide whether her health problem warrants care seeking, and ultimately, men assign the type of care that a woman's concern merits (i.e., allopathic or traditional). As a consequence, less affluent Northern women seek health care less frequently than men. Similarly, Ngom et al. (2003) found that among the Kassena-Nankana of Northern Ghana, women lack authority in their health-seeking decisions.

According to Ngom et al., women's decisions to seek health care do not rest with the women, but on "compound heads and husbands [who] often impede women's prompt access to modern health care [services]" (p. 24). Shaikh and Hatcher (2005) reported similar findings in their study of rural Pakistani women. According to these authors, Pakistani women, like their counterparts in rural Ghana, lack autonomy in regards to health decisions. The authors claimed this is because of women's lack of control over society's productive resources.

Health seeking is consistently a costly endeavor, even for women who possess minimum funds to enroll in insurance schemes (as discussed in Chapter Two). For this reason, men ultimately become the sole decision makers on the basis of their control of family resources. Therefore, a gendered division of labour based on socially ascribed gender roles deprives women of control and management of productive resources as well as severely impinging their autonomy to seek health care services (Hartigan, 2011).

Evidence from Ghana, Sierra Leone, and Liberia indicates that the gendered divisions of labour and socially ascribed gendered roles also disproportionately make women more vulnerable and susceptible to contracting diseases (WHO, 2011). For instance, Northern Ghanaian women's roles as primary caregivers disproportionately expose them to certain morbidities (Gerberding, 2004; WHO, 2011). Women's risk of diseases is increased given that gender norms place women in direct contact with infected persons (e.g., husband, child, parent, or sibling) as their primary caregivers. A recent case in point is the Ebola virus, which wrought havoc and claimed the lives of thousands of women in Liberia, Guinea, and Sierra Leone. According to statistics from these countries,

most Ebola victims were women who provided primary care for infected family members.

Ay et al. (2009) also examined the influence of gender roles on married women's health in Turkey and reported gender to be a strong determinant of health-seeking behaviours. The authors observed that patrilocal⁸ usually results in women's exclusion from decision making pertaining to their own health. The authors further contended that a woman's expressed need for health care may be considered as insignificant by others with greater power within the family formation. This may be because her male in-laws possess the final say in whether or not any symptoms expressed by her warrant medical attention (Ay et al., 2009). Therefore, lack of independence in health seeking may result in women facing potentially dire consequences of delayed access to treatment. Currie and Wiesenberg (2003) identified how a woman's need to obtain consent from gate keeping male kin not only determines whether a woman's illness will be resolved, but also how delays caused by gatekeepers may be calamitous. The potential effects of marital status on a woman's health relative to her ability to seek care warrants investigation, especially for migrant women in Ghana's urban economy. The response of the sole married woman in my study spoke volumes about the potential positive impact of marriage and migration. As Kolby reflected,

Moving from [her village in the Northern region] to Kumasi has taught me a lot. I have learned a lot and got a lot of experiences. I have learned to take care of myself and not to depend on anybody; not my mother or father . . . not even my husband. I can now take care of myself; me alone.

⁸ Distinct from patriarchy, patrilocality is a form of residential custom in which a married couple lives in the husband's household or community.

The above analysis of the impact of gender (e.g., roles, division of labour) on women's health seeking indicates that deeper socio-demographic and socio-cultural structures shape women's health inequities (CSDOH, 2008). These health inequities are not only produced, but also, sustained by socially constructed gender norms, policies, customs, or practices that tolerate and promote the unfair distribution of socioeconomic resources and power between Northern Ghanaian men and women. Gender inequity, caused by patriarchal gender norms, benefit men to the detriment of women. Male empowerment, with the counterpoint of women's subordination, is reproduced through the threat of sanction to those who fail to conform to gender norms or socially and culturally accepted ways of acting and doing (Adjiwanou & LeGrand, 2014; Yakong, 2008). Fearful of these sanctions, women are dissuaded from independence, even in the event of health emergencies, thereby preserving the gendered power structures and relations (Yakong, 2008). One important consequence of this is the deterioration of women's health and wellbeing.

While these observations may be particularly relevant to women in rural communities in Ghana, Turkey, Pakistan, and other developing countries, power inequities and gender norms are not absent in urban centres. Despite the fact that urban migrant working women may gain greater autonomy upon migration from rural Northern communities and, thus, not be wholly dependent on the productive resources or the overt approval of male kin, other contextual factors that negatively impact the health and health-seeking decisions of women may exist. Northern Ghanaian women's health-seeking behaviours may still be impacted by patriarchy, even after migration when they live distant from the physical presence and influence of the familial (i.e., kin) or

community gender norms. Whereas most studies have emphasized individual women's decision making and determinants of health, to offer a partial picture, my findings have incorporated contextual level determinants, which shape, define, and determine actions at the individual level (Adjiwanou & LeGrand, 2014). As such, through this thesis, I demonstrate how, as I have shown, gender norms substantially influence the health-seeking decisions of Northern Ghanaian women who migrate south to cities like Accra or Kumasi.

Class, income, and occupation. Class and income are similarly influential determinants of women's health, health seeking, health service utilization, and wellbeing in Ghana (Buor, 2004). The income a woman individually earns may elevate not just her health and social status, but empower her to independently seek and utilize available health services (Borgelt, O'Connell, Smith, & Calis, 2010). A woman's level of income shapes and defines the quality of determinants such as housing, food security, and working conditions, among other essential health prerequisites (Mikkonen & Raphael, 2010). Hill et al. (2014) emphasized that low income predisposes women to both material and social deprivation, making it less likely that the expense of basic prerequisites such as water, food, shelter, and health care will be met (Buor, 2004). Material and social deprivation further contributes to the social exclusion of less affluent women (and their children) from society's cultural, recreational, and educational activities: a situation that further limits their ability to live healthy and fulfilling lives (Mikkonen & Raphael, 2010). Furthermore, the most financially deprived often experience the highest rates of morbidities or mortalities (Mikkonen & Raphael, 2010).

The WHO's CSDOH (2008) has established that illness follows a social gradient in every country. This finding implies that the lower the socioeconomic position of the nation, the worse the health of its people. Likewise, at the community and individual level, less affluent women consistently exhibit poorer health than more affluent women (CSDOH, 2008). By extension, and according to literature reviewed, the lower the socioeconomic position of women, the worse their health status (CSDOH, 2008; Wagstaff, 2002). In rural Northern Ghana, less affluent women consistently exhibit the poorest health status (Dixon et al., 2014). Women's poor health status mostly results from the fact that they, both single and married women,⁹ by convention are not permitted patriarchal informed custom to own productive resources such as land or property. For this reason, women have no means of self-generating income save what the family collectively generates. These funds, as earlier indicated, are conventionally controlled by male kin. In the absence of economic security in a cash-driven economy, the health-seeking decisions of these women ultimately fall to the discretion of the male members of the household. Lack of self-generated independent income restricts Northern Ghanaian women from independently seeking and utilizing available health services. Furthermore their participation in decisions pertaining to their health seeking is limited (Dixon et al., 2014). For example, the total cost for the treatment of each malaria episode in Ghana, including direct and indirect cost as well as health system costs, ranges between US\$7.99 to \$229.24 (Sicuri, Vieta, Lindner, Constenla, & Sauboin, 2013). For most Northern

⁹ I am making reference to only single and married women because divorce is not practiced in rural Northern Ghana partly because of the strict social norms that are still practiced here.

women, even households,¹⁰ in rural Ghana, this cost for a single episode of malaria treatment is unaffordable.

Moreover, since the cost of health seeking exceeds a singular act of health seeking, such as travel cost or one-time expenditure on medication, but includes other hidden or unaccounted costs such as loss of waged income either due to time spent on health seeking or time spent recuperating, less affluent women, even those who are self-employed as is the case with the head porters studied in this thesis, are hesitant to spend their scarce income and time on treatment seeking (Yakong, 2008; Yiran et al., 2014). Northern Ghanaian women's desire and need to stay healthy, therefore, has a substantial impact on their personal waged income or the collective income of the household (i.e., the family economy). Indeed, an experience with poor health might determine the difference between a Northern Ghanaian woman living below or above the poverty line because poor health usually involves health expenditures these women cannot afford (Dixon et al., 2014). Poor women and their households are, therefore, caught in a poverty trap. Poverty, most argue, breeds ill health, while ill health maintains poverty (Wagstaff, 2002). Evidence from studies conducted in Tajikistan (Falkingham, 2004), and Vietnam (Segall, Tipping, & Lucas, 2000) reinforce the fact that women's health and livelihoods are greatly threatened by poverty more than by any other known risks.

The lack of self-generated income or even household income does not only restrict women from independently seeking or participating in decisions pertaining to

¹⁰ Household here refers to either nuclear family household or extended family household. My point is that majority of individual women as well as households cannot bear this cost for malaria treatment.

their curative health seeking, but also prevents them from engaging in preventive health seeking (Opoku, Benwell, & Yarney., 2012). Less affluent Ghanaian women seldom seek preventive health services such as mammography screening because of the high cost associated with the practice. Macha, Harris, and Garshong (2012) observed that the high cost related to health services, such as laboratory examinations or purchasing drugs, significantly impedes the health-seeking decisions of less affluent women in Ghana. They further explained that during a health emergency, women often alter their health-seeking behaviours as a coping mechanism when facing unexpected expenses. They might, for instance, sell any assets in their possession or borrow from friends or money lenders. However, paying back borrowed money is economically punitive due to the high interest rates that borrowed money often carries. Hence, less affluent Northern woman may fall into a vicious cycle of indebtedness, poverty, and poor health (Macha et al., 2012).

In 127 case studies examining the reasons families had fallen into poverty, Narayan et al. (2000a, 2000b) found low-income and unexpected factors related to coping with poor health to be a common denominator. Poor health is not only a cause of increased poverty, but also potentially an obstacle to escaping it (Ahmed, 2005; Sen, 2003). Studies conducted in Bangladesh (Ahmed, 2005), Pakistan (Shaikh & Hatcher, 2005), Nigeria (Ndikom & Ofi, 2012; Onah, Ikeako, & Iloabachie, 2006), India (Mohinda et al., 2006), Burkina Faso (Storeng et al., 2008), and the Philippines (Jensen & Stewart, 2003) all reported similar results.

Shaikh and Hatcher (2005), in their study in Pakistan, also reported cost of care to be a major barrier to good health among the less affluent. The authors noted that the magnitude of out-of-pocket expenditures on health care may rise to an astronomical high

of 80% per annum (p. 51). At this rate, the financial burden associated with health care significantly impedes the health-seeking decisions of the most vulnerable in society and women, in particular. Similarly, Elsie et al. (2010) observed within the Ugandan context that women in the higher income bracket visited a health facility seven times more frequently than their counterparts within the low-income bracket. In like manner, Oche, Umar, Gana, and Ango (2012) noted that low-income women infrequently seek preventive services such as mammography screening vis a vis their higher-paid colleagues who seek these services more regularly. McFarland (2003) and Zhang et al. (2010) also revealed income to be a significant determinant of women's health seeking in Botswana and China respectively. These findings empirically affirmed that the mere availability of either preventive or curative of health services does not guarantee usage, especially by the less affluent.

Women who are financially capable of paying for health coverage have been observed to have positive attitudes towards seeking and utilizing both preventive and curative health services (Borgelt et al., 2010). However, as reported by Macha et al. (2012) in a transnational comparative study of Ghana, Tanzania, and South Africa, a woman's ability to provide health coverage for herself did not always exempt her from other contextual health determinants. For example, a health-insured Ghanaian respondent in a focus group interview with Macha et al. revealed: "I have diabetes and I have to travel to [mission hospital] every month at my own cost despite being insured, am travelling to get drugs which are not available at the dispensary, which I can't manage that regularly" (p. i51). This comment implies that less affluent women who are financially able to afford health coverage may find it exceedingly difficult to access the

services to which they are entitled with health coverage. As this example demonstrated, the unavailability of drugs in rural dispensaries, a frequent occurrence observed in my own experience of living in rural Ghana, as well as the distance and cost of travel involved to get to a well-stocked dispensary commonly located in the urban core, tend to negatively influence the health seeking decisions of less affluent women (Buor, 2004).

As may be deduced, low income and high cost of preventive and curative health services in Ghana account for reduced health-seeking behaviours among less affluent women compared to their more affluent counterparts (Macha et al., 2012; Opoku et al., 2012). Women who migrate to urban centres, on the other hand, might circumvent these hurdles of health seeking. For instance, employment in both the formal and informal sectors of the Ghanaian urban economy affords less affluent women some financial independence from any male relatives and, thus, may free them to make autonomous decisions pertaining to their health. Migration from rural to urban Ghana also puts these women in proximity to a wider variety of both public and private health facilities as well as grant them access to efficient transport systems.

Education as a social determinant of Ghanaian women's health. Education is yet another vital determinant of women's health and wellbeing. In Ghana, Uganda, and other sub-Saharan African nations, women's opportunities and wellbeing are compromised by unequal access to educational opportunities (Nguyen & Wodon, 2014; Roush, Kurth, Hutchinson, & Van Devanter, 2012). This is especially true of women from less affluent families where due to scarcity of resources, parents commonly favour the education of a male child over a female child (Ghana Statistical Service, 2013). Despite reforms by the Ghanaian government since 1961 (Akyeampong, Djangmah,

Oduro, Seidu, & Hunt 2007) to bridge the educational gender gap, a 2014 study sponsored by the World Bank revealed that more effort is still needed, particularly in regards to transitioning girls from junior high school to senior high school and onward to post-secondary education (Nguyen & Wodon, 2014). Women's lower enrollments in higher education are not unique to Ghana, but are also relevant in other nations. In Bangladesh, Malawi, and Togo, for instance, women's enrollment in higher education also lags behind men by 56%, 40% and 68% respectively (Kitts & Roberts, 1996). Until access from basic to higher education is improved, poor Ghanaian women will reach only the under-waged ranks of both formal and informal employment. The consequences of these barriers to higher education for women include lower incomes than male counterparts, little or no job security, and poor or hazardous working conditions. These conditions have negative consequences on women's health, health seeking, and health service utilization.

The correlation between education and women's abilities to demand, seek, and utilize available health care services has been empirically established by numerous studies (Ahmed, 2005; Remennick, 2006; Zhang et al., 2010). These studies reported that the higher the level of education a woman attains, the more likely her economic empowerment or self-sufficiency. Education is, therefore, a conclusive route to secure women's economic independence from men and to enhance their ability to decide when to seek, demand, and utilize the available health services. For instance, Opoku et al. (2012) observed that educated Ghanaian women were more likely than their uneducated counterparts to seek and utilize preventive health services. The authors also found that educated women were more likely to adhere to treatment recommendations such as

completing the full medication or dosage regimen. Using data from the Ghana Demographic and Health Survey, Addai (2000) further demonstrated that rural women with a secondary level education or higher were more likely to seek and utilize available maternal and child health services than their counterparts without any education. Elsie et al. (2010) observed similar results in the Ugandan context. According to the latter, uneducated Ugandan women were four times less likely than their educated counterparts to utilize preventive health services such as mammography. While educated Ugandan women were observed to be independent of male authority such as husbands or fathers when making health-seeking decisions, uneducated Ugandan women remained dependent on male gatekeepers (Elsie et al., 2010).

The lack of education does not just make women economically or psychologically dependent on male authority for their health-seeking decisions. Lack of education may also cause less affluent Ghanaian women to misunderstand some of the risk factors, symptoms, and treatments options available to them (Elsie et al., 2010; Remennick, 2006). Using cross-sectional analysis of data from Nepal, Lam, Broaddus, and Surkan (2013) reported that Nepalese women's literacy levels were directly proportional to their health-seeking decisions. The authors further observed that the odds of Nepalese women identifying an act of obtaining permission from their husbands as a barrier¹¹ to their health-seeking behaviour were 35% lower in literate women than in illiterate women. Additionally, the odds of educated women making independent decisions that related to

¹¹ Most uneducated Nepalese women considered seeking consent from a male authority to be normal behaviour.

their own health seeking were 57% higher than those of uneducated women (Lam et al., 2013).

Thus, as the literature showed, education may benefit less affluent Northern Ghanaian women's health and wellbeing. A women's level of education not only correlates with her potential to earn higher income, but also with her health and safety in the workplace, among other determinants of health (Mikkonen & Raphael, 2010). It, therefore, stands to reason that less affluent Ghanaian women who gain access to higher education may have improved opportunities to secure jobs with higher wages and benefits such as illness and maternity leave. Economically empowered with better wages and job benefits, Northern women may be well placed to afford the expense associated with both preventive and curative health services (Addai & Adjei, 2013). Educated women may also be better placed to search for, make use of, and benefit from, preventative health information as well as critically evaluate, reorient, and adopt healthy behaviours (Addai & Adjei, 2013). They might, for instance, be more informed about the health benefits of eating eggs during pregnancy and, thus, might be more inclined to challenge traditional customs which prohibit pregnant women from eating eggs (Yakong, 2008).

Despite the valid points raised by the secondary literature regarding the correlation between a woman's level of education and her health seeking behaviour, the impact of gender and class on women's health seeking have been less documented. Consequently, there remains a need to recognize that education is both gendered and classed. Not every woman in Northern Ghana can access education. Currently, almost all uneducated women in Northern Ghana are from financially impoverished households

(Lambert, Perrino, & Barreras, 2012). Hence, for these women, accessing health care is never a simple matter. As a matter of fact, accessing health care is usually a well-thought-out practical matter that involves sacrifices. Cynthia, a respondent in this current study, revealed how health seeking is often a dilemma for her. According to Cynthia, she often forsakes her own immediate health needs by “push[ing] through the pain” in order to be continue her daily work and earn enough money to remit to her mother and siblings back home. She stated,

Well, at times, you will feel pain in your body because of the work. Instead of you to go to the hospital, you will say let me go (back to work), today I will go and get money and add to it (i.e., money that will be remitted to relatives back home).

As a matter of fact, like Cynthia, other less affluent women work longer hours and sometimes make just about enough money to sustain their own survival. Compared to their more affluent counterparts, these women must survive on extremely limited budgets. Hence, their choices on various fronts, including health, may be diminished. Limited by such a budget, Northern women are forced to prioritize other needs (e.g., children’s, siblings’, parents’ needs) over their own as Cynthia’s reflection highlights.

Cultural Beliefs

Cultural values, beliefs, and practices do not merely influence women’s and men’s perceptions of health and their health behaviour, but also inform and shape them (Giuliano et al., 2000). For instance, beliefs regarding masculinity often increase men’s likelihood to engage in risky behaviours, while simultaneously reducing their likelihood to engage in either preventive or curative health seeking behaviours (Courtenay, 2000). Ghanaian women’s health-seeking behaviours are equally influenced by cultural and regionally specific beliefs about femininity, which customarily implies such values as

modesty, preventive care, popular myths about the female body, and the needs for social support (Ofori-Dei, 2013). As a result, allopathic health care services are only sought when traditional avenues fail (Aborigo et al., 2014).

Regarding cultural belief in the need for women's modesty, Ashing-Giwa (1999) noted that women's concerns over the exposure of certain parts of their bodies in their encounters with male physicians negatively impacted their attitudes towards preventive health-seeking options for breast and cervical cancer screenings. Similarly, Mupepi, Sampelle, and Johnson (2011) argued that Zimbabwean women's cultural beliefs about feminine modesty, as well as their concerns about embarrassment, were also interpreted as reasons why they failed to seek care related to screenings for cervical cancer. According to the authors, women who perceived screening as embarrassing were less likely to engage in health-seeking behaviours than those who do not hold such perceptions. Similarly, Tang, Solomon, Yeh, and Worden (1999) reported that Asian and Caucasian women living in the United States failed to access health services like the Papanicolaou test because cultural beliefs about women's modesty meant they did not wish to discuss sexual matters with strangers. Additionally, scholars observed that Vietnamese women residing in the United States were less likely to engage in breast cancer screening due to their belief about sexuality. Similar findings were also found in studies conducted with women in Uganda and South Africa by Elsie et al. (2010) and Krombein and De Villiers (2006) respectively. These findings imply that cultural values, beliefs, and customs influence the health-seeking behaviours of women and men on both preventive and curative health services. The effects of cultural beliefs on Ghanaian women's health-seeking behaviours have been underexplored. In fact, my searches in the

secondary literature have suggested that research on the impact of cultural beliefs on the health-seeking behaviours of north to south, rural to urban, women migrants in Ghana is needed. This study might aid in the development of culturally sensitive policies as well as educational interventions that would benefit women migrants.

Access Factors

During the 1980s, access to health care was prioritized for Ghanaians by the Ghanaian government. By 1992, the constitution of the Republic of Ghana mandated the President to protect and safeguard the rights and liberties of all Ghanaians, paramount among these being the “right to good health” (Constitution of the Republic of Ghana, 1992, Article 34, Section 2). The establishment of the Ghana Health Service under the Ministry of Health in 1996 harmonized with the 1992 constitutional requirement of providing health education, preventive, rehabilitative, and curative health services to all irrespective of age, sex, income, or ethnicity. Ghana’s health policy proposed to “creat[e] wealth through health” (Ghana Ministry of Health, 2007, p. 11). This rhetoric epitomized the importance of health to the Ghanaian government and people. Yet, despite several interventions rolled out by the successive governments, the most recent of which is the national health insurance scheme, general access to health services by its populace, and by women in particular, has not been uniformly successful. Some of the most significant mitigating barriers to access for women, in particular, are geo-physical and economic as well as practitioner-patient relationships.

Geo-Physical Determinants

The barriers against physical access to health services is yet another titanic factor that negatively impact women`s health seeking and health service utilization decisions

(Macha et al., 2012; Mupepi et al., 2011; Shaikh & Hatcher, 2005). In Ghana, geo-physical barriers to accessibility are compounded by poor road networks and lack of efficient transportation systems, especially in rural areas where the dispersed nature of settlements, periodic flooding, poor road networks, and unaffordable transportation costs makes access to health services almost impossible (Macha et al., 2012). One rural woman in a cross-country study by Macha et al. (2012) revealed that the dire conditions that Ghanaian women often face in their attempt to utilize health services: “You travel about 9 miles to get to the health facility. When you are sick and have to travel 9 miles, if God is not on your side, you may die” (p. i51). The situation of women in rural Zimbabwe reinforced the findings of Mupepi et al. (2011) to further illustrate the problems of access for less affluent rural women. The authors reported that 96% of women living in rural Zimbabwe are unlikely to seek and utilize care services because of the travel distance involved. In nations where purdah, a religious practise of gender segregation, is a cultural norm, geo-physical factors perhaps may be the greatest influence in preventing women’s access to the health services, particularly in situations where transportation costs must be provided for both the sick woman and a person(s) who has to accompany her.

Conversely, urban areas boast of several health care facilities, good roads, and efficient transportation systems. The presence of public infrastructure does to some extent eliminate the physical and geographic access gap experienced by residents of rural areas. However, do improved public infrastructures imply that urban residents have optimum access to and utilization of health services? While this may be the case for affluent urban women, the same may not be of less affluent urban residents, especially those who have migrated from rural Northern communities. As the participants of this study were migrant

women from rural Northern Ghana, their access to services and health-seeking behaviour are mitigated by their living and working conditions as well as shifts in understanding access to services that occur with their general transition from rural to urban Ghana. The lived experiences of women porters in Ghana's informal urban economies with regards to any geo-physical factors that may still inhibit their health-seeking decisions in urban Ghana are vital to a comprehensive analysis of migrant women's health.

Practitioner-Patient Relationships

The question of whether other service utilization factors, such as hours of operation, waiting times, and practitioner and client relationships, influence women's health in low-income countries such as Ghana demands empirical verification. Indeed, studies in other parts of the world have reported the above factors as very influential on women's health seeking (Carcaise-Edinboro & Bradley, 2008; Macha et al., 2012). As researchers have shown, the opening hours of health institutions (i.e., hospitals and clinics) as well as long waiting times severely impact the health-seeking behaviours of women (Earp et al., 2002; Gany, Shah, & Changrani, 2006). With regards to the latter, a study by Aboagye and Agyemang (2013) observed that long waiting times negatively impacted the health-seeking behaviours of expectant mothers who often stayed home until the very last minute. Long waiting times, as observed by the authors, led to increased risks of women giving birth at home, unassisted.

Attitudes of both male and female care providers potentially also positively or negatively impact women's health-seeking behaviours. For instance, Crissman et al. (2013) observed that maternal health seeking in rural Ghana is adversely affected by the seemingly negative or uncaring attitudes of health staff, with behaviours of female nurses

particularly signaled. Macha et al. (2012) also observed that clients' perceptions of paternalistic attitudes expressed by health care providers are a huge deterrent to women's health seeking and health service utilization in all three countries: Ghana, Tanzania, and South Africa. A respondent from South Africa pointed to the paternalism of the nursing staff as follows:

I have stopped going to public sector antenatal care because the nurse that was helping us had an attitude when we asked her something she treated us like children or comics. She was so impatient with us . . . shouting all the time. (p. i52)

Another respondent from Ghana echoed similar frustrations: "The nurses here have taken the health facility as their property. Sometimes when you go there with an emergency in the evening, they will tell you they are sleeping" (p. i52).

Carcaise-Edinboro and Bradley (2008) documented similar results in their study that explored the effects of practitioner-patient relationship on women's health seeking. Their study included a total of 8,488 participants, aged 50 and older, to reveal that women who had negative interactions with health care providers were least likely to undergo screening for cervical cancer than were women who had positive encounters. McFarland (2003) also observed that negative attitudes of health practitioners towards Botswana women adversely affected their health seeking behaviours. In Ghana, only a few studies have examined the negative impact of such ground-level factors on women's health seeking, and even fewer focus on the impact of these use factors on internal migrant women (Yakong, 2008; Yiran et al., 2014). Through this study, I conversed with that prior scholarship to explore how systemic factors such as the attitudes of health care practitioners and institutional factors such as the opening hours or long waiting times of

health facilities impacted the health-seeking behaviours of less affluent Northern women migrants working in Kumasi, Ghana.

Conclusion

Pre-existing secondary literature indicated that women's decisions to seek and utilize available health services are influenced by a range of determining factors. The effect of each of these factors, as discussed in this chapter, is profound within the context of developing countries, including urban Ghana. The severity of these disincentives is, in fact, more determinantal on women living in the rural areas or villages of developing countries like Northern Ghana.

Despite the seemingly high volume of research on health-seeking behaviour throughout the globe, few studies were conducted from a Ghanaian perspective. Even fewer have examined the health-seeking behaviour of internal rural north to urban south women migrant worker specifically. An absence of less affluent Northern women's voices in the Ghanaian health literature is, therefore, apparent. Little or nothing is known of the lived experiences of independent women who have migrated from the rural north to work within the Ghanaian informal urban economy. Additionally, researchers examining health services and health behaviours in Ghana neglected gender as a significant category influencing health access. I suggest that the lived perspectives and experiences of migrant women's health-seeking behaviours in urban Kumasi, Ghana, benefits from the use of gender, among other categories, as a tool of analysis. Both theoretical and empirical research on women's specific health seeking and health service utilization in contemporary Ghana is paramount because the expansion of exact knowledge on the barriers to Ghanaian women's health seeking may not only influence

policy, but may also challenge or shift popular attitudes. When attitudes change, the potential incidence of severe and life-threatening diseases may reduce (Taffa et al., as cited in Minne, 2010). In sum, an understanding of the factors that influence the decisions of Ghanaian women to independently decide why, when, how, and where to seek care is useful in developing health promotion interventions that will improve both women's and men's intentions towards health seeking. Correspondingly, this change toward prevention and early intervention will reduce the late presentation for treatment and the current high maternal mortality rates of women in Ghana¹².

¹² For instance, there were 3100 maternal mortalities in 2013 (Ghanaweb.com).

Chapter Four:

Methodology

For my thesis research, I investigated the migration and health-seeking experiences of less affluent Northern Ghanaian women working as head porters in Kumasi, a city in Southern Ghana. A reflexive account of the methods that I employed in conducting this study are provided in this chapter. I begin by highlighting my methodological approach, which was informed by feminist research principles. In line with feminist research practice, I draw attention to the perspectives, experiences, and beliefs that I brought to my research. Subsequently, my research design, data collection methods, as well as data analysis processes are presented. Finally, ethical issues encountered during the conduct of this research are elucidated.

A Feminist Methodological Approach: Reflexivity, Locating Myself

I share the zeal of feminist researchers towards understanding the lived experiences of women from their point of view (Baily, 2012; Hesse-Biber, 2014). For this reason, and since my study neither aimed to classify, calculate variables, nor create statistical models, I employed a methodology that positioned Northern Ghanaian women as experts to share these experiences in ways that best represent them (Ironstone-Catterall, 1998). On this basis, a feminist research methodology was employed. Even though discussions surrounding what constitutes a distinctly feminist method are still ongoing (DeVault, 1990; Doucet & Mauthner, 2006; Harding, 1987; Hesse-Biber, 2014; Kelly, 2010), there was a general consensus among scholars regarding the fundamental principles that all feminist research must embrace (Harding, 1987; Hesse-Biber, 2014). These include (a) asking new questions with a focus on uncovering social relations that

deny the lived realities and experiences of women (Harding, 1987; Hesse-Biber, 2014); (b) being emancipatory, so as to enable women to be active agents in their own right; (c) paying attention to women's ways of knowing by giving presence to women's lived experiences via feminist theories that promote access to the oft-neglected voices of women, and bring to the fore "voices that are often excluded from knowledge production and policy making" (Wambui, 2013, p. 2). Feminist research also acknowledged that research for, rather than on, women needs to be reflexive and cognizant of power relations between researchers and research participants. Furthermore, feminist research must value knowledge held by women as expert knowledge (Baily, 2012).

Applying these feminist principles allowed me to situate the experiences of less affluent Northern Ghanaian women at the centre of my inquiry. Despite my awareness of the potential value of including men (i.e., male porters) in my research, I decided in favour of an exclusive focus on the experiences and voices of women porters. My decision to prioritize women was supported by Devine and Heath (as cited in Gatrell, 2006), who argued that feminist research must give "priority to the voices of the less powerful and the marginalized . . . women" (p. 240). I prioritized the experiences as expressed by Northern women in this study because the most efficient way of truly understanding their experiences of migration and health was through an examination from within, through the voices of the women themselves (Foley, 2005). In-depth interviews functioned as my "point[s] of entry" (Smith, 2005, p. 10) into the world of lived experiences of Northern women as they negotiated their migratory and health-seeking decisions.

In alignment with a reflexive feminist approach, I located myself in my research by highlighting the beliefs, perspectives, and experiences that I bring to my study. My aim in this research was to meaningfully “make sense” (Shaw, 2010, p. 224) of the stories of women porters, with the view to not just learning more about them, but to enhance understanding of their stories, while advocating for change whether in policy or at the institutional level. By so doing, I not only pointed to the facts (i.e., knowledge) in women porters’ stories, but indeed also questioned how I arrived at those facts (Guilleman & Gillam, 2004, p. 274). In other words, by what means do I know what I am presenting as knowledge?

I am mindful of the fact that all knowledge is shaped by the social context in which it is produced (Baily, 2012; Harding, 1987; Letherby, 2003; Probst, 2015). Hence, in order to produce accountable and representative knowledge, the conditions of knowledge production as well as the claims that such knowledge advances must be available for evaluation and scrutiny (Baily, 2012; Probst, 2015). To fully accomplish this, the researcher who spearheads the production of such knowledge, as Harding (1987) noted, must be *located* within the same critical plane as her/his subject matter. As Harding further observed,

[The] class, race, culture, and gender assumptions, beliefs, and behaviours of the researcher her/himself must be placed within the frame of the picture that she/he attempts to paint. . . . Thus the researcher appears to us not as an invisible, anonymous voice of authority, but as a real, historical individual with concrete, specific desires and interests. (p. 9)

As such, for purposes of accountability and in my quest to negate criticisms of lack of transparency (Bryman & Burgess, 1994), I was an active participant in generating knowledge. However, before I could immerse myself in this “muddy” and “messy”

“swamp”¹³ (Finlay, 2002a; Probst, 2015), several scholars (Clark, 2009; Finlay, 2002b; Probst, 2015) drew my attention to the fact that writing reflexively is challenging. Clark (2009), for instance, cautioned that “even the most critical reflexive position will always be one’s subjective analysis of one’s own subjective position and practice. It will, in itself, be limited by the very same limitations and biases of the respective position” (p. 10). Finley (2002a) added that the process of reflexivity may be “perilous,” hence the researcher is wary of falling into an “infinite regress of excessive self-analysis and deconstructions at the expense of focusing on the research participants and developing understanding” (p. 212). These cautions, however, do not imply that I should refrain from “being aware of [my] positioning in relation to the research” (Probst, 2015, p. 42) because “without examining ourselves, we run the risks of letting our elucidated prejudices dominate our research” (Finley, as cited in Shaw, 2010, p. 239). Being mindful of the above was the baseline I used to be honest about my subjectivity, which simultaneously served as a check against naïve claims of neutrality (Shaw, 2010). Being reflexive in this study not only allowed me to know what my voice was, but actually also helped me hear past my voice in order to hear what my participants were actually saying (Probst, 2015) as we co-constructed knowledge.

No researcher, however experienced or inexperienced, starts from scratch because all researchers carry with them some form of institutional “intellectual, emotional and political baggage” (Ramazanoglu & Holland, 2002, p. 148). Letherby (2003) concurred, adding that no researcher can separate herself/himself “from the world from their values

¹³ These are but a few descriptions of the problematic nature of reflexivity.

and opinions, from books they read, from the people they have spoken to and so on” (pp. 5–6). For Letherby, a feminist research should not merely recognize the fact that the product (i.e., knowledge) is inseparable from the means of production (i.e., social context), it should “celebrate it” (p. 6). With this in mind, I was reflexive about my subjectivity, particularly alert to the situations and circumstances in which my gender or social standing might influence not just my data collection and my analysis, but also my study as a whole (Probst, 2015).

I continuously reflected on questions like “how does who I am, who I have been, who I think I am, and how I feel” (Pillow, 2003, p. 176), which influenced my data collection as well as my analysis. These questions allowed me to “fruitfully examine” my “motivations, assumptions, and interests in the research as a precursor to identifying forces that may skew the research in particular directions” (Finlay, 2002b, p. 536). I did not begin the conduct of this research as *tabula rasa*. This means that it was incidental that my research was concerned with less affluent Northern Ghanaian migrant women; I chose this topic. Without a doubt, my history, my heritage, and my past experiences as the son of a strong working Northern woman and as a Northern man influenced my interests and approach to the subject of migration and health seeking among Northern women. This subjectivity has influenced my relationship with women porters and informed my hopes for the research.

“Why are you interested in this research topic?” “And why women?” These are questions that I have been asked on countless occasions by different people.¹⁴ I became interested in researching Northern women because of my personal experiences growing up and being raised together with my three sisters by our single mother. This period was by far the most difficult time of my life, and I know it was not rosy for my sisters or mother. Save for the industriousness of our mother, I cannot imagine where my sisters and I would be today. Despite the immense financial burden and emotional strain of nurturing four children alone, my mother enabled us all to attend school: a feat only a few men from our region can manage. Today, two of my sisters have graduated from the university, while my youngest sister is currently in her final year of senior high school. My family’s story is one of many in rural Northern Ghana; however, not all children, particularly the female children of less affluent families, are often as fortunate. My family’s experience made me interested in researching less affluent women, particularly their children, who due to several factors, have had to migrate to urban Ghana. My hope is that my research will bring the stories of less affluent women into perspective, with particular regards to their health and wellbeing after migration.

My interest in gender awareness, advocacy, governance, and sustainable progressive change and my decision to further my education from a feminist standpoint was further aroused during my undergraduate studies. A bachelor’s degree in sociology exposed to me the weaknesses in Ghana’s rural sector administration and the challenges

¹⁴ My colleagues back home in Ghana, my peers at the University of Lethbridge, my professors, just to mention a few.

facing policy-making processes for women and rural development. Over the years, poor rural sector administration has denied the female child literacy and subsequently resulted in the economic migration of women into urban hubs in pursuit of alternative livelihoods. I also become interested in researching the experiences of less affluent Northern Ghanaian women due to my fieldwork experiences. Working as a Research Assistant at the Navrongo Health Research Centre after my bachelor's degree further exposed the weaknesses within the policy environment in Ghana in regards to analyzing the continuous trend of women's economic migration, hence my interest in this social phenomenon.

Also, as a volunteer teacher in Tampola Junior High School, situated in one of the poorest communities in Navrongo, I realized through my interaction with most high school students that a good majority of them, especially girls, nursed dreams of migrating to urban towns (e.g., Kumasi, Accra) to work. Some cited poverty as the main reason why they would not be able to continue schooling after that level, while others wanted to join their siblings and friends who had earlier migrated to help raise money for the upkeep of the family back home. All these real-life experiences exposed me to the many, but often neglected, challenges facing rural women and children, and these experiences have led me to engage this phenomenon in a study that would promote an enhanced understanding of rural women's situations, the choices they make, and migration as a phenomenon.

By discussing my subjectivity as a Northern educated man, I do not claim my research to be value-free since I am not an "invisible, anonymous voice of authority, but

. . . a real, historical individual with concrete, specific desires and interests” (Harding, 1987, p. 9). Indeed, as Gilgun (2010) maintained,

Researchers are subjective, fallible human beings who are full of biases and favorite theories; hence, on-going scrutiny of ourselves is a way for us to ‘come clean’ so that we are less likely to unwittingly impose our perspectives on the accounts and actions of research informants. (p. 7)

Anyone of Ghanaian origin would, at the sound of my name (Prosper Asaana), immediately recognize that the author of this thesis is from Northern Ghana. I am a proud Northern man, and I respect the values and traditions of my community. My society, intrinsically patrilineal in nature, has ascribed to me certain advantages based on my masculinity, advantages that my sisters do not enjoy, advantages which I have been taught to accept as natural as opposed to constructed in social and gendered relations. I have accepted these privileges until this research granted me insight into the power invested in men that generates inequity for women. However, during the research process and in coursework undertaken as a student at the University of Lethbridge in the department of Women and Gender Studies, I have experienced a challenge to the privilege of masculinity. As a result, I have incorporated some significant understanding of the gendered realities of life, of power, of gender roles and those relations that grant me greater authority within patriarchal society.

Despite my ongoing reflexivity, and in being mindful of the gendered power hierarchies between me, a Northern man, and the Northern women that participated in this thesis, I acknowledge that I am still learning to critically understand, negotiate, and deconstruct some of these heteronormative privileges and the power of class and gender I

possess. As such, there may still be evident some indications of gender informed bias in my analysis that may be obvious to readers.

Participant Sample and Recruitment

Sampling¹⁵ is imperative in research, as it is “rarely practical, efficient or ethical to study whole populations” (Marshall, 1996, p. 522). For this reason, criterion sampling was employed; hence, participants in my study were selected based on a set of predetermined requirements (Creswell, 2007; Tongco, 2007). The criteria employed in this study required participants to (a) be an independent female migrant from Northern Ghana, (b) be an adult of 18 years or older, (c) have a minimum of a year’s work experience as a head porter, and (d) proficiency in English language. These requirements facilitated the recruitment of participants who were able and willing to provide information regarding their migration and health seeking in urban Ghana, by “virtue of knowledge or experience” (Lewis & Sheppard, as cited in Tongco, 2007, p. 147). Furthermore, these requirements were integral to quality assurance, as they ensured that contextual factors such as involuntary migration (e.g., forced migration) and migrants working outside of Kumasi metropolis did not influence the value and expediency of my data collection (Tufeir, 2012). At the onset of my field work, prospective participants were contacted via two key resource persons: (a) the President (Osman Ziblim) and (b) Vice President (Iddrisu Issah) of the Kumasi branch of KAYA¹⁶ (see Appendix A for

¹⁵ Sampling is defined as the process of selecting participants from within a population for a study (Marshall, 1996) via the use of either probability or non-probability methods (Babbie, 2007).

¹⁶ KAYA is one of two informal advocacy groups which seek to improve the wellbeing of women head porters within their respective areas of operation.

letter of support). With the assistance of these resource persons, meetings with prospective participants were set up at mutually agreed upon locations. These preliminary meetings provided an opportunity for me explain the purpose of my study, verify participant's eligibility as per my criteria, answer any questions, and address any concerns of the participants, as well as present a copy of my consent form (see Appendix B) to them for consideration. More so, the preliminary meetings allowed me to schedule interviews according to each participant's availability.

The leadership of KAYA served as a familiar face during my preliminary contact with prospective participants. Hence, after I established contact with potential participants (after I was introduced as a researcher), the KAYA leadership were not involved in any other stage of the research. I must add that the most important condition for the recruitment of participants was their willingness to share their experiences of migration and health seeking with me. I employed the principle of data saturation in my study (DiCicco -Bloom & Crabtree, 2006). Hence, when new categories failed to emerge from my twelfth interview, I brought my fieldwork to a close.

Interview Methods and Process

Interviewing remains one of the most established tools utilized by feminist researchers (Hesse-Biber, 2014). According to the Shulamit Reinharz (as cited in Hesse-Biber, 2014), "interviewing offers researchers access to [women's] ideas, thoughts and memories in their own words rather than in the words of the researcher" (p. 190). This quality of interviewing is of particular importance in investigating women's issues, as "learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for them" (p. 190). As a feminist interviewer, I was interested in those

issues that are unarticulated, but are of colossal concern, to the lives of Northern Ghanaian women. In-depth interviews allowed me to investigate these often unarticulated experiences of Northern women in particular with regard to their health seeking. Interviewing was conducted as a “conversation with a purpose” (Holloway, 1997, p. 94) through which I explored the “lived perspectives, experiences, perceptions and feelings” (Sparkes & Smith, 2014, p. 83) of women porters relative to their migratory decisions and health seeking behaviours.

Employing an open-ended interviewing approach facilitated the active involvement of women porters as experts of their lives and in the construction of knowledge (Crano, Brewer, & Lac, 2014; Reinharz, as cited in Hesse-Biber, 2014). Open-ended interviewing created ample space for the women porters to not only respond to the questions asked, but to also address topics or issues that they felt were important to them (Crano et al., 2014; Ironstone-Catterall, 1998). Women porters’ active involvement allowed for the discussion of issues that would not have been covered as they were not included in my original interview guide (see Appendix C for interview guide).

My open-ended interviewing approach further created space for women porters to speak freely and, thus, contribute as much detail about their experiences as they wished, while also allowing me to ask probing and clarifying follow-up questions. For instance, in some instances during the interview process, I applied the “silent probe,”¹⁷ the “uh-huh probe,” or probed by actively leading the participant with specific questions (Hesse-

¹⁷ Silent probe is when you remain silent but gesture with, for instance, a nod for the participant to elaborate on what she is saying.

Biber, 2014, p. 198). Probing by leading questions, such as “Can you explain further?”, “Is there something more/else you would like to add to what you’ve just said?”, “How did that make you feel?”, and “What do you think should be done about it?” served to support and encourage participants to share their experiences. I also maintained non-verbal cues, such as eye contact and nodding, to assure participants that I was not only paying attention to what they were saying, but indeed understood what they were saying. Interviewing, as used in this study, gave “presence to women’s voices and experience in their own words” and granted me the opportunity to understand their version of life (Ironstone-Catterall, 1998, p. 19). Interviewing was invaluable in allowing me to place women porters’ voices, lived perspectives, and experiences at the heart of my research.

As a researcher, my task during each interview was to observe, ask questions, seek clarifications when needed, and to respect and protect the privacy of each participant (Bourgeault, Dingwall, & de Vries, 2010). However, interviewing is more than asking questions, probing, or asking for clarification from participants. I also needed to listen to what was being said, while simultaneously listening for what remained unspoken. I learned that it was imperative to listen for what was not being said because both verbal cues such as “intonations, nuances, pauses and inflections” and non-verbal cues, such as the body language of participants embody hidden but significant meanings (Letherby, 2003, p. 109). The importance of listening was well stressed by Kasper (as cited in Ironstone-Catterall, 1998), who contended that:

Listening may be more valuable to the collection of data than the most carefully crafted questions. And, listening in active and different ways means hearing the words which are the infrastructure of an account (not merely answers to questions) and which reflect a woman’s effort to give an accurate portrayal of her experience. (p. 34)

I sought and indeed had a vested interest in listening for and identifying “gaps and absences in women’s discourse . . . [as well as] considering the meanings that lie beyond explicit speech” (Hesse-Biber, 2014, p. 16). As De Vault (2004) noted, listening attentively to the silences in gaps, such as “you know?” within women’s voices, promotes access to subjugated knowledge. I recognized that gaps in participants’ speech signaled “the realm of not-quite-articulated experience, where standard vocabulary is inadequate, and where a participant tries to speak from experience and finds language wanting” (p. 235). For instance, in my interview with Kolby, I observed that she used the phrase “really” at specific instances only.

I want to work harder and harder and make money and go back to continue my education again. *Really* . . . me, I suffer for my education, and I am still suffering, so I want to have money and go back and then proceed my education, because I want to go farther . . . further. Just to fight for the family. (Kolby)

In the extract above, Kolby used the word *really* in reference to being financially disadvantaged with the additional responsibility of having to labour for capital in her “fight” for her educational advancement as well as for the sustenance of her family back home. In summary, while employing a more interactive and conversational interviewing approach, I also listened very diligently to the stories of women porters, since “the essential meanings of women’s lives can be grasped only by listening to the women themselves” (Ironstone-Catterall, 1998, p. 32).

Interviews in this study lasted between 30 and 50 minutes and were conducted at mutually agreed locations, allowing each participant to feel comfortable sharing her story. Three of the interviews were conducted within a primary school classroom, which was in proximity to the participants’ places of work. The remaining nine interviews were

conducted at the makeshift residences of the remaining participants after working hours (usually between six and nine p.m.). Conducting interviews at mutually agreed locations, particularly the residences of research participants, made them feel at home, hence comfortable sharing their thoughts and experiences with me. It also facilitated my bonding with participants, which helped create an atmosphere of trust and openness between us, effectively making our relationship friendly and non-hierarchical, which mitigated some of the hierarchies present in the interviewer-interviewee relationship.

My style of interviewing and my interviewing skills as a whole changed over time as I gained more practical experience. My very first interview, for instance, was almost a disaster, in terms of structure, particularly with my follow-up questions. For example, during my first interview, I wanted to ask every question in my interview guide, irrespective of whether it had already been answered in a previous question or not. However, as I became more proficient and less anxious, I developed mental skip patterns that allowed interviews to flow more naturally, like everyday conversations.

As a feminist researcher, I was mindful of “issues of power and control” in my research (Naples, 2003, p. 50). Being conscious of power dynamics between the researcher and participant allowed me to interrogate my privileged status, both achieved and ascribed, relative to my participants. I needed to be aware that my research participants did not “lie on the same plane” as me (Hesse-Biber, 2014, p. 199). For instance, my position as a scholar with training and education allowed me to not only choose a research topic, and thus gain access to the privacy of participants through interviewing, but also allowed me to structure the course of each interview through the use of probes as well as to analyze my participants’ stories and disseminate my analysis

(of their stories) among a wider audience (Dickson-Swift, James, Kippen, & Liamputtong, 2007; Kelly, 2010; Porter, Neysmith, Reitsma-Street, & Collins, 2009).

As a scholar from Northern Ghana studying at a Canadian university, I also occupied a privileged status in relation to my participants, since none of them at the time of my fieldwork had had the opportunity to attend a university. My privileged status as a scholar was evident in participants addressing me as “Nam” (Sir) while responding to my questions with “yes sir/no sir” despite my repeated calls for them to address me by my first name. However, their reference to me as “Nam” and addressing me as “Sir” can be partly explained in terms of convention. In Ghana, there is the tendency for any person who has a higher level of education, especially, a university degree and a formal job, to be called “Sir” by both men and women who are yet to attain that level of education. Regardless of this convention, I was required to be self-reflective about the social relations that I have now entered into with my participants, and further about the power dynamics inherent within.

Scholars such as Ashby (2011), Behar (1993), Kelly (2010), and Naples (2003) have respectively acknowledged the presence of uneven power relations between researchers and participants. Behar, for instance, argued that as researchers, we are constantly asking for revelations of our participants’ experiences and stories, yet “reveal little or nothing of ourselves. . . . [In so doing], we make others vulnerable, but ourselves remain invulnerable” (p. 237). I attended to the uneven power hierarchy that existed between my participants and me through a practice of self-disclosure and reciprocity (Hesse-Biber, 2014).

According to Dickson-Swift et al. (2007), self-disclosure and reciprocity “enable[s] researchers to acknowledge the value of what their participants have shared with them” (p. 334). I began this research on the premise that I must be willing to share my story with participants if I wanted them to share their stories with me. As such, I shared not just my nationality as a Ghanaian, but also my ethnicity as a Northerner. I took ample time to share personal stories about my life as a child being raised by a single mother in a small village, Namolo, in Northern Ghana. As I shared my stories of struggle, poverty, and most importantly of hope to the women of this study, I believe that each of them related (in some way) to my story. My personal story, to a large extent, may have helped to mitigate the uneven power hierarchies of education, gender, and class that existed between us. That is, it was my experience that sharing my life histories with women porters facilitated my acceptance and entrance into their lives, while raising their confidence and trust in me since our stories were very analogous (Naples, 2003).

While voluntary self-disclosure was invaluable to building rapport and reducing uneven power hierarchies, I was conscious of Wolf and Deere’s (1996) caution that volunteering too much personal information can be a burden and a nuisance to research participants and may even defeat the purpose of self-disclosure and reciprocity. With this in mind, my approach to self-disclosure and reciprocity during research interviews, and in my general interaction with participants, was largely based on asking, clarifying, and listening to the stories of women porters; I never commented or shared my personal points of view unless a participant inquired, which usually occurred after interviews. This means that, save the stories about my ethnicity and childhood struggles, I did not invite participants to enquire after my perspectives on issues that we discussed. I, however,

reciprocated (responded) as tactfully yet honestly as I could whenever participants had questions regarding my thoughts on a subject of interest.

I also challenged notion that I had all the “power” (Naples, 2003, p. 4) by continually assuring participants of their right of voluntary participation, their right to refuse to answer any question(s), as well as their right to withdraw from the study at any time. I also informed participants that since we were co-constructing knowledge, they should at all times feel free to initiate discursive subjects that they were more interested in or subjects that I, as the researcher, failed to incorporate into my interview guide or failed to ask altogether. The question, “Is there any other concern or issue that you would like to share or talk about that we have not discussed,” asked during each interview, allowed participants to fully participate in the creation of knowledge that reflected their best interests.

Moreover, contrary to claims that the researcher has all the power (Naples, 2003), I, like Patai and Stacey (as cited in Naples, 2003), was not always exclusively in possession of power. Indeed, the balance of power kept shifting between my participants and me during the entire research process (Letherby, 2003). I felt disempowered when the participant had the power to consent to be interviewed because, without her consent, the research would not have been possible. As soon as the participants agreed to participate, the balance of power shifted in my favour again because the interviewing process were solely designed by me. However, the power shifted back to the participants when they provided answers to the questions being asked. In accord with institutional ethical practices, participants were informed of the right to decide what questions to

answer, what not to answer, or how much information to provide in response to questions asked.

In essence, there was a shifting distribution of power between me and my participants during the fieldwork process. My efforts to reduce the power dynamics in my social relations with participants, however, did not entail that there were no hierarchies in our relationship. The best example of this is the fact that participants, despite my best efforts to minimize the power relations between us, still regarded me as a more educated person and continued to refer to me as Sir. Throughout the research process, I ensured an ethical approach to each phase of the research.

Ethical Considerations

Research ethics began with the establishment of the Nuremberg Code in 1948, following Nazi trials in post-Second World War Nuremberg, Germany. The Nuremberg Code, which emphasized voluntary participation and informed consent by all human subjects, is a key principle of feminist research (Hesse-Biber, 2014). Since the establishment of the Nuremberg code, all scholars attached to Canadian institutions are federally required to follow established guidelines for ethical research. In line with the ethical guidelines of the University of Lethbridge Human Subject Research Committee (2010), I obtained approval (Protocol #2013-072) to conduct research with human subjects. Upon receipt of the approval, I traveled to Ghana to begin my fieldwork with women porters.

As the principal researcher, and in consonance with the ethical guidelines required by all researchers at the University of Lethbridge, I ensured that each participant thoroughly understood the following prior to interviewing: (a) the nature and purpose of

my study, (b) the methods and tools of data collection, (c) their right of voluntary participation and withdrawal, and (d) the time commitment required. I further informed and assured participants that pseudonyms would be used to protect and safeguard their privacy and anonymity according to their preference. Even though each of these details were well stated in the participant consent form (see Appendix B), I also verbally explained these details to participants as a means of ensuring that they perfectly understood its contents. I further provided each participant with my contact information as well as that of my thesis supervisor, along with a statement inviting all participants to freely contact either of us in case they had concerns or questions.

An ethical research is much more than research that has gained the approval of an ethics committee or board (Guillemin & Gillam, 2004). Hence, while adhering to all the university's procedural ethical guidelines, I also made a conscious effort to engage in relational ethics (Blee & Currier, 2011; Ellis, 2009) or what Lincoln (as cited in Ellis, 2009, p. 308) referred to as "ethic[s] of care" (p. 43). I engaged in ethics of care in alignment with my awareness that relational situations and "ethically important moments" (Guillemin & Gillam, 2004, p. 262) that make the "head spin" and "hearts ache" often come up during the field work process (Ellis, 2009, p. 316). Besides, I became conscious of the possibility that some participants might become upset when asked about their experiences of migration and health seeking as well as their living and working situations. For instance, Cynthia became upset while recounting some unpleasant treatments she received from some of her clients, both male and female. When this happened, I immediately stopped the interview, turned off my recording device, and

tried to calm her down by giving her space. I also offered to postpone the interview. Cynthia, however, asked me to continue.

I provided all participants with the contact information, including name, phone number, and location, of professional support services within Kumasi, specifically, at the Komfo Anokye Teaching Hospital, in the event that they wished to pursue professional support. Providing my participants with information on available professional services was important because even though researchers often hope “those involved in our studies will feel better, . . . sometimes they won’t” (Ellis, 2009, p. 316). Additionally, part of my ethics of care involved me spending time with each participant after the interview was completed. I stayed with each participant for a minimum of 30 minutes (at one time over an hour)¹⁸ as a means of ensuring that they were in good spirits (fine) before leaving the field. Without a doubt, women porters appreciated the fact that I cared enough to want to hear their stories. Their appreciation was reflected in them urging me to stay on and chat with them after interviews. Others even offered to cook *touzafi*, a local dish, as a thank you to me for choosing to invest my time in speaking with them.

Data Analysis

Braun and Clarke (2006) argued that:

If we do not know how people went about analysing their data, or what assumptions informed their analysis, it is difficult to evaluate their research, and to compare and/or synthesize it with other studies on that topic, and it can impede other researchers carrying out related projects in the future. (p. 7)

¹⁸ After my final interview for instance, I stayed on to chat with an entire compound of head porters.

For this reason, clarity was an endeavour of my analytic journey. In my attempts to produce accountable knowledge, I, in accord with Baily (2012), came to the realization that “it is not always possible to pinpoint precisely how or why particular ideas arose” (p. 95). Here, I will focus solely on describing the key moments of my data analysis.

Data analysis in my study was not a “discrete phase of the research process confined to the moments when [I] analyze interview transcripts” (Mauthner & Doucet, 1998, p. 7). Rather, data analysis was an ongoing process conducted over the entire research process. For instance, when developing criteria for the selection of research participants, for asking questions or using probes to lead participants “down certain paths and not others (p. 7), I made active thematic decisions regarding those issues worthy of follow up or decided which issues not to follow up. In some instances, I developed new themes or topics for pursuit on the basis of previously conducted interviews in order to either reinforce my line of questioning, or open new lines of questioning. That said, I must acknowledge that most vigorous analysis occurred after, rather than before or during, the conduct of field interviews

Hence, after I completed the verbatim transcription of field interviews, I read each transcript many times to become fully familiarized with the content and prevailing themes. I initiated the data coding process by first familiarizing myself with the core content of the data, as well as with any new or repeated topics of interests articulated by study participants. This familiarization process ensured that any themes that were subsequently discussed arose from the data (Spencer, Richie, Ormston, O’Connor, & Barnard, 2014). This process of familiarization was performed concurrently with the creation of margin notes on individual transcripts. These margin notes highlighted the

relevant or unique responses of each participant. A close reading of each transcript and the marginalia, enabled the identification of significant unique or recurring themes (Saldana, 2009) within the data. A heightened engagement with the data occurred with this sentence-by-sentence and line-by-line close reading of each transcript. This close analysis also informed my preliminary list of codes¹⁹ (Saldana, 2009; Spencer et al., 2014; Richard & Morse, 2013). Codes were largely grouped around the following broad themes: male kin, gatekeepers, women as economic dependents, women's autonomy, high cost of health services, and treatment by health practioners among others.

These codes were used to frame the coding of subsequent interviews. However, as I continued to identify new themes throughout the coding of the remaining interview transcripts, I returned to the first transcripts to re-code them on the basis of the updated code list. Coding in this study was therefore both data-driven²⁰ and theory-driven. The concluding phase of coding revolved around my looking for a final instance into each transcript for unique, similar, or shared themes among the participant interviews.

As previously stated, coding was performed concurrently with the creation of margin notes on each transcript. These notes highlighted similarities, differences, and overlaps in participant accounts (Mauthner & Doucet, 1998). Themes, therefore, varied considerably in terms of occurrence. However, as Braun and Clarke (2006) noted, a

¹⁹ A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing and/or evocative attribute for a portion of language-based or visual data (Saldana, as cited in Spencer et al., 2014).

²⁰ Data driven means some codes were generated on the basis of the data itself; theory driven means I approached the data with specific question and a theoretical framework (feminist standpoint theory) (Braun & Clarke, 2006).

theme appearing in multiple instances does not necessarily imply that such a theme is “more crucial” (p. 10). Rather, “the keyness . . . [of a theme is contingent on] whether it captures something important” (p. 10) relevant to the research objectives and the overall research question. Braun and Clarke advised not to talk about “discovered . . . [or] emerging . . . [themes as] it denies the active role the researcher always plays in identifying patterns/themes, selecting which are of interest and reporting them to readers” (p. 7). With this in mind, I identified different themes that informed my study.

Conclusion

This chapter is a reflexive account of the methods and process utilized in this research. I discussed the feminist research methods employed and expanded on some ethical issues that arose during the research process. Finally, I concluded with a discussion on how I analyzed data obtained from the field.

Chapter Five:

Research Findings

This chapter on my research findings is divided into three sections. My description of the demographic profiles of participants with respect to ages, sex, level of education, Ghanaian region of origin, and relationship status will allow readers to gain some understanding about the demographic composition of the women whose valued experiences and voices have formed the basis of my research. In the second section, I discuss the first two research objectives, including (a) the factors behind the recent increase in feminized labour migrations from Northern to Southern Ghana and (b) the living and working conditions of these women, post-migration. In the third, and final section, I discuss the factors that influence migrant women's health-seeking decisions and their (in)ability to utilize available health care services in urban Kumasi.

Demographic Profile of the Participants

As per my study criterion, participants were recruited because of their status as Northern migrants who live and work in the Kumasi metropolis. For this reason, all my study participants hailed from a region, district, or village within one of the two main Northern regions of Ghana: Upper East and Northern. All participants were female, and their ages ranged between 18 and 25 years. All but one participant were married at the time interviews were conducted, and all were childless. In regards to religious affiliation, 11 participants were Muslim while one was a Christian. This finding was not surprising, given the fact that all but one of the participants in this study hailed from either a village or town within the Northern region of Ghana, which is predominantly Muslim. Previous studies with women porters had already reported that a greater percentage of internal

women migrants migrate from the North (Awumbila & Ardayfio-Schandorf, 2008; Opare, 2003; Van den Berg, 2007). The most striking socio-demographic characteristic of the participants in my research was educational status. Most respondents had attained a significantly high level of education than that reported by participants in previous published studies (Awumbila & Ardayfio-Schandorf, 2008; Opare, 2003; Yeboah & Appiah-Yeboah, 2009). This characteristic was anticipated and thus defined by me, since one of the criteria of my study was proficiency in the English language. This characteristic was employed because previous studies had almost exclusively focused on women porters who could neither speak nor read English.²¹ In my study, seven participants had formal education up to the senior high school level; four had junior high school education; while one had basic primary school education. All participants lived in makeshift structures. These structures are small in size, but yet heavily congested, sometimes housing between 10 and 15 women.²² The socio-demographic profiles of participants are indexed in Table 1.

²¹ This may be due to the fact that this category of migrants is the majority and also quite easy to locate.

²² Even though none of my participants had a child(ren), some lived in makeshift structures that had children of colleague porters living in them.

Table 1. *Socio-Demographic Profiles of Participants*

Name	Age	Living Situation	Educational Attainment	Marital status	Religiosity	Region of Origin
Kolby	22	10 roommates	SHS	Married	Muslim	Impaha - Northern
Cynthia	19	15 roommates	SHS	Single	Muslim	Buipe - Northern
Priscilla	21	14 roommates	SHS	Single	Muslim	Impaha - Northern
Wenia	25	12 roommates	SHS	Single	Muslim	Buipe - Northern
Sharon	20	12 roommates	SHS	Single	Muslim	Impaha - Northern
Jena	21	11 roommates	SHS	Single	Muslim	Tamale - Northern
Donna	21	12 roommates	Primary /Basic	Single	Muslim	Impaha - Northern
Christina	24	14 roommates	JHS	Single	Muslim	Impaha - Northern
Hannah	18	13 roommates	JHS	Single	Muslim	Tamale - Northern
Sheila	21	10 roommates	JHS	Single	Muslim	Tamale - Northern
Olivia	23	10 roommates	SHS	Single	Christian	Navrongo - Upper East
Sarah	18	13 roommates	JHS	Single	Muslim	Tamale-Northern

Reasons for Northern Women's Migration to Kumasi: Economics, Family, Education

In light of my secondary objective to find out the most recent causes of increased feminized North to South internal migration in Ghana, participants were asked the question: "Can you tell me why you embarked on this journey?" Participants' responses revealed migration to be a layered phenomenon, implying that different factors interact to induce the phenomenon as per the stories shared by the participants. For instance, even though economic, education, and family were the key reasons for the migration of women in this study, these individual factors were unique, yet interrelated, at various fronts. Economics, education, and family constituted the main reasons for Northern Ghanaian women's migration to Southern Ghana.

Economics. Numerous economic factors impacted participants in this study. For instance, Wenia stated that "It is poverty that brought me here, what brought me from my house to this place is poverty." Another participant, Sharon, added that:

It's about money, its money problems. My parents do not have (money); we are poor people. My father's farm too is also not giving us enough (yields) because there is no rain these days. We are suffering. So I've come here to find money so that I can use the money and be doing my business small small.

As the above extracts highlight, poverty and economic difficulties in the North were influential in some women's decisions to migrate to Southern Ghana. Similar to the United Nations Children Fund's report (UNICEF, 2000), all the participants in my study complained bitterly about the abject poverty that bedeviled their existence, which was made worse by the unavailability of jobs and start-up capital, particularly for women who nursed various entrepreneurship and educational aspirations.

There is no work there. We don't have any work to do so don't have any money. Me like this, I want to open a store in Impaha market, but I don't have money now. That is why I am working, carrying paa o paa. If I get enough money, I will go back and open the store and be selling things. (Sarah)

Participants stated that being unemployed in Northern Ghana meant they were workhands for their families, engaging in various forms of unwaged labour activities, such as helping their fathers on the farm and helping their mother in petty trading and pito brewing. Culturally regarded as performing their portion of familial duties, these jobs earned participants very little or no income at all. Compounding this, all income earned fell under the control of their parents and, thus, were not accessible to them. As a result, women's personal needs were mostly unattended to, as the needs of the family as a unit and of male kin preceded theirs. Participants viewed this family waged dynamic: Their inability to own any of their family's productive resources was not only an impediment to their autonomy, but also prevented future endeavours as well. By all accounts, poverty, the unavailability of jobs in rural Northern Ghana, and the inability to earn their own money distinct from the family economy motivated the women to migrate south to Kumasi. Respondents explicitly stated that they desired autonomy and economic independence from their families and, as a result, sought the only way to attain economic independence. As Cynthia recollected,

I always go to my father for everything, even money to buy personal things like always²³. I don't like this. It is embarrassing to me. This cannot continue. But since I cannot make money there (back home) because there is no work (jobs), I came here to work as a paa o paa²⁴ and make my own money.

²³ "Always" is a type of sanitary pad

²⁴ Paa o paa is the Kumasi equivalent of Kayaye

Being able to earn their own income, however, meant that women had to migrate to regions where ready employment was guaranteed. Migration to Southern urban Ghana was seen as a portal through which they might not only escape poverty via economic empowerment, but also patriarchal parental control. This finding of economics-induced feminized migration extends previous Ghanaian studies that found that most north to south economic migrants are men while women only migrate for marriage or family unification (Opare, 2003).

Family. Human migration has numerous determinants. As such, the presence of other causes of Northern women's migration besides economics became important. I asked, "Are there any other reasons why you left your home to come to Kumasi?" This question yielded an interesting finding: family. Despite previous claims that African traditional economics-induced migratory patterns, particularly migration over long distances and periods, were the privilege of men on the basis of their gendered traditional roles as breadwinners (Adepoju, 2002, 2006), my study revealed that Northern Ghanaian women are increasingly taking up roles previously, and conventionally reserved for men. This observation, which in part contributes to the ongoing discussion on the changing dynamic of gendered migration in Africa and Ghana in particular, was also affirmed by Abdul-Korah (2011) in his study of the Dagaaba of Northwestern Ghana. My findings indicated that even in the mist of women's independent migrations, another reason for Northern women's migration is family circumstances and expectations. According to the stories shared by the participants, young Northern women are currently heavily relied upon by their parents and younger siblings to migrate for work: their quota to the

sustenance of their family²⁵. Some participants mentioned the need to work and generate money to supplement their family's income as a key determining factor in their migratory decisions. I must clearly state here that while some participants, like Cynthia, pointed out that the decision to migrate was encouraged by their parents/family, others, like Christina, informed me that their families' poor economic standing was enough motivation to migrate and find work in order to support them. Cynthia stated,

Our parents don't have money. I came to look for money and go and help them. They told me them that I should go and work in the city and make money, so they gave me the way to come . . . even they gave me lorry fare too. So they know about me here; they know the work I am doing here.

She further asserted that her parents consented to her migrating:

because of home problems, financial problems. I want to work, but there is no work unless in Kumasi. So I came here to find work, get money, and if they just want something, I will send it home. This way, they will get something. That is why I came here. That is why I am working very hard.

Christina, however, informed me that she voluntarily migrated, even against the wishes of her parents, but with support of her family. She stated that her mother opposed her decision to migrate to work in Kumasi because of fears of possible adverse outcomes. Due to the unsecured nature of their housing facilities, some women porters, unfortunately, are sexually assaulted and often end up with unplanned pregnancies (Van

²⁵ Even though this finding appears to contradict my previous finding, I wish to state that these findings are not as contradictory as they appear to be. This is due to the fact that, even though participants were self-sufficient economic migrants, family support, particularly, support of parents and siblings is considered a duty once they are in a position to lend a hand. And as already pointed out, some of the participants in this study migrated to attain economic independence, not just for themselves, but also for their relatives back home. This is why I previously stated that migration is a layered phenomenon; different factors interact at different levels to induce the phenomenon. These factors are unique but yet interrelated at various fronts.

den Berg, 2007). Christina, nonetheless, chose to migrate and to work for her family because of her brothers' inability to support the family when he migrated. She reflected,

I encouraged myself. At the time, she will say, I will not allow you to go. The place, the way the place is, if you go, you will suffer. My brother went to Accra 6 years ago, and he has not come back home. He used to send us money; that was when he first went. But now dier²⁶, he doesn't send us any because business is not good. So when I just finished SSS²⁷, I decided to go and work so that I can get money and come and take care of them.

While Northern men are required by convention, and in the absence of income-generating activities, to migrate to find work and earn money to support their families, as the commnet above has illustrated, women are presently occupying these roles and performing the associated duties. Expectations that women support their families according to participants are increasingly encouraging the migration of women to become bread winners for their extended families.

Education. Even though participants mentioned education to be a critical factor in their migration decisions, I observed that they mostly mentioned education in my follow-up questions. This pointed to a fact in the literature claiming that Northern women usually prioritize needs of their family over their own (e.g., Christina's reflection) (Abdul-Korah, 2011). Contrary to previous claims that Northern women only migrated to acquire money to fund the purchase of cooking utensils in preparation for marriage (Opare, 2003), none of the 11 participants who were single at the time of my interviews nursed such a thought. While poverty and family support were the most visible forces shaping women's decisions to migrate, participants also identified education as an

²⁶ Dier is a local slang that has various connotations. Its usage above means "nowadays".

²⁷ Senior High School

important reason for their migration. Therefore, besides economics and family, another factor that greatly influenced the migratory decisions of Northern Ghanaian women revolved around the need to secure sufficient funds to complete or to pursue further education. Ten out of the 12 respondents cited the need to secure funding for education as a vital factor for their migration. For example, Sheila stated,

It was a financial problem, and I wanted to go to school. And because of the financial problem, I couldn't get money to go so that I came here to find some money so that I can use the money to go to school.

Sheila's account indicated that despite the obvious determining factor of her migration being poverty, her secondary aim for migrating was to secure funds for education. As she stated, acquiring enough "money will help me pay my fees" at the secondary level as well as cater for other needs when in school. In an almost similar refrain, Priscilla reported that:

When I was back in school, SHS1²⁸ that my father lost his life, and so when I completed, I have to further to tertiary level and due to financial problems, my mum asked me to come here and be doing small small so that I can get small money so that they will also get small and help me to forward my education. That's why I came here.

The above narrative shows that Priscilla's migratory intentions were similar to those of Sheila's. In Sheila's situation, however, the demise of her father, some encouragement from her mother, and the desire to continue her education were key determining factors in her ultimate decision to migrate. For Priscilla, migrating South to work as a head porter was the only way she could secure enough funds to enable her return to school. Sarah echoed similar sentiments:

²⁸ First year of SHS

We have no jobs there. I have completed since 2003, and there is no job for me, and I am not further my education too. And I use to advise myself to come to Kumasi so that I will do some work and get money to further my education.

She further pointed out that had there been jobs in her village, she would not have migrated to Kumasi to work as a head porter. However, the absence of jobs in her village compelled her to migrate to Kumasi to secure a job and save some money towards her education. Cynthia furthered this argument by emphatically and passionately stressing the value and importance of education to her. She explained,

I want to work harder and harder and make money and go back to continue my education again. Me, I suffer for my education, and I am still suffering, so I want to have money and go back and then proceed my education because I want to go farther, further.

From my discussions above, it can be seen that the recent high feminized migrations from Northern to Southern Ghana has several antecedents including, but not limited to, poverty, lack of employment, family support, and the pursuance of education.

Living and Working Conditions

It is my observation that the living and working conditions of Northern Ghanaian migrant women in Kumasi are not only deplorable, but also unacceptable. At her opening address at the Future of African Federation 16th General Assembly, the former Minister of Women and Children's Affairs, Hon. Haji Alima Mahama (as cited in Van den Berg, 2007), similarly stated that the most worrying aspect of the phenomenon of feminized migration was the lack of shelter for migrant women in urban settings. Shelter is arguably one of the most essential basic human needs, and the lack of it exposes women to various vulnerabilities. Women porters were unable to afford the high rent charged by urban landlords and, as a result, often resorted to living in makeshift accommodations, such as

wooden structures or kiosks. Because all but two of my interviews took place at the residence of participants, I was privileged to have a first-hand view and experience of participants' living conditions. I concur with two participants, Wenia and Sarah, who described their living conditions as "very unfortunate" and "very poor" respectively. The makeshift structures housing participants were not only poorly ventilated, but also overcrowded (see Table 1). Spaces meant for two women were being rented for 10 to 15 women at a time. It is fair to say that having a comfortable sleep was impossible in these cramped structures. The overcrowding, poor ventilation, and restless nights had severe implications on women's health. All participants, in fact, complained of chronic body pains that may be caused by some aspect of these living conditions.

Proper sanitation was also visibly absent in the areas where participants lived.²⁹ Choked, open drainages, which support the development of malaria-infested mosquito larvae, unregulated refuse dumps, and open defecation due to lack of/accessible public toilets compounded the already poor living conditions of these women. It was, therefore, not surprising that most diseases³⁰ reported by participants emanated from their poor living conditions. Some participants stated that they sometimes question their resolve in continuing to live in these conditions when they had far better-living conditions at home. For example, Donna had this to say about her living situation:

In our room, we are more than 10, actually we are 12 in number. And you know, those who are having the babies, they are containing the large space than those who don't have the babies. So the moment you are living with those who

²⁹ Poor sanitation is a huge problem in Ghana, and in Kumasi, but it is worse in the overcrowded slums where women porters reside.

³⁰ Cholera, malaria diarrhea

are having the babies, that means that your room will be squeezed, and it will be overcrowded. So in our room, to be frank, me, I'm not comfortable but because of what brought me from my house that makes me to live there.

In addition to their poor living conditions, women porters described their working conditions as a real struggle. These ranged from waking up at dawn, working under the scorching Ghanaian sun, chasing running vehicles (at times falling and getting injured) in anticipation of getting loads to carry, being shouted at and insulted by both market women and customers, being denied fair wages for services rendered, to being taxed by the Ghanaian government. At the end of the day, going home to mosquito-infested and poorly ventilated rooms were just some of the issues women porters had to deal with on a daily basis. It was my impression that the women in this study accepted these conditions because they were viewed as temporary, but necessary, steps towards the realization of their long-term ambitions. Some porters informed me that, save the reasons cited for migrating, they would have returned home (i.e., back to the North) long ago.

Health and Health-Seeking Practices: Meanings of Health

In this section, I discuss the factors that most influenced these migrant women's health-seeking behaviours and their utilization of available care services, including women's perception of health and being healthy. I subsequently discuss their health-seeking behaviours prior to migrating: that is, while they were still in Northern Ghana. A discussion of participants' health-seeking behaviours before, and after, migration is imperative because the stories shared by women porters revealed a correlation between their past and present health-seeking practices.

Health was not only differently evaluated, but also differently interpreted or constructed by respective participants in this study. Women porters mostly relied on their

life experiences in Northern Ghana, their experiences of migration, and their experiences of labour-intensive work post-migration as parameters for measuring their health. Participants sometimes also alluded to cultural and spiritual values to reinforce their interpretations. Health of the body (i.e., absence of disease) and health as wealth are the two main themes that will be discussed in this section.

Women porters equated being healthy to the well-coordinated, balanced, and efficient functioning of the various parts of their bodies or, in other words, “from my head to my toe” as Danna emphatically stated. Being unburdened by illness and having the ability to effectively perform their daily responsibilities were key to participants’ construction of health. For instance, Sharon stated,

Being healthy is everything to me. . . . My health is my everything. When I wake up in the morning, and I don’t feel any pains, headache or tired, it means that I can go to work. I can make money for myself and my family.

Similarly, Cynthia stated,

When I wake up in the morning, and I feel strong, I know I am healthy. To be healthy means I am not sick, my body is not paining me. It means I can work hard, you can make a lot or some money.

The above responses suggest that being physically able to participate in the social and economic opportunities that the urban commercial environment presents is central to women’s health and economic security. They emphasized that a healthy body enabled them to participate fully in the opportunities that they sought to explore upon migration. Participants further stressed that a healthy body allowed them to work and earn a decent living, which in turn, made them self-sufficient. Sharon’s description of the value of health, allowed me to understand that she defined health more complexly than I originally understood or presupposed in the questions or probes I brought to the interviews. In this

instance, health means much more than the absence of disease. That is, even though participants did not elaborate, nor did I probe for a more holistic interpretation of health, participants alluded to a more complex conceptualization of health than I had allowed including, as evident in Sharon's statement, to the spiritual, security and mobility aspects that good health offers. Her statement points to the fact that health was much more than the absence of disease or infirmities.

Participants also made a connection between health and wealth. According to women porters, only healthy women within their cohort (i.e., Kayaye women) had the ability to go to the market (i.e., work) in their bid to either create more capital or make amends for the previous day's losses. A sick woman misses the opportunity to create wealth or make amends and spends even the little that she may have accumulated in seeking treatments. For this reason, poor health was considered by participants to be an expensive burden not only because of the loss of revenue due to the days off work, but also due to the cost and time spent on health seeking or waiting for services. In essence, while good health provided participants with an opportunity to make a livelihood through capital creation, poor health deprived them of these opportunities.

Some participants also spoke about their initial arrival in Kumasi, including the struggles and difficulties that they encountered and endured as a measure of their health. For instance, some women considered their initial experiences of migration from the support of their family into the new terrain of urban Ghana as associated with poor health on the basis that they could hardly afford even the necessities of life (i.e., food, water, shelter). Participants spoke about living in the open during their very first weeks in Kumasi. They were at the mercy of both the weather, physical environment (e.g.,

scorching sun, rain, mosquitoes, filth, noise, etc.), and were also vulnerable and in constant fear of being robbed or physically and sexually assaulted³¹ (They told me they heard this happened to other women in the past). Due to their financial constraints upon arrival, women porters narrated that they were initially unable to properly care for themselves. Others spoke about living in constant fear of the unknown and lack of sleep during their nights in the open. Some women porters, however, viewed these difficulties as temporary and, therefore, were motivated by these challenges. In essence, these challenges motivated and empowered rather than discouraged them from giving up. As Jena reflected,

When I first came here, it was not easy at all. I used to sleep in front of one woman's kiosk. She allow me to sleep there because I promise to always sweep her front in the morning. When there is rain, I cannot sleep. The rain water comes on the veranda, and the whole place becomes wet. It's not only when it rains that I cannot sleep. Sometimes, I don't sleep at all because I fear the men will come and rape me. It was not easy at all. But when I look back home, there is no work there too. So I force myself to stay here. And now it's better. But first, it was very bad. Thank God.

As can be deduced from the above discussion, health was a dynamic ever-changing concept to women porters, and their interpretation of health was mostly based on their present as well as past experiences.

Health-Seeking Behaviour before and after Migration

Distinguishing between women porters' health seeking while they were still in Northern Ghana from their health-seeking behaviours after their migration into Southern

³¹ Participants confirmed reports in the literature that indeed some women migrants unfortunately are sexually assaulted.

Ghana is necessary because of the unique impact that each of these geo-physical locations has had on women's health-seeking behaviours.

As previously discussed, in rural Northern Ghana, women's self-expression regarding their own needs or health have been largely suppressed and disregarded. Consequently, decisions pertaining to their personal health needs were, in most cases, being made for them by their male kin. Participants revealed that their ability to independently make decisions regarding their personal health and utilization of available health care services, whether allopathic or traditional, were severely restrained by male kin who determined all aspects of their health seeking, whether a mere headache or more complicated issues like pregnancy and delivery. Participants stated that the voices of male relatives overwhelmed and muzzled their personal voices. Ultimately, male kin had the final say in decisions about their health needs and health seeking. Women's voicelessness, lack of control over their personal health-seeking decisions or options, and their passive submission to their male relatives when they were in Northern Ghana was evident in the accounts of my participants. Two themes prevalent in participant's accounts were male kin as gatekeepers and economic dependency on men.

Male kin as gatekeepers. While the literature on women's health seeking reports the family as having both positive and negative impact on women's health seeking and ultimate utilization of care services (e.g., Shaikh & Hatcher, 2005), I mainly found the impact of the patriarchal Northern Ghanaian family on women's health seeking to be negative. According to participants, Northern women are embedded in deep-rooted historical, cultural, and socially constructed social relations of power that empower men and disempower women. In their disempowered position, women lack autonomy to

independently determine any aspect or stages of their health seeking. Their agency was not only silenced by the empowered and dominant male relatives, but further, also by the actions of those holding power and authority were perceived to be culturally appropriate. For this reason, women, prior to migration, viewed the act of asking the consent of male kin prior to engaging in any act of health seeking as the norm. While the act of asking permission from these patriarchal gatekeepers was established in previous Ghanaian studies (e.g., Ngom et al., 2003), the process of seeking approval was left to the background. Participants spoke about these processes, thus bringing them to the light.

Women revealed that prior to migrating, their health-seeking intentions revolved around their empowered male kin, structured by socially constructed and culturally defined hierarchical patterns of communication. Women's disempowered social position meant that they were deprived of autonomy to independently determine, hence engage in acts of self-improvement (e.g., health seeking), without the prior consent and approval of men. For this reason, women with health concerns had to carefully negotiate specific cultural channels of communication with male kin if their goal was to obtain external care. The devaluation of women's autonomy also meant their health and wellbeing remained within the domain of male privilege. The only way women's health concerns would be heard and considered by men was if they accepted men's empowered social position and adhered to society's socially constructed and culturally defined chain of command. Participants recounted circumstances of having to carefully negotiate these gendered socially accepted standard operating procedures whenever they needed to seek care.

When I was in Impaha, who am I to just get up and go to the clinic. Herr!!! Do you want my father to beat me? Me, I cannot just go to the hospital. I cannot even go to my father straight (directly). I have to tell my mother first. Then my mother will go and tell my father. If I don't get well, feel better in two or three days, then my father will allow my mother to take me to the clinic. That's how it is there. But here, I don't have to do that. (Sharon)

Here, I can do anything I want . . . go to the drug store or the hospital. My sickness will decide. But there, it is a different story. Hmmm. Ok, I will tell my mother first, and then my father. No, my mother will tell my father. My father will talk to my grandfather, but now he will talk to my uncle, and they will go and see the gods. It is a big process. So no oh, [laughs] I cannot just say I want to go to the drug store or the clinic. I cannot oh. Hmmm. (Donna)

Participants further revealed that failure to comply with these male-dominated channels of communication: that is, not submitting to male authority would result in unnecessary delays or outright refusal to access care. This illustrated the extent to which women's autonomy in rural Ghana is devalued, necessitating women's submission to these dominant forces.

Economic dependency. In order for women to have the power to independently and autonomously decide when and where to seek care, they need access to either financial capital or productive resources that can be utilized in defraying the cost associated with health seeking. Unfortunately, men are the guardians of all financial and productive resources (e.g., land, property, etc.) according to the conventions of Northern Ghana's patriarchal culture. Men, not women, are the proprietors of all monetary and productive assets; this cultural predisposition makes women economically dependent on men. Women's lower economic position has several liabilities as participants revealed. First and foremost, women's economic dependence on male kin negatively impacts their autonomy on various fronts, but especially, on their independent health-seeking endeavours. Health seeking is a costly endeavour, and women's subordinate economic

position not only limits their independent health seeking intentions, but also their general health seeking efforts as well. As Sharon stated, “If you don’t have your own money to take care of yourself . . . go to the hospital or buy drugs from the drug store when you are sick, you have to suffer until he decide to give you money.”

Participants acknowledged that before migrating, they were wholly dependent on their male kin for all things financial. They recognized this dependence as a huge inhibition on their autonomy to do whatever they wished, at their own pace. Based on the narratives of my participants, none of whom possessed any financial security or property, not having access to and control over their own money and resources severely curtailed any thought of seeking health services. These circumstances endangered their health status in the long run. They emphatically stated that poor health had to become unbearable before they would speak out about it. For example, Sarah stated,

I did not have any work, so I didn’t have any money. So I always have to ask my father for money for hospital. He too didn’t always have. Because he too didn’t always have, I don’t just go to him when I have small pain. I have to wait for it to become big before I go.

Severity of an illness was not only a measure of poor health, it was also very influential in determining the expediency with which women’s health needs were taken seriously by those with money (i.e., their male kin). Family members, the majority of whom were uneducated,³² relied heavily on the severity of the concern before sanctioning women’s health-seeking behaviour. Women were consistently denied permission to engage in any form of health seeking, which was regarded as a waste of the family’s

³² None of the parents of my participants had formal education. Some had basic education, but the majority was illiterate.

resources, until there was sufficient proof that there was indeed something seriously wrong with them.

Perceived severity, as per participant's narratives, has been unconsciously but deeply internalized by Northern women. This situation directly limited their ability to demand immediate access to health services at the onset of a health problem. Study participants recounted that while they were in Northern Ghana, they only felt the need to demand and to seek care when "I cannot help my father on the farm because of sickness" (Sharon), or when "I don't . . . I cannot move, go to the market . . . when I just can't do anything" (Wenia). Participants' responses demonstrated that severity was a gendered guise, employed by male kin because of the indispensable nature of women's labour. Influenced by patriarchal gender norms, male kin mostly stretched women's health continuum to the limit because of the value of their unwaged labour, both within and without the household. As seen in Sharon's recollection, it is only when women are unable to effectively perform their gendered roles that male kin grant them permission to seek care.

Health-Seeking Behaviour after Migration: Relations with Health Practitioners, Delays, and Health Care Cost

Given that all the above hurdles were encountered while participants were still in Northern Ghana, some changes occurred when participants migrated. I asked, "Was the status quo challenged, or did other conditions or circumstances change?"

Participants reported that once they migrated out of the shadows of their male kin and the authoritative patriarchal power structures at play in Northern Ghana, they felt a new dawn of limitless possibilities in regards to the choices and decisions they might

unilaterally make about their personal lives, their finances, and more importantly, about their health seeking. Despite these new freedoms, they also stated that all was not rosy. As they informed me, certain elements continued to undermine their agency and impede their ability to utilize the health resources at their disposal. However, for a few positive accounts, participants mostly recounted negative experiences in accessing health care. Participant accounts covered three common themes: (a) experiences of negative treatment by health practitioners, (b) experiences of delays when seeking care, and (c) the high cost of allopathic care.

Relations with health practitioners. Poor treatment by nurse practitioners in the Ghanaian health care system is another factor that exacerbated Northern Ghanaian women's already diminished autonomy in regards to their health-seeking intentions and behaviours. The narratives of research participants suggested that while availability of health facilities was integral to women's health-seeking behaviours, availability was only just a minor aspect. This was due to the fact that while availability was not a problem to women porters in Kumasi, other factors still impeded their prompt access to care services. These factors not only affected women's present health-seeking endeavours, but also their future health-seeking endeavours as well. The conversation below, between myself and Cynthia, sheds some light on this concern:

Moderator³³: Do you know any health facility . . . hospital or clinic around here?

Cynthia: Yes, the Manhyia hospital is behind us here points towards location of the hospital.

³³ I was the moderator in this exchange.

Moderator: Are you registered with the national health insurance scheme?

Cynthia: Yes

Moderator: So you have health insurance, and the hospital is just behind you. You just told me you have been sick for some time now, and yet you haven't gone to the hospital? Why?

Cynthia: Hmm, if you go to the hospital, they will just be treating you bad. They will be shouting at you and calling you bad names. They don't treat us like human beings.

Moderator: Who?

Cynthia: The nurse people. They will be telling you shit things. They just don't respect us . . . we paa opaa³⁴. Hmmm. It's very bad. My sister [fellow headporter] even went there just yesterday, and the same thing happened. All paa o paa know that the nurses are bad. So we just advise ourselves not to go there, unless we are dying. Hmmm.

This exchange and similar stories from other participants made it evident that Northern Ghanaian women's demands were not only being silenced by their male kin, but also by the nursing staff in the public allopathic health care sector.

Eight of the 12 study participants specifically stated that they had stopped going to the hospital because of various forms of negative treatments they encountered in getting the attention they sought. Participants reported that nurses, who are usually their first point of contact upon arriving at the hospital and whose role is to facilitate their prompt access to care, expressed various degrees of indifference towards the health and wellbeing of female clientele. Nurses, as observed by participants, were actually impeding women porters' prompt access to much-needed care. Women porters struggled to understand why some nurses were usually very warm and welcoming during

³⁴ Paa o paa is the Kumasi version of Kayaye

community visitation, but at other times, unwelcoming, disrespectful, and discourteous. “Are they not the same people who say we should come to the hospital regularly?” queried Wenia. “So why don’t they take good care of us when we go?” she added. Participants added that they not only had to endure abuse, but also had to accept poor treatment if they were to receive the care they sought. They were, thus, voiceless because expressing their feelings on such poor treatments only generated further abuse or delayed care.

Participants further indicated that nurses consistently shouted at them or insulted and blamed them for their illnesses. According to participant accounts, some also heavily chastised them for not reporting their symptoms much earlier. Hannah, for example, stated, “One wicked nurse even punish me” by refusing her pain medication so that she would “learn a lesson from it.” To these clients, public health nurses had the reputation of being supportive, loving, and caring. Yet negative experiences like these were disincentives that shaped their health-seeking behaviours away from health services provided in public facilities. Participant accounts of nurses in the private sector diverged from the negative accounts of the public health system. Contrary to experiences of negative treatment by nurses in publicly funded health institutions, nurses in the private sector were reported to not only treat women with respect, but, in fact, also showered them with love and unwavering attention. Seeking care from private health facilities, however, had its hurdles; private care was a lot more expensive than public care. The extra financial cost associated with private care discouraged women from continued patronage.

Delays. Long, seemingly unnecessary, waiting hours at public health care facilities were not only a huge disincentive to women's use of these services; it also influenced their health-seeking behaviours. This disincentive was especially true for women who could not afford to lose a full day's wages. For this reason, women porters often endured ill health until it became unbearable. As Kolby explained,

Sometimes, I am not feeling well, and I want to go to the hospital but I change my mind because there are too many people there. Because if I go there, I have to wait the whole day before I will see the doctor. You can even go early, 5am, by the time you get there, there is a long queue waiting for you. If you even get to see the doctor by afternoon, you will spend the rest of the day at the dispensary because another queue will be waiting for you there. Imagine, you can go at 5am, and you come home in the night, 6 pm. You can't even go to the market that day. That's money like that oh.

The narratives of participants on health seeking at this juncture mirrored their initial accounts when they were still in the north. That is, in light of anticipated long waiting hours at hospitals, illness severity became the foremost determining factor of women's health seeking. Consistent with their experience prior to migration, Northern women porters relied on their internalized perceptions of illness severity in determining when to seek care. This decision was also mediated by the expectation that waiting times would be long and the fact that women did not want to lose wages waiting for care. Care was then sought only for major and life-threatening health problems. Hence, once "I can still walk, carry load and make money, I don't, I won't waste my time and money there" (Cynthia). Like Cynthia, most participants distinguished in their process of self-assessment between major and minor health problems and, thus, sought care accordingly. For instance, when illness severity was perceived as low, self-medication was cited as the initial course of action. As Cynthia explained, "when my body is just paining me, or

when I just have some headache, I always take the medicine in this bag” (shows me a bag of unused medication). Self-medicating with previous drugs is a common practice among women porters in Ghana (Yiran et al., 2014). Cynthia, Wenia, and Kolby specifically stated that they always take note of all the medication that their doctors prescribe for them on their rare visits to the hospital and then purchase the same drugs at a pharmacy shop whenever they experience similar symptoms.

Reminiscent of their accounts of health seeking in the North, participants told a story of women who internalized the notion of care seeking only when an illness became unbearable or untreatable by the patient. Participants’ narratives revealed some preconceptions about the appropriate time to seek formal care. Most believed that only severe illnesses should take them to the hospital. The severity of illnesses were measured by the extent to which activities such as working, eating, and talking were restricted or hampered. Another significant reason for delayed health seeking was the value of lost time and, correspondingly, lost income. Lost time, particularly the loss of time in seeking care, was so gargantuan that women could ill afford to admit that they were indeed sick.

As Kolby explained,

Me, I can’t get sick oh, else trouble. See, I am not working this paa o paa for me alone oh. I am working for my child, my younger sisters, and my mother back home too. I have to send them money every week. So there is no time for me to be going to the hospital. I need that time to search for people, carry their things and get money.

From Kolby’s account, it is quite obvious that she was not merely earning for herself, but also for relatives back home. She, like other women porters, had to remit on a consistent basis, and as a result, any sick days lost from ill health implied they could not fulfill their duties to themselves and their family. A high value placed on women’s labour

by the family meant that the pressure on women to avoid lost time in seeking care for an illness was correspondingly high. As a consequence, women usually had to endure and push through high levels of discomfort, aches, and pains until they became bedridden. Only then would they resort to care services available. For example, Hannah stated,

Well, at times, you will feel pain in your body but because of money. . . . Instead of you to go to the hospital, you will say let me go, today I will go and get money and add to it. Tomorrow when you come, and it is better, you will not think of it, you will say, the next day I will go. When you go, it will disturb you again, you will come back, you will not go to the hospital.

Participants stated their migration south for employment in Kumasi's informal economy empowered them to be the sole decision makers of their finances, health, and wellbeing. Sarah explained her new-found autonomy with a reflection on how she no longer depends on kin for financial support. She also reinforced the reality that she is free to spend her money the way she sees best:

I take care of myself now. Only me. I don't need money or anything from anybody [kin] this time because I am making my money with this Kaya work that I am doing. Even if I don't make enough [money], that is my problem. Nobody will tell me how I should spend my money.

Health care cost. Being economically autonomous from kin, however, did not imply that women's health needs were correspondingly met. Economic autonomy implied that participants no longer depended on the financial support of male kin nor on their approval to seek care. Moreover, they were no longer barred by customs or norms or by a long chain of consent-seeking process before obtaining consent to seek care. In light of the erosion of these barriers, it might be reasoned and expected that women porters would be able to make full use of all the health services at their disposal. While this should be the case, the accounts of participants in this study did not corroborate it. The

high cost of health care in Kumasi became a major determinant of women's health-seeking decisions and behaviours. Even with their employment, participants like Kolby and Wenia respectively stated, "we paa o paa, we don't make enough money" because "our customers, they don't pay us enough." Participants explained that they hardly made enough money, as all their incomes were based on the benevolence of their clientele. Respondents explained that the increasing feminization of migration meant that there were currently more women porters in Kumasi than there used to be. A rise in supply (i.e., women porters), with a relatively stable demand (i.e., patrons) meant that prices for the services rendered by women porters went down. As Jena explained,

We are too many here, and more and more girls are coming every day to also carry things and get money. So if somebody just offer you small money to carry big . . . heavy load, you have to carry it. If you say you want to argue [negotiate] for them to add small money to it, another kaya will just come and carry it.

Lower incomes verses the high cost of health care subsequently accounted for women's reduced usage of allopathic health services in Kumasi. Besides, women porters felt the costs of allopathic health services were not only expensive, but unaffordable. As Sarah pointed out:

Hmm . . . if you go to the hospital, they will be telling you to go and do this . . . go and buy that. All that is money. So me, I don't go to the hospital because it's not cheap there. If it is cheap, like I will always be going there when I don't feel myself [feel well]. But to go there is money and we paa o paa girls; we don't have that kind of money to waste on hospital card and their expensive medicine. So me dier, I only go there when my sickness is too big, and I have small money.

At this juncture, I asked participants about their enrollment in the Ghanaian NHIS. All but three were registered and, thus, had state-funded health coverage. The remaining participants stated they were once insured, but were currently uninsured because they had failed to renew their registration when their subscription expired, due to

lack of funds. Being uninsured meant that all health needs and expenditures are supposed to be financed via out-of-pocket payments. Out-of-pocket payments, however, proved to be beyond the financial capacities of the women and, therefore, resulted in the low patronage of available health services.

Finally, I asked participants whether they seek preventive care services as a means of detecting, and thus preventing, the possibility of being overwhelmed by critical or life-threatening health problems. In response, participants stated that they had never sought any preventive health service. “Why?” I asked. These women, however, turned the question back on me: “Why should I?” (Sarah). Hannah further asked, “Why should I got to the hospital. . . . Am I looking for sickness trouble [meaning, is she looking for a disease or to get sick]?” Participants seemed unaware of the various preventive health care services at their disposal (e.g., mammography). For instance, each of the 12 women in this study asked me what mammography meant and what it was. Women porters’ narratives about preventive care were like those of “someone searching for trouble.” To them, not being aware about the potential presence of an illness was far better than knowledge of its presence, since “we don’t even have money to treat it, so not knowing is better” (Wenia). Furthermore, these women saw it as strange for a *healthy* person to seek medical services.

While the underlining factors behind women’s reluctance to seek preventive care might be explained from a socio-cultural standpoint³⁵, the most significant factor that I deduced from women’s narratives was the burden of the financial cost associated with

³⁵ After all, their parents, grandparents, or ancestors never sought any preventive care.

care seeking. Some of the women spoke extensively with me after the interviews and inquired first about the benefits of preventive care and then about the cost (i.e., time and money) associated with such services. At the end of our discussion, women porters concurred that preventive care was a good practice, yet they also countered this with the argument that preventive care was a huge waste of both time and resources, both of which were hard to come by for “poor people like us.” As Sharon pointed out after our discussion:

We Paa ooo paa live from hand to mouth. Many times, we cannot even go to the hospital when we are sick because we cannot pay, and now you want us to go to the hospital when we are not even sick?

Self-Care and Traditional Health Care

Despite participants’ awareness about the efficacy of allopathic care, the challenges they encountered greatly reduced their regular usage of such services. For this reason, I asked participants whether they had access to other care options in the urban environment. They informed me that their limited utilization of allopathic was supplemented by self-care and traditional Ghanaian health care services. Participants revealed that whenever the option of seeking care from an allopathic facility was impossible, they either engaged in self-care by self-medicating or by utilizing traditional care services. The latter, they stressed, were familiar, and they were aware of their efficacy. On utilizing traditional care, some participants specifically informed me that whenever the option of allopathic care was impossible, their next point of call was a traditional health care provider who came from a similar socio-cultural background, who spoke the same language as they, and most importantly, who provided cost effective care. Others added that due to the difficulty in accessing allopathic care, they have brought

along with them to Kumasi some of their preferred traditional medicines for the treatment of ailments such as malaria, back pain, and flu. Hannah specifically made mention of some herbal medicine for menstrual pain.

Participants stressed that their use of traditional options was not because of the non-availability of allopathic health care services. Rather, they stated that traditional health care was cost effective compared to hospital bills and highly priced drugs; thus, why incur debt for an illness that can be treated with very little money? Moreover, there existed the option of deferred payment when it came to traditional health care. Cynthia explained,

There is one man beside us; he is just a traditional man, and he is also from the north. So usually, those who are falling sick. . . We usually send them there, for him to give us medicine. And after, if the money is there, we will pay him, and if the money is not there, we will come home, and later, we will go and pay him. He is just the man for us, and he is just sitting beside us.

Furthermore, since the *traditional man* usually came from the same ethnic and cultural background or region as participants, women porters felt able to communicate more freely and effectively, hence secure reasonably priced treatment for almost every health condition.

Conclusion

Individual narratives discussed in this chapter have allowed an understanding of Northern Ghanaian women's experiences of health seeking and health service utilization before and after migration. Participants' accounts of health seeking and health service utilization illuminated the extent to which Northern women lacked both authority and autonomy in decisions pertaining to their personal health care needs. Findings specifically reveal that women's personal health options were heavily impeded by several

influential factors, including (a) cultural norms and gatekeeping which empower men and disempower women, (b) the Ghanaian health care system, and (c) the negative treatment by health care providers within the public sector. Women's efforts to improve their health and wellbeing via the utilization of available health care services before and after migration were influenced and heavily limited by numerous factors. Decisions regarding where, when, and from whom to seek care were made for women by husbands and fathers, as was the case before migration, or by health staff, as was the case after migration. In both circumstances, women were overtly denied opportunity and autonomy and, hence, the means to represent themselves or voice their own health concerns. The heavy censorship and control of all aspects of women's health seeking in both rural and urban Ghana sometimes led to women's internalization of pain, while *self-silencing* their personal health needs at the same time. The next chapter discusses the implications of my research.

Chapter Six

Research Implications

The implications and significance of my findings as informed by the lived perspectives and experiences of twelve Northern Ghanaian women are discussed in this concluding chapter. Even though participants in my study represented a diverse group in terms of their individual historical and current experiences of migration and health seeking in both rural and urban Ghana, the findings of my study may not be wholly generalizable to all migrant women who have migrated from rural to urban Ghana. This may be because Ghana is a multicultural country, with vastly different regional-specific cultural beliefs, norms, and practices. Nonetheless, my findings may be transferable to the three regions in Northern Ghana, as these predominately rural regions have similar cultural beliefs, norms, and practices. My findings may prove helpful in recognizing and identifying sustainable approaches to support migrant women's employment, living and working conditions, health seeking, and their utilization of available health care services in both rural and urban areas in Ghana. My findings also provide some guidance and direction for future research.

The Northern Ghanaian Family

In Northern Ghana, the patriarchal dominated family prevails as the norm, and women in male-headed family formations experienced the effects of this cultural bias. Women's health-seeking behaviours, their wellbeing, and their lives revolved around their family, and their decisions were particularly influenced by male kin. The role of male kin, according to participants' narratives, regarding the women's access and utilization of health services was largely negative. That is, while preexisting studies have

presented the family as potentially having equally positive and negative impacts on women's health-seeking endeavours (Shaikh & Hatcher, 2005), my study found the male kin who dominate decision making within the family to be injurious to women's health-seeking behaviours. Male relatives severely limited women's autonomy, and women's needs were entertained only if they followed a strict socially constructed protocol of communication with men. Women, especially, confronted the overarching power and influence of male kin prior to their North-to-South migration. For example, women would conventionally need to secure the consent of male kin, who were the culturally proclaimed gatekeepers of women's health. Prior literature showed that this hierarchy within the family, with male kin making all decisions for women members of the family, was not only culturally accepted but also desirable (Ngom et al., 2003; Yakong et al., 2010).

The participants in this study revealed that women's dependence on gatekeepers for all their health-seeking needs while they remained closer to their families while in Northern Ghana resulted in delays in seeking appropriate care for any health problem. My study has indicated that women's social disempowerment within the family, especially in Northern Ghana, and the expectation of male kin that they follow strict socially constructed, male-defined protocols of communication, has compounded their current plight for bettering their health. These protocols have caused extended wait times and increased the women's pain and suffering, as approval from male kin must be consistently sought prior to obtaining care.

Unlike women, fathers and husbands, as participants revealed, are socially empowered. They hold positions as guardians of all productive and financial resources,

and this control of the resources served to restrict women's ability to seek health care. Hence, prior to their migration from the North to urban and Southern Ghana, the women in my study were wholly dependent on the resources and permission of their male kin whenever they needed health care. Similar findings have been reported by studies conducted in other patriarchal-dominated societies in countries, including Bangladesh (Ahmed, 2005), Pakistan (Shaikh & Hatcher, 2005), Nigeria (Ikeako & Iloabachie, 2006; Ndikom & Ofi, 2012), and Ghana (Adongo et al., 1998; Ngom et al., 2003).

My study, however, moved beyond the impediments to health women face in male-dominated family formations in rural Ghana to examine how migration away from these restrictions and social control mechanisms impacted the lives and control of Northern Ghanaian women. Participants reported that their decision to migrate from rural Northern Ghana, away from family and male control, greatly enhanced their autonomy and ability to act as they wished without fear of adverse consequences. Participants reported that migration granted them financial independence from male kin, and, as a result, migration afforded a new ability to unilaterally make decisions regarding their personal lives, finances, and health.

The Role of Health Staff (Nurses) in Ghana's Allopathic Health Care System

While women's ability to seek care improved once they left the controlling environment of family life, difficulties were also encountered after migration. Northern rural Ghanaian women experienced diminished autonomy with regards to their ability to demand or utilize care services upon migration as a result of barriers within the modern allopathic Ghanaian health care system as opposed to barriers created by male kin experienced in the North. Similar to other studies from Ghana (Aborigo et al., 2014;

Yiran et al., 2014), Pakistan (Shaikh & Hatcher, 2005), and South Africa (Jewkes, Abrahams & Mvo, 1998), my study illustrated the extent to which health service quality, availability, opening hours, and waiting times in urban Ghana's health care system impeded women's health-seeking intentions and health-seeking behaviour. As previously discussed, restrictive or limited opening hours for low-income working women and underdetermined waiting times shaped women's health-seeking intentions away from allopathic care. However, another factor that disadvantaged working women was the negative attitudes of health staff towards women porters seeking services. This relationship, according to my participants, was an influential determinant of women's present and future health-seeking endeavours in urban Ghana.

Similar the findings reported by Jewkes et al. (1998), in a study that sought to answer the question "*why do nurses abuse patients*", participants in this current study isolated the negative treatment received from nurses at public allopathic health facilities as having a major impact on their health-seeking behaviours. Women consistently reported that they expected positive reinforcement from their female nurses and were often appalled by the treatment they received. Contrary to the expectations, or belief, that it is the duty of health staff to assist them with respect and dignity, participants at times found themselves at the receiving end of various forms of verbal abuse from nursing staff. Participants complained that nurses did not value their point of view and failed to listen to everything they had to say. They described experiences of disrespectful treatment; they experienced insults and were refused treatment for not making a trip to the hospital sooner rather than later. For these reasons, participants described being terrified of frequenting the hospitals, and whenever they did go, they faced maltreatment

in order to receive care promptly. Thus, these participants revealed the consequences of negative provider attitudes on women's health seeking as preexisting studies confirmed (Aborigo et al., 2014; Jewkes et al., 1998; Shaikh & Hatcher, 2005; Yiran et al., 2014).

While many examples of abuse, as discussed by Jewkes et al (1998) might be interpreted as the noble intentions of nurses endeavouring to change certain patient practices that may be unsafe to women themselves, hence "frighten them into compliance" (p. 1786), most of the accounts of participants in this study identified these practices as more punitive than corrective. While previous studies (Jewkes et al., 1998) argue that abuse from nurses may be the result of poor working conditions including wages, the findings of this study, however, demonstrate that less affluent women porters, who were at the receiving end of nurses maltreatment, are significantly more socially and economically disempowered than the nurses they encounter. I would argue, therefore, that negative nursing attitudes or maltreatment of less privileged clientele may not be attributed to conditions experienced by staff in their working environment. Nonetheless, an investigation of other contextual reasons, for instance, of a structural or political economic nature may provide an explanation of their behaviours towards the women. However, in this research, no further explanation surfaced nor was it evident in my interactions with participants. Hence, I would strongly advocate for the inclusion of nurses as participants in any future studies to understand more fully such punitive reactions as reported by the women participants in this study.

Working Women Migrants Negotiate Power

Upon migration, Northern Ghanaian women gained a fuller consciousness of the negative impact that socially constructed, normative, gendered roles had on their ability

to act autonomously and, hence, on their health and wellbeing. Being self-employed and not having to depend on the goodwill of male kin for all their needs, including permission or resources to allow them to seek health care, women experienced empowerment and autonomy. In the midst of this changing gender status quo, women spoke of their journey from being voiceless to gaining a voice; with this came greater autonomy to act as they deem fit. Evidently, women's self-employment granted them economic independence and also accorded them a higher social status. Economic independence was key in women attaining a voice and autonomy to seek health care whenever they needed, regardless of what others thought. With economic independence, women became less dependent on the authority of others, particularly male kin.

Even though Northern women's prolonged dependence on their male kin had a sustained influence that exceeded their migration south, with respect to waiting for a health problem to become severe before seeking care, participants in this study expressed optimism that once they gained greater financial security, some of these self-doubts might gradually wear off. Despite women's inability to find a sustainable solution to dealing more effectively and assertively with public health nurses in urban Ghana's healthcare system, they were confident that with time, things would get better.

Women in this study, thus, envisioned a brighter future. While some anticipated earning sufficient money to pursue higher education and pursue occupational opportunities as teachers and nurses, others were saving to open their own businesses. Attaining greater economic independence and becoming self-reliant motivated the women. They were aware that economic independence was the surest way to better their own lives and those of their children.

Implications of My Research

My findings have highlighted the broader social and persistent structural factors that have consistently disempowered Northern Ghanaian women workers in contemporary Ghana. Moreover, this research, based on a modest sample of women working in an informal labour sector, has raised important questions regarding equity of care in Ghana's health care system. Health care affordability remains a strong determinant of women's health-seeking behaviours despite Ghana's implementation of an NHIS. Even though Ghana's NHIS was implemented with the health needs of the less affluent in mind, recent studies have continued to identify major flaws in the scheme. Some scholars suggested that the NHIS benefits the rich even more than the poor for which it was implemented (Dalaba et al., 2014; Mills et al., 2012). There is, therefore, urgent need for a re-evaluation of Ghana's Health Care Act (2013) and a need to improve the health care scheme in order to better addresses the needs of all, including the less affluent.

Additionally, due to the strategic role played by nurses in the public healthcare delivery chain, as noted in the findings that portrayed nurses as obstacles to improvement in women's health-seeking behaviours, there is an immediate need for nurses to be better educated to be sensitive and respectful of the needs of working rural migrant women. Nurses' potential strategic roles in empowering less affluent working women cannot be overemphasized. Nurses have the potential to assist the less affluent who face cultural censorship and accepted barriers on various fronts. Exposing instances when women seeking care experienced maltreatment or verbal abuse from nurses and raising nurses' awareness of the negative impact of this treatment on women's health and wellbeing may

help. Currently, poor treatment received in the health care system reinforces the hegemonic power structures that not only silence but also negatively impact working women of the rural north. Lastly, nurses must extend health education, particularly, the importance of early health seeking to gatekeepers, particularly husbands, fathers, and brothers, as a means of broadening men's awareness of the importance of health care for wives, daughters and sisters.

In sum, the findings from my research have shown that Northern women migrants face a myriad of structural and social constraints in their attempts to seek and utilize available health care services. My findings further illustrated that a more nuanced understanding of all the factors that negatively impact women's health seeking is imperative for enhancing women's wellbeing and empowering their utilization of the various care options available to them. Modifications in care delivery, in particular, with regard to asking for improvement in ethical nursing education, are worthy of immediate consideration.

The negative impact of the family, male kin in particular, on women's health seeking has been a key finding of this research. However, it is also clear that the family, and the socially constructed empowerment of male kin in the decision-making process, continues to be influential on the health of women. It is my contention therefore that novel approaches are required to ensure that women's autonomy and health are not compromised by the social hierarchies embedded by custom and social relations.

What novel approaches might be tested? One such approach revolves around the active engagement of men in "gender work"; in other words actively engaging men in consciousness-raising about power and gender. Encouraging the active involvement of

men in “gender work” is important because to achieve gender equality the attitudes of men’s empowerment must be positively renegotiated, and changed. Northern Ghanaian men, as discussed in my thesis, play significant roles as gatekeepers of their families and communities at large. As gatekeepers, men often engage in traditionally accepted sexist practices such as controlling women’s reproductive and health seeking behaviours, limiting women’s direct access to economic and productive resources, among others. It is my opinion, therefore, that for sustainable change to occur in regards to women’s empowerment, particularly within the family, social customs must not only change, but men must be sensitized to recognize the social, gendered inequality that pervades society, and must, therefore, be ready to embrace gender parity by first, acknowledging the privileges they hold and second, by relinquishing power to women. Men are “unavoidably involved in gender issues” (Flood, 2007, p 9). And since men are intrinsically located at the centre of gender inequity men must participate in discussion about ending inequity. Addressing the attitudes and roles of men will not only be crucial in reconstructing gender and power relations, but will go a long way in achieving parity between men and women.

On the other hand, the absence of men as active participants in gender work may provoke male antagonism and retribution. Male antagonism and retribution may deepen gender inequalities and thus leave women with less to bargain with, urge men to be more unsympathetic and leave patriarchal power in tact (Flood, 2007). The participation of men who support gender equality in the renegotiation of gender relations may therefore make interventions more relevant and workable and create the desired sustainable

change. Involving men who are already living in “gender-just”³⁶ ways (Flood, 2007, p. 10). Additionally, male inclusion and active involvement in gender work, will increase their responsibility for change and may allow them to understand that they have something to gain from gender equality. Men’s understanding of gender work may actually aid in addressing men’s fear and apprehension as traditional masculinities are renegotiated. Novel approaches like the creation of workshop opportunities, among other platforms, to grant men the opportunity to analyze their own empowerment may ensure women’s autonomy and health are not compromised.

³⁶ Men who respect and advocate for equal rights while rejecting patriarchal norms of manhood (Flood, 2007).

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Appendix A

KAYAYO YOUTH ASSOCIATION

KUMASI BRANCH

Email: kayaghana@gmail.com

(+233-0266441300, +233-0247073271)

August 05, 2013

LETTER OF VOLUNTARY PARTICIPATION

Dear Mr. Prosper Asaana,

I have reviewed your research proposal entitled: Contemporary Rural Urban Migration and Access to Health Services: The Perspective of Female Head Porters in Kumasi Ghana. I am happy to inform you that the necessary support and cooperation will be given you to interview migrant female head porters who are members of the Kayayo Youth Association (KAYA). Each individual's participation will however be voluntary and at her own discretion.

I am also happy to volunteer in assisting you find and select members of KAYA who meet the selection requirements of your research as well as facilitating the participation of members who voluntarily agree to participate in your study.

As a leader of KAYA, I confirm that I am authorized to approve research involving members of this association. I look forward and I am hopeful that findings from your research may draw the attention of policy makers in Ghana to gear policy formulation towards the concerns and needs of women head porters.

I understand that the data you shall obtain will not be made available to anyone outside your research team. I therefore appreciate the steps outlined to protect the confidentiality of information you will obtain from participating members of this association.

Sincerely,



Mr. Iddrisu Issah

Kumasi Branch Secretary

Kayayo Youth Association (KAYA)



Mr. Osman Ziblim

Kumasi Branch Chairman

Kayayo Youth Association (KAYA)

Appendix B

Migration and Migrants Health Care Practices: Perspectives of Female Head Porters in Kumasi, Ghana

Dear Participant,

You are invited to take part in a research study entitled “Migration and Migrants Health Care Practices: The Perspective of Female Head Porters in Kumasi, Ghana”. This research is part of a longer research paper that will qualify me for a Master’s graduate degree. You are selected as a possible participant because you are an adult (18 years or older) migrant who has been and is still engaged in the business of head portage in the past two years. This study seeks to; (a) determine the current reasons for increased women migrating to become and staying as head porters (b) explore migrant women’s living and working conditions, the challenges arising from such conditions, (c) examine their health seeking behaviour and experiences therein, including the facilitators and barriers, all within the urban environment.

If you agree to participate in my research, I will ask you several questions about your history and experiences of migration, the labor you perform, your living conditions, and your access to health care within the city. The interview process will last between 30 minutes to 90 minutes. I will conduct this interview outside your work time and at a location and time both you and I mutually agree on. I will use a digital recorder to tape this interview for my research records. I will transcribe this interview and will share a copy of this typed transcript of your responses if you are interested. I am committed to accurately representing all that will be said in the interview.

Your decision to take part in this research is completely voluntary. There are no ramifications if you decide to not participate. Hence, you will not lose any benefit or services from anybody or any organization if you choose not to participate. If you do decide to participate in this research, you are free to withdraw at any point, for any reason, and without any explanation to the researcher or anyone else. There are possibilities of emotional risks in participating in this research; however as noted above if you feel at any point you do not wish to participate you are free to withdraw. Should you decide at any point to withdraw from this study, I will destroy all information obtained from you. Hence, such information will not be included in any written thesis or publication that results from this research. Also, if you consent to be a part of this study but wish not to be audio recorded, written notes will be taken as an alternative to audio recording.

More so, during the interview process, you can choose not to answer any question asked without any consequences or prejudice to you. Additionally, at your request, I will turn off the recording device during the interview and will only turn it back on with your consent. Any information generated during that non-recording period will only be used as data with prior approval from your person. Furthermore, should you at any point choose to withdraw from this study, your consent shall be obtained on what should be done with the data generated thus far. If your request that such data should not be used in any part of this thesis, it shall be destroyed.

The benefits of participating in this study include the opportunity for you to share your perspectives on factors contributing to women's decision to migrate to become, and stay as head porters. As noted earlier, I am also interested in your experiences with

regards to accessing health services in the city. The findings from this study may aid in the improvement of state or municipal policies that will help bring improvement or address any concerns of migrant women.

PAYMENT:

No payment or direct benefit will be provided for participating in this study.

PRIVACY:

There is a possibility of emotional distress due to some of the questions that I will be asking you during the interview section of this research. However, in light of these anticipated risks, several steps will be taken by the researcher to minimize any potential harmful effects of the them on you. Hence, should you experience an episode(s) of painful memory(ies), the researcher will immediately stop the interview, turn off the recording device and try to calm the participant. The interview will be postponed or continued at your discretion. Additionally, I will provide information that will be helpful to you in deciding whether or not to pursue professional counseling.

Besides this, any information you provide will be confidential and used for the purposes of this study only. I will use a pseudonym to ensure confidentiality, replacing your actual name with another to protect your identity. A transcript of our discussion will be made available to you to check for any missing details, details that should omitted, or for details that should not be revealed. You will be asked to suggest mediums through which such details can be successfully disguised in order to maximize anonymity. More so, you have the right to request for the non-revelation of such details at all. All things being equal however, there might be some limitations to the degree of anonymity that can be assured. For instance, there is the possibility that your concealed identity may still be

recognizable to some persons within the head porter community on the basis of your limited population within Kumasi.

The researcher will keep all electronic data for the study in a password protected computer and only I and my thesis supervisor (Dr. Carol Williams) will have access to them. Also, all transcripts and digital recordings will be destroyed after the completion of my thesis.

The information that you will share with me during our interview will be used in the production of a Canadian University Master's thesis, and research findings may be presented at conferences as well as published in academic journals. Publications that result from the findings from this research will however not be subject to your review. I will, however, ensure that your anonymity is protected with the use of pseudonyms in any unpublished or published materials.

To include you in this study, I will need your permission as indicated by reading this letter and agreeing to participate. Finally, I will ask you to sign this consent form, and I will also sign the form to witness this agreement between us. I will give you a copy of this form to keep. My supervisor and I will also have copies.

Thank you for thinking about being a part of my graduate research.

Sincerely,

Prosper Asaana.

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (phone # or Email: [email address]).

Also, if you wish to learn more about the study, or would like to speak to me or my supervisor, please call or email using the contact details below.

<u>RESEARCHER</u>	<u>THESIS SUPERVISOR</u>
PROSPER ASAANA	DR. CAROL WILLIAMS
University of Lethbridge	University of Lethbridge
Email: asaanap@yahoo.com	Carol.williams@uleth.ca

Statement of Consent:

[] I have read the above information and I feel I understand the research sufficiently to make a decision about my involvement. I consent to participate in this graduate Master's research project. By signing below, I understand that I am agreeing to only the terms described above.

Printed Name of Participant _____

Contact information of the participant:

Place & Date of consent _____

Participant's written signature _____

Researcher's written signature _____

[] Kindly tick if you will like to be directly contacted and informed of the published results of this research?

Appendix C

Good Morning/Afternoon/Evening and thank you for accepting to participate in this student research. The information you share with me will be kept confidential and used only for the purpose of my research, so please speak freely and share your honest opinions.

At this time, I am now going to turn on my audio recorder.

I WILL LIKE TO BEGIN OUR DISCUSSION BY ASKING A FEW QUESTIONS ABOUT YOU AND YOUR FAMILY.

Can you kindly tell me about yourself and your family?

Probes/follow-up questions:

- Age
- Village of origin
- Level of education
- Relationship status
- Do you have children
- Family size, Occupation of parents. Are your parents literate? Level of education attained by your parents?

I WILL ALSO LIKE TO ASK ABOUT YOUR EXPERIENCES WITH MIGRATION (MIGRATING FROM YOUR VILLAGE TO YOUR PRESENT LOCATION)

Can you describe your migration process and also share your migration experiences with me?

Probes/follow up questions:

- Can you tell me why you left your village to embark on this journey?
- Did you have to seek permission from anyone before you could migrate?
- Did you embark on this journey for the sole purpose of becoming a head porter? If yes why Kayaye? If no, how did and why did you come to be in this line of business?
- What accounts for you staying in the business for the past two years?
- For how long do you intend to remain in this line of business? And what reason informed your response?
- Is there anything else you would like to add to the above discussion?

I WILL LIKE TO ASK YOU A FEW MORE QUESTIONS ABOUT YOUR WORK...THE KAYAYE BUSINESS.

Can you describe to me a typical work day as a head porter?? When does your day begin, what do you do during the day, what is the nature and requirements of your job, when does your day end?

Probes/follow up questions

- Working conditions, relationship with clients/colleague kayaye, any challenges
- Living conditions/ challenges
- Earnings/Savings/ remittances
- Is this the sole work that you are engaged in?
- Security/ challenges... have you ever been fearful of your physical safety? Have you faced any violence since migrating? If yes, of what nature was this violence or threat of violence? What actions did you take afterward?

I WILL NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR HEALTH AND WELLBEING AND YOUR EXPERIENCES WITH ACCESSING HEALTH CARE SERVICES IN THIS CITY.

WHAT DOES BEING HEALTHY MEAN TO YOU? AND YOUR BUSINESS?

Can you describe to me the actions you take when you need to seek treatment for a medical condition? / What do you do when you need to seek medical attention either for yourself or your dependents?

Probes/follow-up questions

- Where do you usually go to seek such treatment? Hospital/Clinic/herbalist? Drug outlet or Pharmacy? Why do you choose to utilize that medium of health care/what informs your choice of utilizing such treatment choice?
- What is the distance involved in traveling to attain health care? Does distance, how close or how far, play any role in your choice of a health facility?
- Can you describe the experiences you have had with accessing health care services of any kind in Kumasi? How was the process?
- Did you find it easy to access health services? Did you encounter any difficulties or obstacles? Can you elaborate more on either the positive experiences or the difficulties you encountered?
- Do you get any information on health care services provided by various health facilities? From who or where do you get such information? Would you want to get this kind of information?

I WILL NOW LIKE TO DISCUSS MORE ON YOUR EXPERIENCES WITH HEALTH CARE SYSTEM AS A HEAD PORTER?

Does your status as a head porter affect your access to health care in any way?

Probes/Follow-up questions

- Does the health care system make provisions for the needs of migrant women like yourself?

- Do you have any input or recommendations on how the health staff or government can make health care more accessible to migrant women?

Can you share your experiences with me with regards to how you pay for health services?

Probes:

- What do you do when you have a health emergency, and there are no immediate funds to take care of the emergency?
- Are you registered under the national health insurance scheme? If no, why not? If yes, are there any advantages in being under the scheme, as a head porter?

What language do you usually use as a medium of communication when you visit a health facility?

Probes/Follow-up questions

- Do you feel there are difficulties in communicating with health personnel because they do not speak the same local dialect as you?
- Does this affect your access to services provided by health facilities? If yes, in what ways?
- What measures have you employed in addressing this difficulty?

IS THERE ANY OTHER CONCERN OR SITUATION THAT YOU WOULD LIKE TO SHARE OR TALK ABOUT THAT WE HAVE NOT DISCUSSED?