Priorities and Challenges Accessing Health Care Among Female Migrants

Health Services Insights
Volume 11: 1–5

DOI: 10.1177/1178632918804825

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ABSTRACT: Women's ability to access health care requires access to and control of resources as well as the ability to make personal health decisions. Female migrants may experience additional challenges in accessing health care due to marginalization and vulnerability resulting from both their gender and their migrant status. Rural-to-urban migrant women working in the informal sector, such as Ghana's head porters (*kayayei*), experience exclusion from the health system, risk of being uninsured, and poor health outcomes. *Kayayei's* survival needs (eg, food, water) and a need to provide for their families can mean that migrant *kayayei* avoid health care expenses for illnesses or injuries. To ensure equal access to health care for migrant and non-migrant populations, health insurance is crucial. Yet, improving access to health care and service uptake requires more than health insurance. Incorporating culturally appropriate care into the provision of health services, or even developing specific migrant-friendly health services, could improve health service uptake and health awareness among migrants. Public health systems should also take account of migrants' financial situations and priorities in the design and delivery of health services.

KEYWORDS: Health insurance, health care-seeking behavior, determinants, perceptions, poverty, access, urban health, gender, informal sector, population movement, migration, Ghana

RECEIVED: September 13, 2018. **ACCEPTED:** September 13, 2018.

TYPE: commentary

FUNDING: The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The London School of Economics and Political Science funded this research.

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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COMMENT ON: Lattof SR. Health insurance and care-seeking behaviours of female migrants in Accra, Ghana. *Health Policy Plan*. 2018;33:505–515. https://www.ncbi.nlm.nih.gov/pubmed/29462305

Introduction

Women's ability to access health care requires access to and control of resources as well as the ability to make personal health decisions. Female migrants may experience additional challenges when accessing health care due to marginalization and vulnerability resulting from both their gender and their migrant status.[1] In Ghana, our study among rural-to-urban migrant girls and women found that female migrants working in the informal sector as market porters (*kayayei* [plural], *kayayoo* [singular]) experienced exclusion from the health care system, risk of being uninsured, and poor health.[2] Self-reported health status declined on arrival in Accra, with one in three participants reporting their health as bad or very bad. Both the prevalence of recent illness/injury among participants in our sample (38.4%) and the prevalence we estimated for Accra's migrant *kayayei* population using respondent-driven sampling (23.2%) exceeded that of the general female population in Ghana's capital, Accra (10.0%).[2–4]

This burden of ill health among female migrants warrants greater attention given the prominence of the Greater Accra Region in contemporary female internal migration patterns. As Ghana's most urban region (90.5%, as indicated in Figure 1) and home to the nation's capital, the Greater Accra Region consistently receives the West African country's largest inflow of female internal migrants.

Although participants in our study who were ill or injured in the 2 weeks preceding the study (hereafter 'recent illness/injury') desired health care, less than half sought formal or informal health care.[2] Prior experiences with stigma or discrimination at health facilities and the unpredictability of out-of-pocket expenses restricted both insured and uninsured female migrants from seeking formal health services. Financial barriers, including the risk of out-of-pocket expenses, significantly limited participants from seeking health care, from taking time away from work, from registering with Ghana's National Health Insurance Scheme (NHIS), and from renewing their expired health insurance policies.

Female migrants experience more negative health effects of migration than male migrants.[5] Female migrants are also likelier than male migrants to experience lack of food, labor abuse, sexual abuse, and inadequate health services.[7] The literature on health outcomes of female migrants compared with female non-migrants exhibits greater variation. Like Ghana, rural-to-urban migrant women in Zambia reported poorer health outcomes than urban non-migrant women along with higher levels of illiteracy and lower levels of advanced education.[8] A lack of formal education and low-income affect health status adversely among urban women.[9] Other studies, however, report better health among female migrants. Female internal migrants in Myanmar reported better health outcomes than female non-migrants and were significantly more likely than

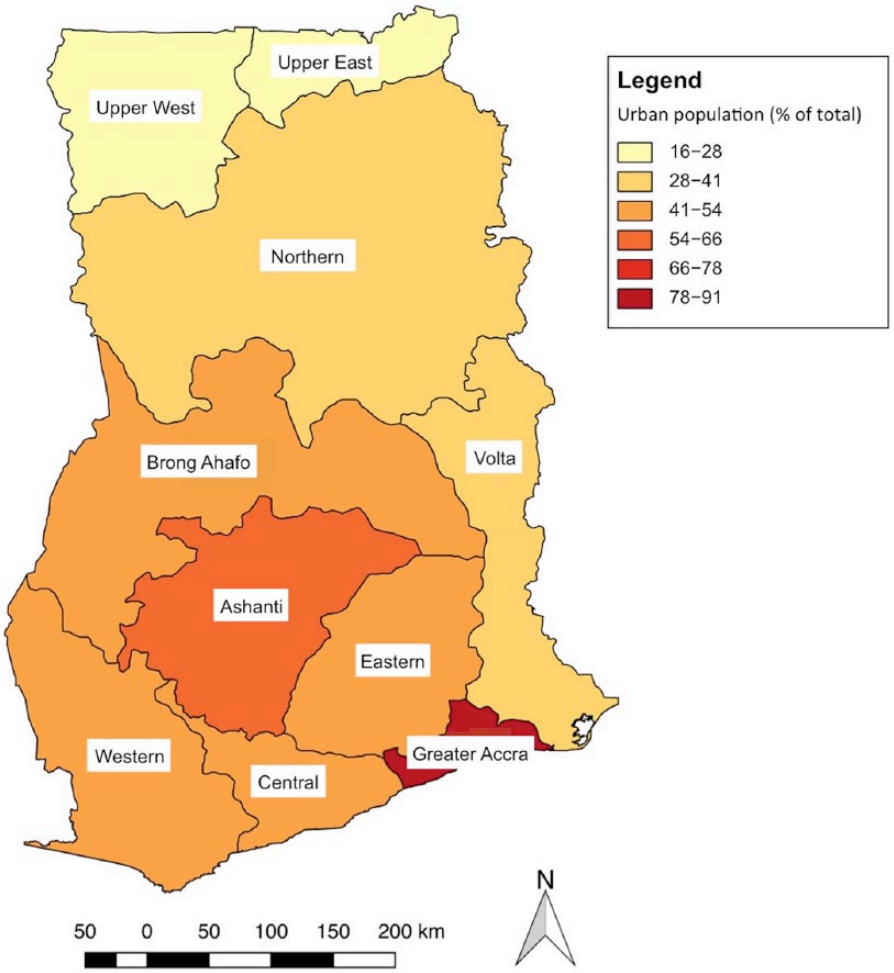

Figure 1. Map of Ghana by region with differentiated urbanization levels (2010).
Source: Map created by the authors.

female non-migrants to be from a higher socioeconomic status.[10] This finding is noteworthy given that increasing women's incomes can translate into improved health outcomes.[6] The differences between these studies in Ghana, Zambia, and Myanmar illustrate the weakness of examining health outcomes solely as a result of migrant status. Migration's impact on health is affected by the interplay of factors such as socioeconomic status, gender, and occupation.

Using new quantitative and qualitative primary data from our study, for which the methodology is described in detail elsewhere, we provide additional insights into how these factors affect female migrants' ability to access health care in Accra.[2,4] This study examined contemporary north-south migration using primary survey data on 625 migrant *kayayei* living in Accra using respondent-driven sampling and in-depth interviews among 48 *kayayei* who experienced a recent illness/injury. Quotations here have been lightly edited for the conventions of standard written English. Although this commentary focuses on the experiences of migrant girls and women, migrant boys and men may experience some of the same issues.

Female Migrants and Barriers to Health Care

In Ghana, gender dynamics affect women's enrollment in and drop out from the NHIS. Compared with men, women are more likely to drop out of the NHIS if they have unreliable incomes, live with young children, and are food insecure.[11] Poor people may be effectively penalized by the NHIS since the scheme has a mandatory delay in health insurance coverage before members who dropped out can re-enrol.[11] Although 77.3% of participants in our study reported being insured at some point in time, only 58.2% of participants were currently insured. Three in four currently insured participants reported lacking a valid health insurance card in Accra. Migrants often forget to bring their insurance cards when migrating, particularly if the migration was urgent, such fleeing an abusive partner. Delays in processing health insurance cards in the north meant the cards were not always ready by the time migrants left for Accra. Migrants with unsecure housing or who were homeless in Accra reported losing their health insurance cards to fire, flood, and theft. Without valid health insurance cards, insured migrants faced similar financial barriers to care as uninsured migrants.

At times, migrant *kayayei's* exclusion from the health system results from tough choices between survival needs and health care. Many migrants only sought health care when it was critically necessary. Consequently, female migrants reported prioritizing self-care for illnesses and injuries since seeking formal medical care involved the loss of both earned income and potential income due to long waiting times at health facilities:

> Sometimes, you go. If you can go, if you even reach there [the health facility], there will be plenty of people. So you waste your time now and when they reach you, [opening] time is over. You have to go back the second day or the next week. (Kussasi woman aged 19 years)

Kayayei must work to pay their daily survival costs (eg, water, food, toilet, market tax [at the time of data collection, the Accra Metropolitan Assembly (AMA) charged *kayayei* a daily market tax of GH₵ 0.50 to work. Study participants of all ages, including children under the age of 18 years, reported paying this tax. Participants who could not pay reported abuse from ticket collectors that included beatings or the confiscation of their sandals and carrying pans. Since then, the AMA has reportedly abolished this market toll on *kayayei*.[12]]) and cannot rely on extended family networks for support at a distance. They may seek temporary fixes (eg, tablets of unknown efficacy from a peddler) to address their health problems until the health problems are so serious that they can no longer work.[13] No formal safety net exists for migrant *kayayei* who require health care but are uninsured or require money to pay for treatment out-of-pocket. If migrants were unable to borrow money, they turned to begging to pay for their medical expenses:

> When I am sick, I buy medicine in the drugstore. But I hear that some people, if they go there [to the hospital], they can spend money, more than even 100 Ghana [cedis]. One of our sisters was sick. We had to take a bowl and go round and fetch some money and bring it [to the hospital]. First, when we went [to the hospital] they said 300 cedis. And we brought it. Second time, they said 500 [cedis] and we went round again. So they were just using us. We had to come home and take a bowl and go around and beg for money to pay her bill. […] The hospital did not help with the bill. It only called her husband, and her husband came and helped pay the money. (Mole-Dagbani woman aged 30 years)

Healthy Migrants or Healthy Families?

Female mobility increasingly shapes household-level economics, as migrant women working in the informal sector contribute to the livelihoods of their households.[14] Opportunity for employment and greater earnings in Accra minimized the potential risks of north-to-south, rural-to-urban female migration among study participants. Accumulating and saving money in Accra and sending remittances provided a crucial lifeline to northern families experiencing financial struggles, disabilities, and elderly parents. Migrant *kayayei* prioritized the health and survival of their children, siblings, and families. Avoiding health care expenses for illnesses or injuries perceived as non-immediately threatening to the ability to work is one way that migrants provided for their families. Participants often sacrificed their own health care needs to save and remit money. Another financial strategy was to go without shelter:

> **Interviewer:** If you have to give something up, why do you give up shelter to save more money?
> **Respondent:** Because if I am using my money for that thing, the money [savings] would not be what I want. Because everyday, if I wake up, I'm thinking about the children. And everyday, they call me to say 'come back, come home, come.' So I need to get the money. (Mole-Dagbani woman aged 25 years)

With space in a shared room costing a median of GH₵ 3.01 per week (US$1 = GH₵ 4.75 as of August 8, 2018), going without shelter allowed migrants to meet their financial goals sooner so that they could reunite with their families. This strategy, however, has significant health risks. Migrant *kayayei* sleeping outside reported problems like rape, assault, and malaria. Significant health risks accompany the *kayayoo* occupation as well. Working as a *kayayoo* is a physically demanding job that requires agility, an ability to work in extreme conditions (eg, high temperatures, storms), endurance, and strength. In a convenience sample of the first 40 *kayayei* to walk by the study office, the average woman carried 88.3% of her bodyweight (range 65.0%-122.2%) on her head and earned GH₵ 1.80 (range GH₵ 1.20-3.00) to carry the load 1.5 km in distance (range 0.8-2.0km). Among the six women who carried babies in addition to loads, these women carried an average of 114.8% of their bodyweight (range 80.3%-155.3%) (Figure 2). Physical injuries that restricted *kayayei's* abilities to work threatened participants' survival and their ability to send home remittances. Migrants were likelier to obtain medical care for conditions that affected their ability to carry a load (eg, sprained ankle, deep gash to the hand) than for symptoms like fever that may be indicative of malaria.

This research has broader implications for female migration beyond female migrants' exclusion from the formal health system and the vulnerabilities they experience as a result of their gender, migrant status, and work in the informal sector. Female migrants tolerate far more risk than female non-migrants, and this difference in risk tolerance is especially notable when compared with males.[15] Migrating to Accra to work as a head porter is inherently risky. For some migrants, these risks resulted in greater hardships, including deteriorating health, difficulty parenting remotely, starvation, rape, theft, and illness. For others, these risks returned dividends in the form of money to start a business in the north, to pay for family medical bills, or to pay for school fees for the next term.

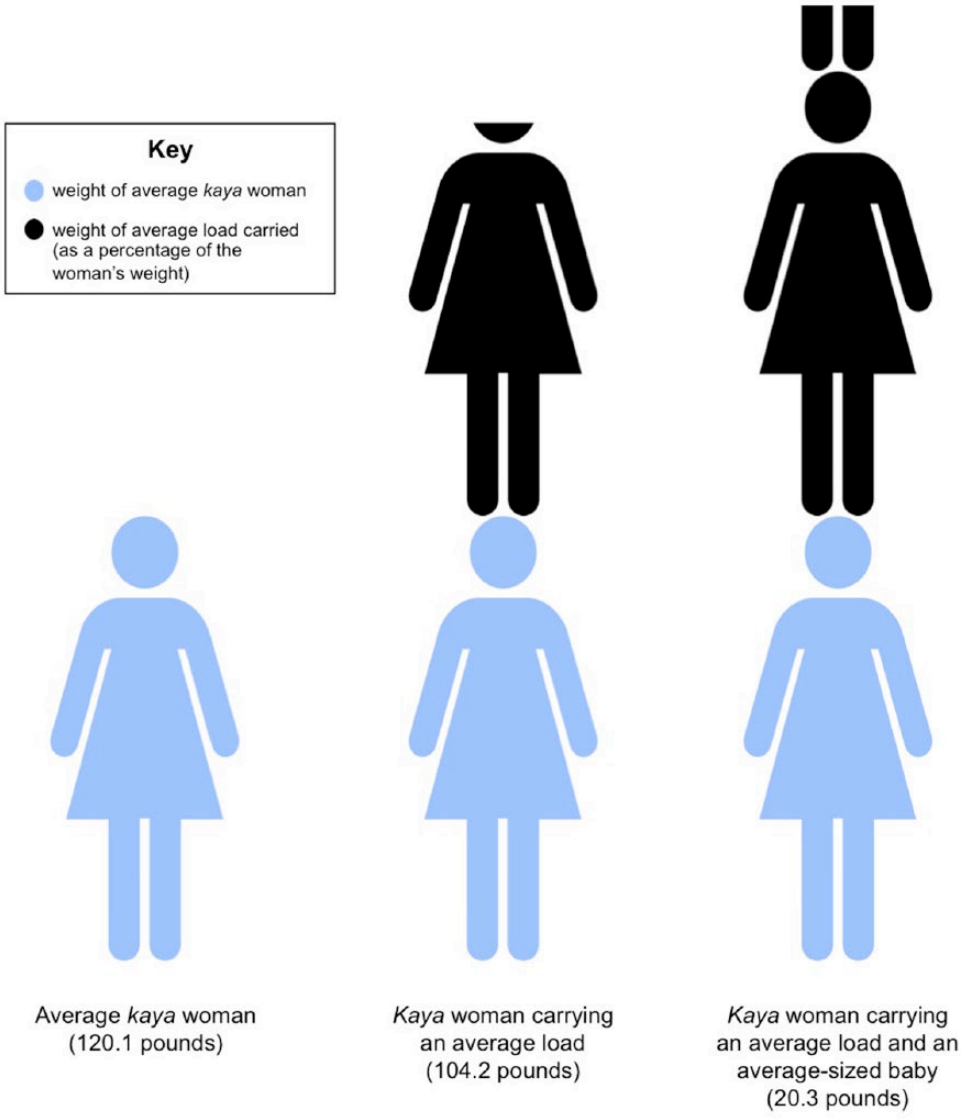

Figure 2. Load size in comparison to the weight of an average woman working as a head porter.
The length of the stick figure, in black, corresponds to the percentage of the load's weight in relation to the woman's bodyweight.

Achieving Equity in Migrant Health

Financial barriers and a lack of health insurance exclude migrant workers from utilizing health care in many settings.[16,17] Young, low-paid, less educated female migrants in China were likely to be uninsured and to pay for health care out of pocket, much like migrant *kayayei*.[16] To address these barriers and ensure equal access to health care between migrant and non-migrant populations, health insurance is crucial. Yet, research from Thailand suggests that improving access to care and service uptake requires more than health insurance. Migrants experience unique barriers to care, including harassment and real or perceived discrimination from health providers.[18]

Incorporating culturally appropriate care into the provision of health services, or developing specific migrant-friendly health services, could improve health service uptake and health awareness among migrants by helping migrants navigate health services. Policymakers interested in achieving universal health care should consider implementing similar public health models for migrants that use volunteer community health workers, mobile clinics for migrant communities, bilingual signs and information, and workplace outreach.[19]

Ghana is still struggling to achieve the NHIS's goal of universal health care due to members' failure to renew their policies annually.[20] If the scheme is to improve equity, then policymakers must revisit implementation of the NHIS's indigent exemption. Rising migration within Ghana necessitates access to affordable, quality health services across domestic borders. Public health systems also need greater awareness of migrants' financial situations and priorities when designing policies and services. Migrant *kayayei* migrated to Accra from districts with higher percentages of poor residents than the national average. Mandating that Ghana's poorest districts enroll higher percentages of individuals under the indigent exemption would benefit

many migrant *kayayei*, especially those who could not afford to renew their insurance policies and those for whom family medical expenses triggered their migrations.

Policymakers could also improve equity by strengthening mechanisms for community organizations to provide District Mutual Health Insurance Scheme Managers with lists of individuals in greatest need of an exemption. Community organizations like the Kayayei Youth Association are well positioned to help ensure that the indigent exemption is effectively applied to those most in need and to link migrants with mobile clinics and health outreach programs.

Acknowledgements

Thanks to Mohammed Salifu and the Kayayei Youth Association for permitting this research to be conducted through their organization; and to Gifty Danwah, Lariba Ibrahim, Akos Kwaku, Enyonam Nanewortor, Humeida Sayibu, Nazira Abdulmajeed and Abigana Akolgo for their assistance with collecting the data. We especially thank the migrant kayayei who participated in this study.

Author Contributions

SRL wrote the first draft of the manuscript. SRL, EC, and TL all contributed to the writing and editing of the manuscript. SRL, EC, and TL all reviewed and approved the final version of the manuscript.

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