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URBAN POOR AND SOCIAL EXCLUSION

EXPLORING THE ACCESSIBILITY OF MATERNAL HEALTHCARE SERVICES AMONG FEMALE HEAD PORTERS (KAYAYEI) IN THE ACCRA METROPOLIS

PAUVRETE URBAINE ET EXCLUSION SOCIALE

EXPLORATION DE L'ACCESSIBILITE DES SERVICES DE SANTE MATERNELLE CHEZ LES PORTEUSES DES CHARGES (KAYAYEI) DANS LA METROPOLE D'ACCRA

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ABSTRACT

In Ghana, urban areas are the most equipped with facilities and social amenities. However, these benefits have not trickled down to the urban poor. Such is the case of female head porters, locally referred to as Kayayei working at informal markets in the Accra Metropolis, who although have greater reproductive health needs, still encounter barriers which limit their access to maternal healthcare services.

To find out more about some of the challenges that these women face when seeking maternal healthcare services as a result of their status in society, a qualitative research design was adopted. Individual interviews were organised with 10 female head porters who provided information on their socio-demographic characteristics, their knowledge on maternal healthcare, the problems they came across in their attempt to access maternal healthcare services, their personal experiences with healthcare service providers, and the influence of social capital on their maternal health choices.

The answers provided by the interview participants were then analysed using an adapted version of the Andersen Behavioural Model of Healthcare Service Utilisation as a conceptual framework for organising interview responses into the following main themes: environment, population characteristics, health behaviour and outcome.

The results of this study revealed that although a majority of Kayayei accessed maternal healthcare services, they experienced many inconveniences such as high cost of medical care and drugs, long distance from residence to health centres and long waiting times. Moreover, despite a majority of the Kayayei receiving maternal healthcare services, they were found to engage in activities which exposed them and their children to health hazards.

This study concludes that policies such as free National Health Insurance Scheme registration in markets, public education and awareness and reduced medical costs be adapted to enhance access to maternal healthcare services.

Keywords: exclusion, poverty, healthcare, urbanisation, migrants

RESUME

Au Ghana, les zones urbaines sont les plus dotées en infrastructures et en équipements sociaux. Cependant, ces avantages ne se sont pas étendus aux pauvres des villes. C'est le cas des porteuses des charges, appelées localement Kayayei, qui travaillent sur les marchés informels de la métropole d'Accra. Bien qu'elles aient des besoins plus importants en matière de santé reproductive, elles rencontrent des obstacles qui limitent leur accès aux services de santé maternelle.

Afin d'en savoir plus sur certains des défis auxquels ces femmes sont confrontées lorsqu'elles recherchent des services de santé maternelle en raison de leur statut dans la société, un modèle de recherche qualitative a été adopté. Des entretiens individuels ont été organisés avec 10 porteuses des charges qui ont fourni des informations sur leurs caractéristiques sociodémographiques, leurs connaissances sur les soins de santé maternelle, les problèmes qu'elles ont rencontrés dans leur accès aux services de santé maternelle, leurs expériences personnelles avec les prestataires de services de santé, et l'influence du capital social sur leurs choix en matière de santé maternelle.

Les réponses fournies par les participants à l'entretien ont ensuite été analysées en utilisant une version adaptée du modèle comportemental d'Andersen sur l'utilisation des services de santé comme cadre conceptuel pour organiser les réponses à l'entretien selon les thèmes principaux suivants : environnement, caractéristiques de la population, comportement en matière de santé et résultats.

Les résultats de cette étude ont révélé que, malgré le fait que la majorité des Kayayei aient accédé aux services de santé maternelle, elles ont subi de nombreux inconvénients tels que le coût élevé des soins médicaux et des médicaments, la longue distance entre la résidence et les centres de santé et les longs délais d'attente. De plus, bien que la majorité des Kayayei bénéficient de services de santé maternelle, elles se sont engagées dans des activités qui les ont exposées, elles et leurs enfants, à des risques sanitaires.

Cette étude conclut que des politiques telles que l'inscription gratuite au régime national d'assurance maladie sur les marchés, l'éducation et la sensibilisation du public et la réduction des frais médicaux doivent être adaptées pour améliorer l'accès aux services de santé maternelle.

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ABBREVIATIONS

B-SEM: Bristol Social Exclusion Matrix

CBD: Central Business District

CHPS: Community Health Planning and Services

COVID: Coronavirus Disease

FHD: Family Health Division

GDHS: Ghana Demographic an Health Survey

GDP: Gross Domestic Product

NHIS: National Health Insurance Scheme

SAPs: Structural Adjustment Programmes

SDG: Sustainable Development Goals

UN: United Nations

WHO: World Health Organisation

PREFACE

In Ghana, maternal mortality rate as of 2017 was 308 deaths per 100 000 live births. As a member of the United Nations which is committed to the achievement of the Sustainable Development Goals (SDGs), this falls woefully short of the target of 70 deaths per 100 000 live births maximum. Many of these deaths have been linked to the lack of access to maternal healthcare services. However, most research work has focused on the rural areas and the inadequate resources they have as compared to urban areas.

In the wake of rapid urbanisation and the mass migration of unskilled labour from rural areas to cities, the exclusion of the urban poor from services and social amenities is also on the rise and this takes an exceptionally heavy toll on the most vulnerable among them, which include migrant women and children.

This exclusion has serious implications on every facet of their lives, including their health. The situation becomes more critical when it involves pregnant women and mothers of new-borns, as this could become potentially life-threatening. In addition to that, the health hazards that surround them in their environment because they are dependent on the informal sector, makes it even more important to seek maternal healthcare services. Unfortunately, this is not the case as a result of the social factors which have become barriers limiting their access to these services. It is for this reason that I have developed interest in exploring the social factors which limit the access to maternal healthcare services of female head porters in the Accra Metropolis.

As a child to parents in the informal market in the Central Business District of Accra, my first encounter with female head porters was during a visit to my parent's shop where I observed what they have taken upon themselves as a tradition. This made me curious to know more about them and how they live. Further information about them revealed that they encounter many challenges as urban residents with regards to their access to housing and other basic social amenities. This makes them the ideal case to demonstrate how marginalised people face many limitations in accessing services such as maternal healthcare services in spite of a relatively abundant supply of these facilities in cities.

The focus on a group that shares some social characteristics in common will ensure that the research presents detailed information on the experiences of this specific group women in the Accra Metropolis, the capital of Ghana which is the most urbanised and possibly the most polarising area of the country. Thus, through studies like this, policymakers would be able to implement specific policies to combat the challenges that the group of people in question encounter.

CHAPTER 1: INTRODUCTION

1.1 Introduction

The ability to access maternal healthcare services during pregnancy, childbirth and after childbirth are essential to the health and well-being of both mother and child, and also potentially lifesaving for them (Kazanga et al., 2019). It is for this reason that women are encouraged to fully utilise these facilities. Indeed, the SDG 3 target of reducing the global maternal mortality rate to 70 by 2030 is heavily dependent on the optimal utilisation of maternal healthcare services (Olonade et al., 2019).

Accordingly, Mehedi Hasan et al. (2021) support that to reduce maternal mortality, the improvement of maternal healthcare services is indispensable. A study by Figueiredo et al. (2018) also revealed that increased service provision by health workers in the Northeast of Brazil contributed significantly to the reduction of maternal deaths, and Nour (2008) provides evidence which suggest that in countries where the percentage of skilled births were high, maternal mortality ratio was low.

Despite the evident importance of these services, many women are unable to access them for various reasons. It is therefore no coincidence that global maternal mortality average is still high and progress towards the achievement of the SDG target has been rather slow. However, some regions bear a greater burden of these maternal deaths than others. According to the World Health Organisation, in 2017, Sub-Saharan Africa and Southern Asia accounted for 86% of all maternal deaths globally and most of which were avoidable, while developed countries like Poland and Norway recorded as low as two deaths per 100,000 live births (World Health Organization, 2019a, 2019b). This implies that on an international scale, there are significant gaps in access to maternal healthcare services.

Literature example of where deaths were higher where services were few

Several studies have shown that some groups of women, such as women with low income, those with low educational background, rural residents, informal settlement dwellers, migrants, among others are at a higher risk of underutilising maternal healthcare services because their social status renders it more difficult to use these services efficiently (Fotso et al., 2008; Jong, 2018; Mumtaz et al., 2012; Olonade et al., 2019). Consequently, they often constitute the majority of women with poor maternal health outcomes. Therefore, socioeconomic factors determining the use of maternal healthcare services has contributed to unequal maternal healthcare access.

In the case of Ghana, maternal mortality rate in 2017 was 308 deaths per 100 000 live births, which is almost five times above the SDG target. Maternal healthcare access also remains a challenge for many women. Despite policy interventions such as free maternal healthcare, the National Health Insurance Scheme, and the

construction of CHPS compounds which had the primary purpose of bridging the rural-urban divide in healthcare service provision and alleviating the financial burden of seeking medical care, they have not succeeded in creating the desired change. This is because these policies have not succeeded at targeting some of the most vulnerable members of society, such as the urban poor.

For this reason, this research aims to explore the challenges migrant female head porters, locally referred to as 'Kayayei', face as urban poor women in accessing maternal healthcare services in the Accra Metropolis.

1.2 Statement of the Problem

As one of the most rapidly urbanising regions, many countries in Sub-Saharan Africa are experiencing a mass exodus of people from rural areas to more urbanised areas for greener pastures and Ghana is no exception. The centralisation of development in the capital of the country, following the adoption of neoliberalist policies in the 1980s has become a pull factor for rural residents who are mainly unskilled labour, resulting in a population growth which has outpaced economic and infrastructural development, and thereby, diminishing the advantages of urban settlement.

Among the migrants are female head porters originating from the northern parts of Ghana who live and work in informal markets in the capital. Due to the high cost of living, they are unable to fully integrate in society. They usually live in slum areas or sleep in the open at the markets and rely on public bathrooms. This exposes them to health risks, especially reproductive health hazards. Their situation becomes particularly concerning during pregnancy and childbirth where they have increased health needs.

Nevertheless, these women encounter situations which bar them from utilising maternal healthcare services. Indeed, the fact that urban areas have better provision of healthcare facilities does not equate to every resident having the ability to utilise them. Factors such as low level of education, cost of medical services, distance to health facilities, transportation costs, waiting times and the attitude of service providers.

In spite of the problems faced by these women, there have been very few policies to target these urban poor women because of the relatively better access to maternal healthcare services in cities which masks the stark inequalities within the urban population. Indeed, some of these vulnerable women may have worse health outcomes than their rural counterparts. Consequently, there is a high prevalence of maternal mortality, child mortality, as well as other pregnancy- or childbirth-related morbidities among them.

This is why it is important to draw the attention of decision makers, civil society organisations and other stakeholders to this issue which has not been appropriately addressed.

1.3 Purpose of the Study

Regardless of global advancements toward the design and delivery of quality maternal healthcare programmes in Ghana, the extreme poor, particularly migrant women from the northern part of the country, remain one largely excluded from quality maternal healthcare services. Consequently, maternal morbidity and mortality rates, and child and infant mortality rates remain high in Ghana. This research aims to ascertain the gamut of factors influencing this deprivation amidst the visible signs of progress chocked nationwide to promote healthcare access in Ghana. The study explicates the sociocultural and institutional determinants of healthcare access among Kayayei with the view to suggest ameliorative protocols to avert its devastating consequences on maternal and child health and development in Ghana.

1.4 Research Objectives

1. To examine the influence of culture, health system and related policies on the uptake of maternal healthcare among Kayayei.

2. To determine the impacts of the population characteristic on health-seeking behaviour.

3. To ascertain the Kayayei's satisfaction with health outcomes during and after the uptake of maternal healthcare services.

1.5 Research Questions

1. What are the effects of culture, healthcare system and related policies on the health-seeking behaviour of Kayayei?

2. Do the population characteristics of Kayayei influence their health-seeking behaviour?

3. How do Kayayei evaluate their healthcare status following the uptake of maternal healthcare services?

1.6 Significance of the Study

Amid the current global health crisis, it is critical to understand how minority groups will cope with already overstretched healthcare facilities in Ghana. Against this backdrop, a vital justification for this research is its capacity to recommend pro-poor and gender-based policies to guarantee access to healthcare services among the most vulnerable populations in the country.

As global markets have slowed down and economic hardships are rife in many countries, including Ghana, there are predictions of a greater influx of migrant women from the north during the post-COVID era. Knowing

the health ramifications this exodus is likely to have on the wellbeing and development of the Kayayei and their children, the outcome of this research established a roadmap to contain the underlying causes of the migration of women from deprived areas to Accra.

Finally, albeit there is a plethora of literature on migrant women in Ghana, to the knowledge of the author, only one literature was found to discuss their maternal healthcare access and a few others on their general and reproductive health. Using the concept of social exclusion and the Andersen Behavioural Model of Healthcare Service Utilisation, this current research filled this gap and updates existing knowledge on the determinants of maternal healthcare among migrant women during pregnancy, childbirth and after childbirth. The main themes of the model, which include environment, population characteristics, health behaviour and outcome will facilitate organisation and analysis of data from field work. The recommendations are practical enough for community developers, policy implementers, public health professionals and relevant non-state actors to adopt relevant intervention modules to avert the problem.

1.7 Scope of Study

Despite its concentration on migrant women from the northern belt of Ghana, the research will be focused entirely on Kayayei who work in the clusters of informal markets around the Central Business District (CBD) of Accra. This is because as the majority of these women are located at the markets around the CBD to engage in economic activities, it is easy to select the Kayayei mothers who are actively engaged in head porterage for participation in the study. At the same time, although the study is focused on women of reproductive age, there were no specific age limits defined so as to diversify the group of participants. Moreover, the selection of Kayayei was pinned to the number of years Kayayei had spent in Accra before this current research was carried out. Only Kayayei who had lived in Accra for at least one year were considered for the research. This enabled the researcher to collect a rich depth of information that characterised the everyday experiences of migrant women in Accra. Bearing in mind the importance of social capital in an unfamiliar environment such as an urban destination, the research will also expatiate a little on how this contributed or not to their healthcare-seeking behaviours.

1.8 Organisation of the Research

The research was structured under six chapters. Chapter One covered the background of the study, the research problems, objectives, research questions, scope, the significance of the study, and the structure of the study. Chapter Two reviewed the literature and presented the theoretical and conceptual frameworks for the research. The third chapter explained the research methodology employed, including the design, the research area, sampling design, data collection approach, data management and analysis and the ethical issues explored.

Chapter Four presented the findings of the research. Chapter Five covered the discussion of findings and the thematic framework; and the final chapter, chapter six, presented the conclusion and recommendations from the research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The main aim of this chapter is to discuss the key concepts of this thesis, which are social exclusion and inclusion, and maternal healthcare as well as to establish a link among them by reviewing different works in literature on them. Under social exclusion and inclusion, we will discuss why social exclusion has gained much importance in current times, compare different definitions of social exclusion and inclusion, explain why social exclusion is distinct from poverty, examine identity and urbanisation as drivers of social exclusion, and finally highlight the domains of social exclusion as identified in literature.

The next part under this chapter will explain what maternal healthcare is and why it is important for pregnant women and new mothers to access maternal healthcare services. Following this will be a discussion of how social exclusion is played out in the access to maternal healthcare services which fall under one of the domains of social exclusion/inclusion. Here, both individual constraints and institutional barriers which create the inability of some women to benefit from maternal healthcare services will be considered.

Lastly, the chapter will introduce the Andersen Behavioural Model of Healthcare Service Utilisation, which is the conceptual framework that will direct the empirical research of this study.

2.2 The Social Exclusion and Inclusion Discourse

Social exclusion and inclusion as concepts have gained considerable attention in recent times among policy makers, civil society organizations and advocate groups thanks to the growing awareness on the need for an equitable development beyond economic growth. While this current generation can boast of achieving commendable economic growth across many countries and a record low in extreme poverty on a global scale, it has also witnessed the highest polarization between the rich and the poor. Moatsos (2021) demonstrates that global extreme poverty has fallen from about three-fourths of the total world population in 1820 to only 10% in 2018, thus, proving that remarkable progress has been achieved in combatting this problem that has plagued so many countries. However, it is also important to note that despite this drastic fall in extreme poverty, the disparity among the high income group and the low income group continues to grow (Alvaredo et al., 2018). The increase in disparity has been accompanied by the marginalisation of the disadvantaged who have limited participation in social domains such as education, health care services, employment, among others. For this reason, poverty eradication has proven to be insufficient to promote development if disparities persist and therefore justifying the rising consciousness on the need to address social exclusion problems and to improve social inclusion.

2.2.1 Definitions of Social Exclusion and Inclusion

The origin of the concept of social exclusion is attributed to Rene Lenoir, the French Secretary of State for Social Action between 1974 and 1978, who in his publication (1974) entitled *Les Exclus: Un Francais Sur Dix* (translating as *The Excluded: One in Ten French*), described the socially excluded as people who on the basis of factors such as disability, mental illness and poverty, supposedly consisting of one-tenth of the French population at the time, were isolated from the mainstream society (Peters & Besley, 2014). Since then, it has gained more popularity in literature and among decision-making bodies while the meaning continues to expand.

From the above definition, it can be observed that the author makes a connection between social exclusion and identity. Some authors still support the idea that persons are treated on the basis of different aspects of their identity which intersect, and as a result, determine whether they belong to the mainstream group or the subordinate group (Das, 2016; UN Department of Economic and Social Affairs, 2016; World Bank, 2013). To cite an example, a woman from an ethnic minority may experience some challenges in the healthcare system because of discrimination from hospital staff based on her ethnicity (Mumtaz et al., 2013).

Levitas et al. (2007, p.9) define social exclusion as "a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole".

The definition of the United Nations' (UN's) Report on the World Social Situation also states that social exclusion is "a state in which individuals are unable to participate fully in economic, social, political and cultural life, as well as the processes leading to and sustaining such a state" (UN Department of Economic and Social Affairs, 2016, p.18).

In contrast to the definition of Lenoir, the more recent definitions place an emphasis on process. While they all mention that some groups face barriers which prevent them from participating in activities deemed normal to their environment, only the definition by Levitas et al. suggests that it has negative implications on society as a whole.

Social inclusion on the other hand is described as "a process which ensures that those at risk of poverty and social exclusion gain the opportunities and resources necessary to participate fully in economic, social, political and cultural life and to enjoy a standard of living that is considered normal in the society in which they live. It ensures that they have greater participation in decision making which affects their lives and access to their fundamental rights"(Commission of the European Communities, 2003, p. 9, as cited by UN Department of Economic and Social Affairs, 2016). Social inclusion is therefore a conscious effort to first identify victims

and people at risk of social exclusion, and put deliberate measures in place to make sure they are able to fully integrate into their society in all dimensions.

Thus, whereas social exclusion is a process and a result, social inclusion is a process and a goal.

2.2.2 Distinguishing between Social Exclusion and Poverty

Poverty and social exclusion are often analysed together in a manner that makes them appear as an inseparable duo (Levitas et al., 2007). Although the two terms are distinct from each other, a conceptual shift in poverty has made it more difficult to distinguish the two terms from each other.

Recently the concept of poverty has expanded and is therefore no longer limited to economic poverty. Similar to social exclusion, poverty is also considered as multidimensional (Nolan & Whelan, 2010). Nowadays, other forms of poverty are discussed in literature such as educational poverty, poor health and so on. This conceptual shift of poverty can be attributed to the fact that the concept of resources has also widened. According to Nolan & Whelan (2010), non-monetary indicators are important in analysing poverty and social exclusion because they are not limited to inadequate financial resources. Even though the authors acknowledge that social exclusion and poverty are different, this juxtaposition blurs the contrast between the two terms.

In certain instances, poverty can complement social exclusion as one of its risk factors of as well as one of its outcomes. In other words, people are excluded because they are poor and people become poor because they are excluded. As quoted by Silver (2007 p.5), the Joseph Rowntree Foundation observes that: "… people in poverty find it hard to participate in society because they lack resources to do so. Conversely, lack of participation exacerbates poverty, both directly (exclusion from paid work) and indirectly (exclusion from social networks enabling people to improve their lives)".

Nevertheless, social exclusion distinguishes itself from poverty in the sense that poverty is a 'state' while social exclusion, as implied in its definition, is both a 'process' and a state (World Bank, 2013). Since poverty concerns inadequate resources, it can be quantified to identify those who are lacking these resources (Levitas et al., 2007). Reference can be made to indicators such as the poverty line where people living below it are considered poor and those above it are not. This, however, does not answer the 'why' and the 'how' the poor are in such a situation. Thus, social exclusion could provide further information on the poor; for instance, the marginalisation of people because they belong to lower castes explains why they are overrepresented among the poor (UN Department of Economic and Social Affairs, 2016).

Additionally, social exclusion is very dynamic and even transcends poverty which is only one of its dimensions. Indeed, not all cases of social exclusion involve poverty (Das, 2016; Levitas et al., 2007; World Bank, 2013). An example of this is that, an ethnic minority group could lack political participation but may not necessarily be poor.

The challenge though that arises with analysing social exclusion is that, it is very broad and abstract. As Levitas et al. (2007) describe it, social exclusion is conceptually clear but empirically unprecise.

2.2.3 Drivers and Process of Social Exclusion

As established in its definition, social exclusion entails the negative discrimination of some groups and individuals. Some of the reasons that account for why some individuals and groups are excluded, as discussed in literature are identity and systemically-created exclusion.

2.2.3.1 Identity

The reason why some people are unable to participate in their society are due to identity factors, some of them include ethnicity, religion, and migration, among others (World Bank, 2013). However, because groups are heterogeneous, individuals within the groups experience social exclusion differently – to illustrate this scenario, women may experience discrimination as a result of their gender, but their socioeconomic status will play a role in the extent to which they will experience this discrimination (World Bank, 2013). According to the World Bank (2013), identity is constructed based on two factors – others' conception of a person or a group, and their own self-conception. Nevertheless, how a person self-identifies – whether with a certain race, ethnicity or religious group – has fundamental social and psychological underpinnings. Thus, while some may affirm their identity as a form of empowerment and a means of claiming space, for instance indigenous people claiming rights of heritage land, others conceal it to avoid stereotyping (World Bank, 2013).

Stereotypes are characteristics incorrectly assigned to an individual or a group which are perpetrated by the excluder and the excluded (Appiah, 2000; World Bank, 2013). The latter are considered partakers in the play-out because stereotype threats trigger their response (Begeny et al., 2019). Begeny et al. (2019), like the World Bank, also identify the two main ways people respond to stereotypes as increased engagement, where stereotyped individuals strongly affirm their identity with their group or work hard to change the stereotype; and disengagement, which involves the stereotyped individual displaying qualities desired by the dominant group, hiding aspects of their identity, or self-isolating from other members of their group with the aim of gaining acceptance from the dominant group. The World Bank (2013) and Begeny et al. (2019) therefore reveal how identity, which is influenced by society, can become grounds for discrimination and eventually affect the social dynamics of those being discriminated.

The UN report on the world social situation makes a similar differentiation between identities of marginalized groups. In the first scenario is having a sense of membership among a certain group of people, sharing beliefs and values, and acting in a manner that makes them distinct from others such as caste and religion; and in the second category is the shared characteristics where members of the group do not know each other and share

little in common except for the discrimination they face – among these are street children, migrants, and the like (UN Department of Economic and Social Affairs, 2016).

Further, the World Bank attributes the genesis of exclusion to household and family dynamics where the less 'valuable' members, such as the disabled, are given little acknowledgement, which subsequently develops into a societal norm (World Bank, 2013). These excluded groups then become prone to stigmatisation, an extreme form of stereotyping, which severely damages their reputation in various social domains such as the labour market. Language is also identified as a means to reinforce exclusion and desensitise people to the unjust treatment of subordinate groups; once these exclusionary practices are normalised, they could become established in ideologies, rules, and religious practices (World Bank, 2013). The long-term exposure to negative stereotypes that society has about the excluded could be incorporated within themselves, leading to low self-esteem and discouragement; this is referred to as 'learned helplessness', which can affect performance and expectation at group and individual levels, therefore becoming a self-fulfilling prophecy (Begeny et al., 2019; World Bank, 2013).

However, a weakness to this school of thought is observed by McGranahan et al. (2016), who argue that identity-based analysis presents limits to the concept of social exclusion which is broad and dynamic. They cite an example of a systemically-created disadvantage such as unequal participation caused by the current trend of urbanisation, which cannot be explained by identity alone (McGranahan et al., 2016).

2.2.3.2 Systemic Exclusion: The Urbanisation Example

Many developing countries are rapidly urbanising around the world. This urban transition, which has been very unequal among these countries, stems from the implementation of neoliberalist policies in the 1980s in order to receive aid from multinational bodies during economic crisis (Heidhues & Obare, 2011; Konadu-Agyemang, 2000). This system focuses on a growth-first strategy which encourages the centralisation of resources in the most promising areas, by transforming them into hubs for economic growth, in expectation of a trickle-down effect to other parts of the population in the country (Didier et al., 2013). One of the means of achieving this economic growth has been to increase attractiveness and become world class cities, so as to make them able to compete with other countries or even cities within the same country for the interest of foreign investors (McGranahan et al., 2016).

This approach to development has produced many undesirable consequences, among which the most evident is the extreme polarisation between rural and urban areas, as well as between the upper- and lower-classes within cities (McGranahan et al., 2016). The increased opportunities in cities has become a pull factor for many rural unskilled workers who are eventually unable to fully integrate into cities as a result of high cost of living, among other factors (Awumbila & Ardayfio-Schandorf, 2008). The rural-urban migrants therefore depend on informal markets to make a living and resort to building slums as an alternative to the expensive formal

housing. As a consequence of this, there is an increase in the prevalence of informal settlements which policymakers perceive as a threat to the aesthetics and order in cities and ultimately, the pursuit of becoming an internationally competitive city (McGranahan et al., 2016).

The response of decision-makers to this problem has often been the deliberate neglect of slum areas or for forced evacuations (McGranahan et al., 2016). The slum dwellers who are usually victims of evacuations are those living in city centres with insecure land tenure (Afenah, 2009). The newly-created urban spaces, resulting from the evictions, are then seen as an opportunity to develop the built environment, with the aim to encourage the consumption patterns of the middle and high class population, while the urban poor are relegated to precarious lands which are more prone to disasters or peri-urban areas which further exclude them from markets (McGranahan et al., 2016). Again, existing slums are consciously neglected by the government and lack basic social amenities to thrive. Even in certain countries like Kenya, slum dwellers are made to pay extremely high fees if services such as potable water are made available to them (Fotso et al., 2008). These unhealthy power dynamics are strategies to 'illegitimise' the citizenship of the urban poor in hopes of deterring more rural residents from migrating to urban areas, while mainstreaming the middle and high class status to desensitise people to the harsh and unacceptable actions of government (Afenah, 2009; McGranahan et al., 2016).

Conversely, these actions have not had the desired effect of resolving the influx of migrants from rural areas but rather, only increased exposure to higher vulnerabilities (Amoako, 2018). Indeed, women bear some of the most serious implications of such policies, among which are reproductive health issues due to poor sanitary conditions, low levels of security, and lack of access to reproductive healthcare services such as contraception and maternal healthcare facilities (McGranahan et al., 2016).

This demonstrates that the current trend of urbanisation in developing countries is unsustainable, does not produce the desired results, and eventually diminishes the initial advantages that urban areas had over rural areas (Fotso et al., 2008).

2.2.4 Domains of Social Inclusion/Exclusion

As we can understand from previous sections, social exclusion is multidimensional. The aspects of life where it plays out are referred to in literature as dimensions or domains (Das, 2016; Levitas et al., 2007; UN Department of Economic and Social Affairs, 2016; World Bank, 2013). There is however, no universal method of classifying these domains. This section will demonstrate some examples of how they are discussed in literature.

The World Bank (2013) defines three domains of participation in society, which could either be opportunities or barriers to social inclusion, namely: markets, services and spaces (**Figure 1**). These domains intersect, just as how the different attributes of identity also intersect to create disadvantage.

First, 'markets' as a domain consists of land, housing, labour and credit. These sub-domains are both historical and existing areas of exclusion. The historical exclusion of women from land ownership, for instance, still affects their property rights today (World Bank, 2013). This example also highlights how unequal gender relations can influence the land market. With regards to the labour market, there are unexplained wage and unemployment gaps between indigenous and non-indigenous people in some American countries after accounting for differences in education and skills, thus suggesting the prevalence of discrimination not based on qualification (World Bank, 2013). In the housing market, people of low socio-economic status in Nigeria, for instance, are the most affected by housing insecurity and their situation is exacerbated by administrative and political inaction of authorities (Soyinka & Siu, 2018).

Second, the domain of services plays a crucial role in the participation of individuals and groups in society because services enhance human capital, protect the vulnerable, improve mobility and connectedness, and are essential for good health (World Bank, 2013). The services that people can be included in or excluded from, whether public or private consist of social protection, information, electricity, transport, education, health and water (**Figure 1**). A person's exclusion from any of these services severely impacts their human development and consequently, their ability to participate in the other dimensions of social inclusion. Regardless of policy amendments to improve access to services, some groups are still unable to benefit from them (World Bank, 2013). To cite an example, racial disparity in the use of skilled birth attendants still persist in South Africa, despite many years of free antenatal care. Indeed, subordinate groups generally tend to have lower access and receive poorer quality of basic services (World Bank, 2013).

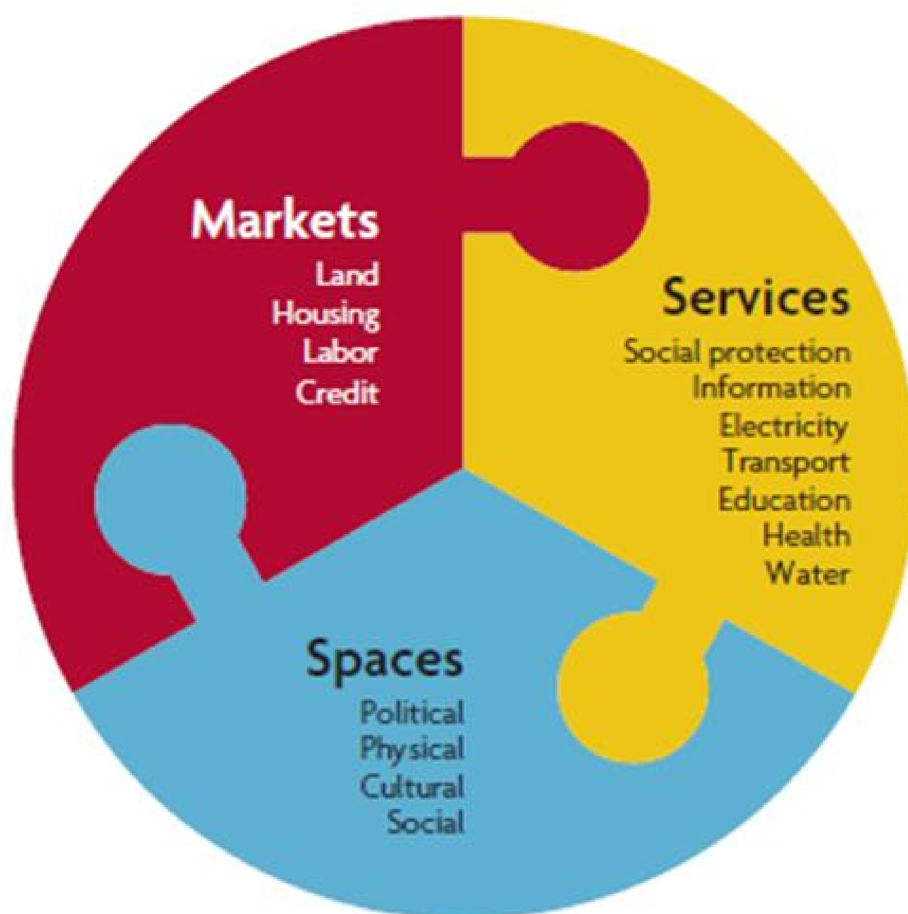


Figure 1: Domains of Social Inclusion. (World Bank, 2013, p.92)

Third, spaces are discussed in terms of physical, social, political and cultural spaces (**Figure 1**). Segregation of neighbourhoods is one of the common ways of exclusion from physical space in history and still persists today. The marginalized respond by claiming other spaces, which could have mixed effects: on the one hand, clustering may enable them create an alternative market for social and economic mobility when the primary one excludes them; on the other hand, they may not be able to achieve this social and economic mobility due to deprivation of basic services (World Bank, 2013). Also, poverty and minority status underpin exclusion from political space and as a result, minority groups face the risk of having their interests excluded from consideration.

The Bristol Social Exclusion Matrix (B-SEM), proposed by Levitas et al. (2007) is another model for assess the social exclusion of individuals. It consists of three main domains and 10 sub-domains grouped under the main categories (**Table 1**). This model was created with the purpose of achieving better empirical precision of the social exclusion concept. It was applied in the authors' report on a cross-sectional analysis of different national surveys, in order to track social exclusion across all stages of life, from childhood to adulthood (Levitas et al., 2007). The authors however remark that such a method of analysis presents its own limitations

because the worst victims of social exclusion such as the homeless, children in foster care, among others are usually excluded from national surveys.

The B-SEM model and the World Bank model have a similar method of categorising the domains of social exclusion, which is by creating main domains and their respective sub-domains. Also, both models address topics such as services, political participation, health, and education. However, the models discussed have very clear differences as well. While the two may have an identical method of classifying the domains of social exclusion, the main domains are totally different; on the one hand, those of the World Bank consist of markets, services and spaces, and on the other hand, the B-SEM domains are resources, participation and quality of life.

Moreover, the World Bank model places a higher emphasis on demonstrating the interconnectedness of the different domains are and how they interact whereas the B-SEM focuses more on solving the challenges pertaining to the quantification of social exclusion. As a result of the priority placed on attaining empirical precision, the B-SEM lacks the ability to establish an interaction among the different domains identified (Levitas et al., 2007).

Table 1: Bristol Social Exclusion Matrix (B-SEM). (Mack, n.d.)

Resources:	Material/economic resources
	Access to public and private services
	Social resources
Participation:	Economic participation
	Social participation
	Culture, education and skills
	Political and civic participation
Quality of life:	Health and well-being
	Living environment
	Crime, harm and criminalisation

Although both models include services, the World Bank addresses it as a main domain and classifies health, education, and other social amenities under the services, the B-SEM model places services, both public and

private, under the main domain of resources. Moreover, with regards to health, the B-SEM model makes health a sub-domain of quality of life. This may suggest that the model differentiates between health which is a state of being, and healthcare services which concern the availability of facilities and medical staff.

2.3 Maternal healthcare

Another key concept in this topic is maternal healthcare. The World Health Organisation (WHO) defines maternal health as "the health of women during pregnancy, childbirth and postnatal period" (World Health Organization, n.d.). The maternal stage of the human life-cycle is a very crucial one because it could have some of the most extreme effects on the mother and her unborn child (Filippi et al., 2006). To ensure optimum health during the maternal period, it is important for women to have access to the necessary healthcare services. As recommended by the WHO, these services should consist of a minimum of four antenatal care visits in a health facility with the first visit occurring during the first trimester, skilled delivery, and post-natal care visits (Kiross et al., 2021). A mother's ability to access all these services during pregnancy and after childbirth, as per the recommendation of WHO or the country of residence, is referred to as the continuum of care or optimum maternal healthcare service utilisation (Filippi et al., 2006; Kazanga et al., 2019; Kiross et al., 2021). The term 'continuum of care' also includes the mother's care outside the medical facility, that is, the living conditions in the community which goes hand in hand with medical care to ensure maintenance of good health (Filippi et al., 2006).

It is required that a pregnant woman fully utilises these antenatal care services because they are indispensable for the wellbeing of the mother and child, and could also possibly save their lives (Kiross et al., 2021). In the process of receiving antenatal care, a mother is administered a tetanus immunisation which could prove crucial for her and her child's survival (Lincetto et al., 2006). Moreover, supplements necessary for healthy foetal development and prevention of deficiencies are prescribed, underlying diseases such as malaria and STIs are treated, complications are detected and addressed early, and other health needs specific to the mother's situation are met; some health centres even use antenatal care visits as an avenue to give advice on other important topics such as nutrition and breastfeeding (Kiross et al., 2021; Lincetto et al., 2006). Fotso et al (2008) also point out the potential of these visits to reduce the prevalence of HIV through the prevention of mother-to-child transmission. It is therefore evident that women must be encouraged to attend antenatal care because of the numerous benefits they obtain in doing so.

The importance of a skilled delivery care, which is delivery based in a formal health facility with the assistance of a skilled birth attendant, cannot be overemphasised. A majority of maternal deaths cluster around labour and post-partum periods (Fotso et al., 2008; Yiran et al., 2015). Indeed, on a global scale, it is estimated that almost half of maternal deaths occur within a day after delivery and about 65% of them happen within seven

days post-partum (Patel et al., 2018). This is because in the event of a complication, which often occurs during labour and post-partum, the risk of maternal death increases considerably with every moment of delay (Van Der Land et al., 2018). Thus, a skilled delivery care ensures the mother and child receive urgent care needed in such situations. A skilled delivery is recognised by WHO as a critical strategy in reducing maternal and neonatal deaths (Moyer et al., 2014). Nevertheless, Filippi et al. (2006) argue that the added attention given to emergency could be symbolic of the missed opportunities to avoid complications, therefore, reinforcing the importance of antenatal care.

The post-natal care also contributes to the health and wellbeing of the mother and child. Routine post-natal care visits allow medical staff to monitor the health of the mother and the child who are both highly vulnerable at that point in time, especially mothers with underlying health conditions and babies born underweight (Warren et al., 2006). According to Warren et al. (2006), some of the health services that are rendered to the new mothers during these health examinations are the identification and treatment of health threats such as infections, bleeding and nutritional deficiencies; the new-born also receives special care in case of low birth weight, low body temperature, among other dangers. Additionally, they highlight that post-natal care visits facilitate immunisation and birth registration, while serving as an opportunity to counsel mothers on home care and additional services such as family planning (Warren et al., 2006).

In view of the need to prioritise maternal health issues, international bodies such as the UN, and national governments, especially in developing countries where unmet need for healthcare services is still high, have taken steps to ensure an increased utilisation of maternal healthcare services. Efforts to track progress include setting a target maximum maternal mortality rate of less than 70 maternal deaths per 100,000 live births, which member countries of the UN have committed themselves to meet by 2030 (United Nations, n.d.). There is also a growing interest in other indicators of maternal health such as injury and disability resulting from childbirth which is reported to occur about 30 times more than the rate of maternal deaths (Lassi et al., 2016). Maternal mortality rate is considerably low in developed countries and some developing countries have demonstrated remarkable progress in reducing the rate of maternal deaths. However, the number of women that still lose their lives from avoidable causes during childbirth is still very high: according to the WHO, 810 women died daily from preventable pregnancy- and childbirth-related causes in 2017 (World Health Organization, 2019a). Consequently, many countries are still lagging behind in achieving the UN SDG 3 target of reducing maternal mortality rate to less than 70 deaths per 100,000 live births, which is a cause for concern.

2.4 Social Exclusion in Maternal Healthcare Services

The maternal mortality rate persistent in the world today is not homogenous. According to the WHO, low- and lower middle-income countries account for 94% of all maternal deaths globally (World Health Organization,

2019a). The high rate of maternal mortality in some regions of the world is indicative of significant gaps in the use of maternal healthcare services between countries, as well as among socioeconomic classes (Fotso et al., 2008; Kazanga et al., 2019; Van Der Land et al., 2018). It is therefore no coincidence that Sub-Saharan Africa, which is one of the regions with the highest maternal mortality rates also has one of the lowest coverage of maternal healthcare services. These variations in use are influenced by different individual, social, and structural factors. Among the individual and social factors which affect access to these services are economic status, employment, gender, migration, level of education, ethnicity and cultural background, religion, place of residence, perception of healthcare facilities, and the like (Kifle et al., 2017; McTavish et al., 2010; Say & Raine, 2007).

Women with inadequate financial means would encounter difficulties in fully utilising healthcare services due to the inability to afford medical bills. Such women have the ordeal of choosing between using their limited resources for basic survival needs and paying for maternal healthcare services if they decide to use them, but often they settle with the former (Lattof et al., 2018). They also tend to avoid using formal health facilities because of the fear of anticipated cost (Filippi et al., 2006). According to a recent survey in Rwanda, over 40% of women stated that obtaining money for hospital bills created problems in accessing maternal healthcare services (National Institute of Statistics of Rwanda - NISR et al., 2021). A study in Mali also revealed that women in the poorest wealth quintile were two times less likely to utilise maternal and other reproductive health services (Gebreselassie et al., 2020).

The employment status of a woman is also a major determinant of whether she would seek maternal healthcare services or not. Women who are employed and have their own sources of income tend to have more independence than those who do not and have to rely on a spouse or a partner to provide their financial needs (Kazanga et al., 2019). Contrary to this finding, a study carried out in Ethiopia reported an opposite trend among the participants in a rural community: the women employed in the informal sector were less likely to visit the hospital as compared to housewives because they had to spend their entire day in the market thus, visiting a health facility only incurred opportunity costs which was not the case for housewives (Kifle et al., 2017). Given the differences in how both works cited in this paragraph analyse the influence of employment on maternal healthcare service utilisation, it appears that the relationship between employment and maternal healthcare access is complex – the mere fact that a woman is employed does not directly translate to her increased capacity to access maternal healthcare services, the type of employment also plays a role. Unlike the situation of women in the informal sector, women with formal jobs who have more convenient working hours may find the time for maternal care visits as in the case of housewives. Ultimately, employment can positively influence maternal healthcare service utilisation if in addition to providing economic independence, working hours allow women to visit health centres during pregnancy. One could also say that women who work in the

informal sector face exclusion from the maternal health system because the working hours of health facilities do not give them the opportunity to benefit from the needed services.

Another barrier to seeking healthcare services during pregnancy is the established gender norms in society which limit women. In some cultures, gender roles are clearly defined in marriage and women have the responsibility of carrying out domestic work at home. During pregnancy, men are sometimes unwilling to take up these duties, thus leaving the woman with no time to visit healthcare facilities (Van Der Land et al., 2018). This demonstrates the lack of decision-making power that have made women more vulnerable to maternal health issues (Filippi et al., 2006). The situation among single mothers and expectant mothers was found to be no better in Zambia, where these mothers were denied services and insulted for not showing up with their partners, thus, inevitably discouraging them from receiving skilled healthcare (Sochas, 2019).

In a like manner, women with little to no education tend to underutilise maternal healthcare services. This is because education is one of the main influencers of knowledge on the benefits of seeking professional healthcare, so accordingly, the uneducated women may not have sufficient knowledge on its importance of maternal healthcare services nor the risks of pregnancy (McTavish et al., 2010; Zhao et al., 2009). Again, they are more likely to face the same discrimination in health facilities as poor women, who are often also uneducated (Moyer et al., 2014; Sochas, 2019). McTavish et al. (2010) also highlight that these women may also be the least beneficiaries of public health programmes as a result of the lack of access to maternal healthcare information. A research on the determinants of maternal healthcare utilisation in Nigeria discovered that only 11% of women with no education delivered in a medical facility (D. N. goz. Ononokpono & Odimegwu, 2014).

Urban areas may generally have better economic opportunities and medical facilities than rural areas but this does not imply that there is equal access among the urban population (Yiran et al., 2015; Zhao et al., 2009). In the wake of the global trend of urbanisation which is occurring at a higher rate in developing countries, many women have migrated from rural areas to cities. They encounter challenges in accessing maternal healthcare services at their destination because they may lack information on the available facilities at their new destination (Zhao et al., 2009). In many urban areas in Africa, rural-urban migrants are concentrated in slums which are deliberately deprived of basic social amenities including health facilities. This is because their informal settlements are judged as illegal by the public administration, which is concerned that efforts to improve their living conditions would only attract more migrants from rural areas (Fotso et al., 2008; McGranahan et al., 2016). Additionally, they are underrepresented in demographic health surveys and consequently, masking the huge disparities that exist in accessing maternal healthcare services in urban areas. (Fotso et al., 2008). Indeed, urban poor women may have worse health outcomes as compared to their rural counterparts (Fotso et al., 2008; Lattof et al., 2018). A study conducted on maternal healthcare service utilisation in Malawi revealed that urban women were less likely than women in rural areas to receive a

continuum of care (Kazanga et al., 2019). Also in Ethiopia, Kaba et al. (2018) reported that women in urban slum areas, among whom were migrants and daily labourers overlooked the use of maternal healthcare services.

The ethnic identity and cultural background also appear to influence both the acceptance of maternal healthcare services by women and the acceptance of women by healthcare staff. Some cultures may frown upon the use of maternal healthcare services because medical centres do not allow the women to observe certain traditions which are important to their cultural identity (Moyer et al., 2014; Van Der Land et al., 2018). In other cases, the ethnic or cultural identity of the women make them subject to discrimination. An analysis of the 2007 maternal survey in Ghana showed evidence of disparities among ethnic groups in the use of maternal healthcare services (Ganle, 2015). The caste system in countries like India and Pakistan, despite its abolishment still has significant influence on how women are treated by medical staff in hospitals: the perceived and experienced differential treatment have discouraged many women in ethnic groups belonging to lower castes from seeking professional care during pregnancy and childbirth (Mumtaz et al., 2013; Patel et al., 2018). Several other studies in developing countries such as Nigeria, Mali, Senegal and Kenya have also observed ethnic disparities in maternal healthcare utilisation (D. N. Ononokpono et al., 2016; Smith & Sulzbach, 2008; Srivastava et al., 2015).

As previously discussed, the discrimination of certain groups of women as a result of their individual characteristics has been a major deterrent to the use of maternal healthcare services. This is further exacerbated by the unequal power relations between healthcare staff and the women receiving the health services. Some health workers take advantage of their position to mistreat women in healthcare facilities (Sochas, 2019). In the North of Ghana, vulnerable women experienced some forms of physical and psychological abuse during labour such as hitting, verbal abuse like insults and other inappropriate things being said to them, as well as neglect during labour and immediately after delivery (Moyer et al., 2014). Mumtaz et al. (2013) made a similar observation among lower caste women in Pakistan who perceived that they were treated differently at healthcare facilities because they were from a lower caste. It was also observed that women in Zambia, who were unable to comply with rules enforced by nurses and midwives because their financial situation made it more challenging for them, for instance their inability to buy list of items provided before labour, were stigmatised (Sochas, 2019). The author also emphasised that some of the rules had no scientific foundation but because the nurses and midwives were esteemed to be the ones possessing all the medical knowledge, they had the power to demand women who were illiterate to comply; an example was telling women to be strong by not making noise or crying during delivery (Sochas, 2019). These and many other negative experiences and stories shared among vulnerable women have created in them fears of visiting formal facilities for maternal healthcare (Moyer et al., 2014; Mumtaz et al., 2013).

Other structural limitations of the use of maternal healthcare are the unavailability of healthcare facilities within neighbourhood of residence, long distance between home and hospital or clinic, and long waiting times (Rispel et al., 2009; Yiran et al., 2015). Efforts to motivate vulnerable women to seek maternal healthcare have had their shortcomings. One of the most common interventions is the removal of user fees to reduce financial burden of poor women. Even though this made maternal healthcare services more accessible, failure to consider the effects on existing facilities resulted in challenges such as overcrowding and inadequate staff who became overwhelmed and were eventually unable to give the needed care to all patients, hence, leading to poor quality of services rendered (Filippi et al., 2006; Kazanga et al., 2019). Health centres also suffered losses from uncompensated revenue from public authorities which made some health facilities resort to taking illegal payments from patients and making them purchase their own supplies, therefore defeating the purpose of eliminating user fees in the first place, and also indicating a lack of accountability (Lang'at & Mwanri, 2015; Patel et al., 2018). Moreover, the individual factors which prevent people from going to the hospital such as health beliefs, illiteracy, and cultural background were not taken into consideration in making maternal health policies, thus, making free maternal healthcare services unable to significantly increase utilisation among vulnerable women over a long period of time (Kazanga et al., 2019; Lang'at & Mwanri, 2015; Van Der Land et al., 2018).

Some authors also discovered that, public policies on maternal healthcare ended up having the most benefits on the wealthiest, while demand among the targeted population only changed slightly, or long after the rich and educated have gotten the most advantage from these policies (McTavish et al., 2010; Mumtaz et al., 2013). Furthermore, the impact of these policies on the vulnerable are unknown in many developing countries that have adopted them because there were no systems in place to track progress attributable to these policies (Rispel et al., 2009).

2.5 The Andersen Behavioural Model of Healthcare Service Utilisation

The Andersen Behavioural Model of Healthcare Service Utilisation was initially developed by Ronald M. Andersen in the late 1960's to discover which conditions encouraged or limited the utilisation of general health services by families (Andersen, 1995). It has since been used widely in many forms of health-related research. The popularity of the model also made it subject to heavy critique. In response to this critique from the academia as well as the evolving scope of health research, the author revised and expanded this model to include new causal and outcome factors that could influence access to healthcare services (Andersen, 1995). The model can also be used in a predictive or explanatory manner. At the core, around which all the other aspects were developed, are three population characteristics that influence the next stage of health-seeking behaviour; namely predisposing characteristics, enabling resources and need (**Figure 2**).

The predisposing characteristics are made up of demographic factors, health beliefs, and social structure. These predisposing characteristics are shaped by the healthcare system and the external environment. According to Andersen, the demographic factors, which include variables such as age and gender represent biological imperatives which could determine a person's health needs. The social structure also refers to the status of a person in their community. Some traditional measures include education, occupation, and ethnicity. In the context of vulnerable people, migratory status is also a key variable (Gelberg et al., 2000). The health beliefs also seek to explain how an individual's attitudes, values, and knowledge of health and health services may influence their perceptions of need and use of health services. Examining health beliefs about a particular disease, or in this context, a specific health risk such as pregnancy and childbirth, is esteemed to result in establishing stronger relationships with need than for the analysis of general state of health (Andersen, 1995).

The enabling resources may either improve or reduce access to healthcare services. These are grouped into personal/family factors and community factors. Within a person's community, the availability of health personnel and facilities could encourage them to seek healthcare. Moreover, organisational factors as well as the quality of social relationships play an important role in explaining and predicting use of medical services. Some of the personal enabling resources mentioned by the author include income, health insurance, a regular source of care, and travel and waiting times. In an adapted version of the model for vulnerable people, competing needs and self-help skills are some additional variables indicated (Gelberg et al., 2000).

Need, the final part of the core, is defined in terms of evaluated need and perceived need. While evaluated need is influenced by biological imperatives from predisposing factors, perceived need is influenced by social structure and health beliefs. On the one hand, perceived need considers how people view their health and their judgement on whether their situation is serious enough to seek professional help or not, and evaluated need on the other hand refers to the health status of a person and their need for medical care according to professional diagnosis. These population characteristics, which have influence within themselves, determine health behaviour.

The health behaviour, which is impacted by the population characteristics, consists of personal health practices and the use of health services (**Figure 2**). Andersen, in his article explaining the behavioural model of healthcare service utilisation, also introduces the concept of access by pointing out that equitable access occurs when demographics and need are the major determinants of the use of healthcare service but access becomes inequitable when social structure, health beliefs, and enabling resources determine who receives medical care (Andersen, 1995). Some examples of personal health practices, being the second indicator of health behaviour, include diet, exercise, and self-care, among others (Andersen, 1995). The use of formal healthcare services and personal health practices will interact to determine outcomes.

The outcomes, being the last stage of the model, are discussed in three dimensions: perceived health status, evaluated health status, and consumer satisfaction (**Figure 2**). The user of a health service should experience an improvement or maintenance of health status, both as per their perception and as evaluated by professionals. The service user should also be satisfied with the quality of care received, not only in terms of health outcomes but also in terms of communication, time spent, interpersonal aspects, among others. These outcomes are influenced directly and indirectly by the environment, made up of the healthcare system and the external environment indicated at the beginning of the model (**Figure 2**).

To demonstrate the direct influence of the environment on health outcomes, if there are sufficient facilities and adequate skilled medical staff, patients will receive quality healthcare and the contrary will occur if health facilities and staff are lacking; in a like manner, if a person lives in an environment with good sanitary conditions, they will have less exposure to health hazards while those living in poor sanitary conditions will be more vulnerable to health hazards. The indirect influence of the environment on health outcomes is demonstrated through its effect on population characteristics, which are determinants of health behaviour that finally affects outcomes (**Figure 2**).

The Andersen Behavioural Model of Healthcare Service Utilisation thus illustrates the multiple influences on the use of health services and eventually, health status. It also factors in feedback loops, which show how outcome can in turn affect future population characteristics need and health behaviour and the health behaviour can also affect the population characteristics.

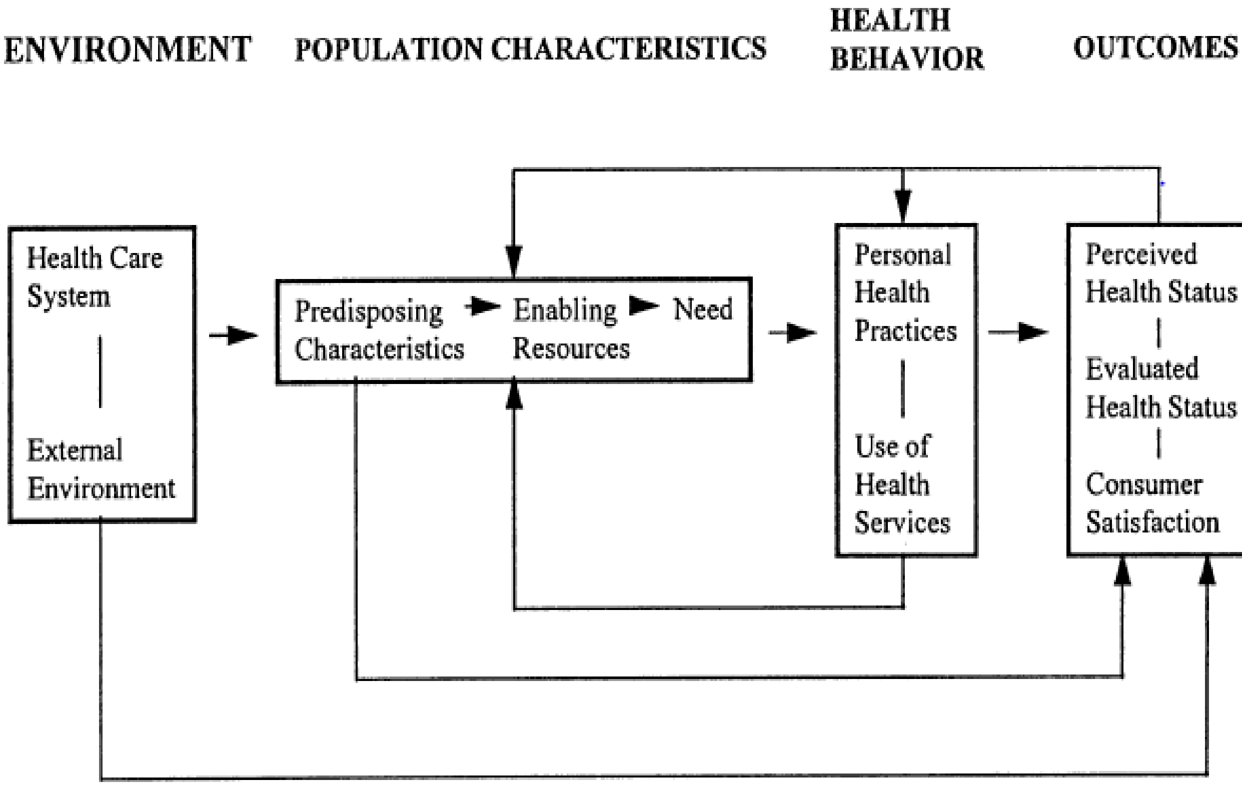


Figure 2: The Andersen Behavioural Model of Healthcare Service Utilisation (Andersen, 1995, p.8)

CHAPTER 3: METHODOLOGY

3.1 Introduction to study

This chapter will explain the chosen methodology for this research. This study used a qualitative research approach to explore the various barriers that hinder a population of migrant female head porters from fully accessing maternal healthcare services. A qualitative research approach was esteemed most appropriate for this study because there is little information on how the target group accesses maternal healthcare services in Ghana. Moreover, its capacity to explore concepts that quantitative methods would not provide answers to made it preferred over other methods. It would also allow the researcher to describe complex interactions, which in this case is social exclusion and access to maternal healthcare services.

To add to that, the chosen approach to studying the topic in question is highly advantageous to the group of people being studied. The participants would be allowed to freely answer questions as they deem fit, which would eventually give a voice to the other marginalised women in their group as opposed to close-ended questions (Sofaer, 1999). A qualitative research would also provide the possibility of recalling and describing events to help participants get across a point better.

The use of a conceptual framework would also contribute to a more organised analysis of data and a better presentation of results and discussion.

3.2 Description of the context of study

In this research, Ghana will be used as a case country to analyse intra-urban social exclusion in the domain of access to maternal healthcare services. The urban area of focus will be the capital city, Accra, which is the most urbanised part and one of the most densely populated territories in the country. This section will present Ghana and Accra as the national and territorial contexts of study.

3.2.1 Ghana

Ghana is a West African country with 16 administrative regions and 275 constituencies having their parliamentary representatives (Parliament of Ghana, n.d.). Ghana is classified as a lower middle-income country and is one of the most politically stable countries on the African continent. Although considered one of the fastest developing countries on the continent , the development has been very unequal. The country has adopted a centralised form of government where all political power is concentrated in the capital. Accordingly, local authorities barely have any power or autonomy and rely heavily on the central government especially for funding local projects.

Moreover, Ghana was among the developing countries which had to implement Structural Adjustment Programmes (SAPs) by the International Monetary Fund (IMF) in order to receive financial support from them (Awumbila & Ardayfio-Schandorf, 2008). The SAPs required that the government to reduce public spending and this was carried out by the removal of subsidies and the investment of public funds into the most promising parts of the economy, which in the case of Ghana was the capital, in in the pursuit of a growth-first development strategy. The logic behind this strategy is to create a competitive city to attract foreign direct investment which will have positive influence on the national economy through a trickle-down effect from the capital to all other parts of the country.

Nonetheless, the adverse occurred: while the capital is well equipped with good public infrastructure, other regions developed at a slower rate, with the least developed parts situated in the north of the country, where natural resources are not as abundant as the central and southern parts. The northern parts of the country have the most land mass but are sparsely populated while the south has a high population concentrated on a relatively small area of land owing to the high rate of migration to the capital. Indeed, the Gini index of Ghana as of 2016 was estimated at 43.5 which indicates a high level of inequality in the country (World Bank, n.d.).

3.2.2 The Accra Metropolitan Area

The Accra Metropolitan is the capital city of the Greater Accra region and Ghana as a whole. It is also considered the economic hub of the country because of the high rate of economic activity present there. The city is dense and has a population density of about 1,300 people per square kilometre (World Population Review, n.d.). It has a CBD where the headquarters of many businesses in the formal sector as well as public service offices such as the Ghana Cocoa Board and the Ghana Export Promotion Authority are located. In proximity to the CBD is a booming and ever-expanding informal sector which has become an important source of livelihood for people who are unable to integrate into the formal market as a result of their low level of education or simply the unavailability of employment opportunities.

The informal sector is characterised by crowded and chaotic markets where all sorts of merchandise are sold in market sheds, at transport terminals, and on pavements close to streets designated for vehicular movement. This has created a tensed environment where people, goods and vehicles have to compete for space. The rapid expansion of these local markets has caused its extension to the CBD and a merge of the formal and informal spaces.

The economic opportunities in the informal sector for unskilled labour have attracted migrants from other regions of the country and resulted in rapid population growth and a haphazard urban sprawl. Similar to other cities in developing countries, this population growth has occurred faster than infrastructure development, hence causing pressure on social amenities such as housing and healthcare services; it is estimated that 58% of city dwellers depend on informal housing and Accra has a housing deficit of about 300,000 housing units

(Accra Metropolitan Assembly, n.d.). Even though one may argue that urban areas have better provision of infrastructure, it is not equally distributed among all neighbourhoods, especially for people living in informal settlements. Due to this, bad sanitary practices such as open defecation and dumping of refuse in undesignated areas are common, making residents vulnerable to health hazards.

This territorial context was chosen for this research because its diversity in the way of life of the people, the polarising nature and income heterogeneity of the city serves as a strong example of the prevalence the social exclusion within cities. Moreover, the author is familiar with the context as a result of residing there for many years and frequent interaction with people in the market. This has also created a sense of attachment to the context and a desire to expatiate on factors accounting for why vulnerable people in society experience some challenges in fully integrating into society and accessing some basic services and the scope of marginalisation they face.

3.2.3 The Health System in Ghana

The health system in Ghana is overseen by the Ministry of Health (MOH) and the Ghana Health Service (GHS) (Ghana Health Service, n.d.). The healthcare sector has three levels of organisation namely: national level, regional level, and district level (International Trade Administration, 2020). This arrangement is in attempt to decentralise healthcare however, distribution of health facilities tend to favour urban areas – majority of hospitals, clinics, and pharmacies can be found in cities. Rural areas are heavily dependent on traditional African medicine as a result of the difficulty in geographically accessing formal healthcare services (International Trade Administration, 2020). Ghana spends an average of 6% of its GDP on health infrastructure

The GHS is made up of eleven directorates or divisions. These are:

1. Finance Division (FD)
2. Health Promotion Division
3. Family Health Division (FHD)
4. Public Health Division (PHD)
5. Research and Development Division (RDD)
6. Internal Audit Division (IAD)
7. Institutional Care Division (ICD)
8. Human Resource Division
9. Supplies, Stores and Drugs Management (SSDM)
10. Policy Planning, Monitoring and Evaluation Division (PPMED)
11. Health Administration and Support Services (HASS) Division

The FHD has two departments, among which is the Reproductive and Child Health Department, responsible for all maternal-related health issues. The main programmes currently under the department include Safe Motherhood, Child Health, Family Planning, and Adolescent Health. The department aims to improve Ghana's maternal health through education on general reproductive rights and enhanced access to care and reproductive services (Ghana Health Service, n.d.).

The Government of Ghana also has a National Health Insurance Scheme (NHIS), a social intervention programme which provides financial access to quality healthcare for residents in Ghana (National Health Insurance Scheme, n.d.). The programme was implemented in 2005, followed by free maternal healthcare in 2008 (Agbanyo, 2020). One is required to have a NHIS card in order to benefit from the health insurance, and the card can be obtained by paying a premium at any NHIS registration centre. There are groups of people, however, who can be exempted from paying the premium and women in need of antenatal, delivery, and post-natal care (National Health Insurance Scheme, n.d.). The card is valid for several categories of health facilities, on the condition that they have been credentialed by the National Health Insurance Authority (NHIA). The NHIS covers many diseases and about 95% of drugs from the pharmacy (National Health Insurance Scheme, n.d.). Nonetheless, users have reported that they still are made to pay some user fees despite the free maternal healthcare policy and being registered on the health insurance scheme (Agbanyo, 2020).

3.3 Presentation of the Kayayei

For more than a decade, southern Ghana has seen an increase in the number of young women and teenage girls whose primary occupation is the porterage of goods in metallic pans. These migrants are known as Kayayei). They travel to get away from places where the main source of income is inadequate subsistence farming; where girls are expected to perform housework and raise their male and younger siblings rather than attend school; and where education, infrastructure, and health care lag behind the rest of the country. It is difficult not to notice ladies carrying objects that appear to be triple their weight on their heads if one visits a market in Accra, the capital city of Ghana, or other southern markets in Ghana.

Kayayei' is a term derived from the Hausa word 'kaya' which means load and 'yei' ('yoo' for singular) which is a feminine qualifier in Ga (Kwankye et al., 2007). The term is used to describe girls and women who carry goods on their heads in markets at a fee negotiated with the client (Awumbila & Ardayfio-Schandorf, 2008). They play a pivotal role in trading activities and their services are employed by travellers, buyers and shop owners who need to transport goods around the market (Ahlvin, 2012). The head porting or kaya business was previously dominated by men who transported goods on manual trucks and carts. Although men still push carts with goods within the markets, the quickly rising need to move goods around on the head because of the

competition for space among vehicles, goods and humans influenced women to adopt it as an occupation in the informal sector (Yeboah, 2009).

The majority of the Kayayei are migrants from the northern parts of Ghana who move independently to cities in the south, notably Accra and Kumasi in the Greater Accra and Ashanti regions respectively in search for better economic opportunities (Awumbila & Ardayfio-Schandorf, 2008; Yeboah, 2009). Many of them who work in the kaya business come from the Mamprusi, Gonja, Kotokoli, Mossi, Frafra, Bimoba, and Dagomba ethnic groups in Ghana's northern regions; which include The Northern, Upper East and Upper West regions, with a few Kayayei from Burkina Faso and Togo. The majority of Kayayei women are forced to seek refuge in Accra as a last resort in order to make ends meet. Their pattern of migration appears to be temporal and cyclical because they usually do not intend to work as head porters in the long-term (Kwankye et al., 2007). Some of the Kayayei move back to the north after every couple of months to spend time with their spouses and families and travel again to the cities to generate more income; others also use the kaya business to raise capital for another business or purchase items for marriage (Ahlvin, 2012; Awumbila & Ardayfio-Schandorf, 2008). This pattern of migration is in contrast to that of their male counterparts who migrate on a long-term basis and are later joined by their family in the city (Kwankye et al., 2007).

This trend of north-to-south migration by females to work as head porters is primarily as a result of development disparities between the north and the south of Ghana. The cause of this uneven national development has been attributed to colonial legacies which encouraged investment in cash crops and industries in the south while deliberately abandoning the north in order to use it as a labour reserve for the more economically promising south (Kwankye et al., 2007). Because of the country's ethnic conflicts and wars, as well as the low standard of living in their native lands, the markets are their only viable alternative for sustaining themselves and their families, and it at least offers some relief from the danger of death from militants in the north. Furthermore, many are afraid of the hatred and rejection they would experience if they return home after working in the city. Crop failures, limited opportunities, rural poverty, inability to save, low earnings, and insufficient jobs have also forced many rural women to migrate. In the face of decline in agricultural activity due to land degradation, coupled with the implementation of SAPs which reduced government expenditure by removing agricultural and health subsidies, fewer agriculture-related employment remained in the north thus, serving as a push factor to the more developed south where there were better opportunities (Yeboah, 2009).

However, many of these economic opportunities remained inaccessible to them because of low levels of formal education, lack of skills and financial capital. For this reason, head porting is an ideal occupation for these migrant women as it does not require any skills or heavy financial investment – all one needs is a head pan to carry clients' goods (Awumbila & Ardayfio-Schandorf, 2008). Migration to the south has provided an avenue to escape extreme poverty endemic in the north and pull their families out of poverty as well by sending

remittances (Ahlvin, 2012; Kwankye et al., 2007). Some of these migrant women work with the view to invest their meagre earnings on furthering their education. Others are just relieved to be freed from their parents' control, while having total independence of their finances and belongings for the first time in their lives.Indeed, migration has the potential to positively influence women's socioeconomic status but could also expose them to circumstances that could put them in even worse situations (Awumbila & Ardayfio-Schandorf, 2008).

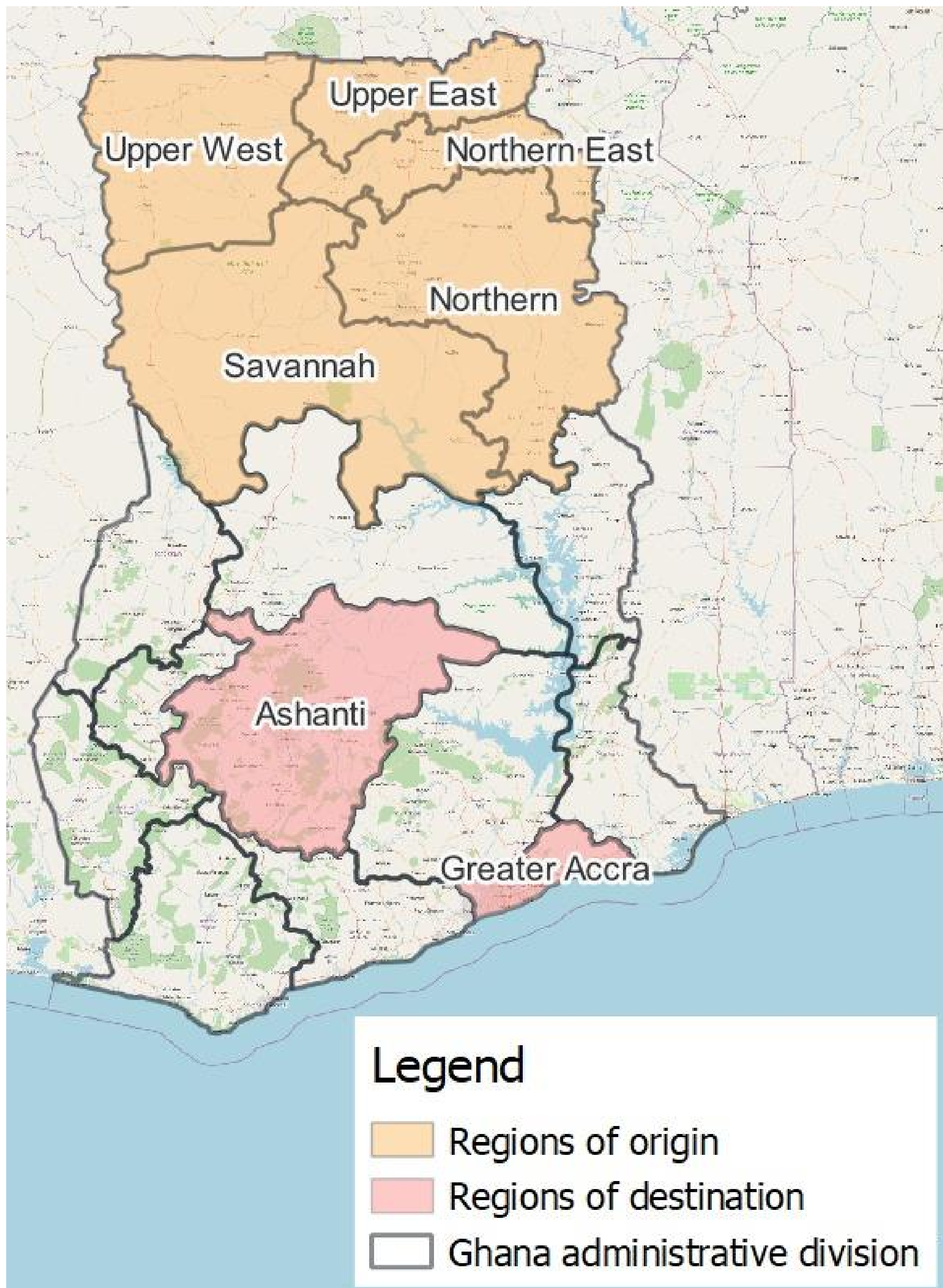


Figure 3: Map of Ghana showing the regions of origin and popular destination regions of Kayayei (by author)

The majority of these female migrants who relocate to the south and middle belts are have little or no formal education. As a consequence, the Kayayei have no or very little chances of finding work in the formal sector in the cities, so they turn to the kaya business as a short-term source of income while accumulating enough

money to invest in more profitable operations in the future. According to a mapping exercise conducted by the Ministry of Gender, Children and Social Protection (MOGCSP) in 2018, there are more than 100,000 Kayayei, including their children, working across the country. There are about 85,600 in the Greater Accra area, 22,500 in the Ashanti Region, and about 1,000 in the Brong Ahafo Region. These figures are estimates, and it is probable that they are higher.

'Kayayei,' like many other informal sector jobs, is unaccounted for and consequently, invisible in the Ghanaian labour market. Their living conditions are not favourable at all. For starters, these Kayayei move south having any form of accommodation. After a long day, they sleep in the open, where they are vulnerable to the weather, armed robbers, and rapists. Kayayei are frequently mistreated by their customers. This is because the majority of people look down on northern migrants. They also have very little or no say when it comes to how much customers should pay for the services rendered. According to Opare (2003), almost half of all Kayayei children delivered at the Korle-Bu Teaching Hospital in Accra are abandoned by their mothers each month. To some of these immigrant women, going to the hospital to deliver their children is not an option. They deliver in the open space with the help of other Kayayei. This is attributable to the fact that, the Kayayei not only lack the financial means to pay their medical expenses, but they also face more fundamental issues such as where to sleep with their new newborns.

The Kayayei encounter challenges such as abuse and disrespect from clients who sometimes do not pay the full fee for the services they have received (Yeboah, 2009). Carrying a traveller's luggage or one's shopping is among the jobs that these porters do. On their heads, most women carry more than their own weight. They also help market traders with tasks such as stocking shelves, packing, and tidying up vending spots, among other things. Kayayei are also employed by local eateries (commonly known as chop bars) to tidy up, prepare meals, and serve guests. They are occasionally brought into private houses to preform domestic duties as they create working connections with their customers. While some become domestic employees, others continue to work as head porters while also doing domestic labor. Fridays and Saturdays are the busiest days for Kayayei in urban areas, especially in Accra and Kumasi. There are male Kayayei as well who work mainly in the construction industry. Another problem, which is the major one they encounter, concerns housing. These women sleep either in rented kiosks, uncompleted buildings, in front of shops or at bus terminals on the street, or they stay with relatives (Kwankye et al., 2007). Sleeping on the streets puts them at risk of contracting malaria and also makes them vulnerable to crimes such as rape and theft and consequently, reproductive health risks (Yeboah, 2009). Further, they are prone to gastro-intestine diseases through buying from food vendors who often prepare food in unhygienic conditions (Yeboah, 2009). They are also reported to have chronic body pains from carrying heavy loads on their heads and walking long distances throughout the day (Kwankye et al., 2007). Theft for instance, occurs frequently at night when the Kayayei are sleeping. People periodically set buildings on fire in order to plunder the commodities in the resulting turmoil. Illegal drugs are a concern in

these markets, as they are in many slums in Ghana. Men often take advantage of and sexually assault young women while they sleep, resulting in an issue of sexual harassment, abuse for female residents and the contraction of Sexually Transmitted Infections (STIs). In Agbogbloshie, the frequency of unwanted pregnancies and hazardous abortion practices is significant. Hence, the confirmation that indeed, “each month, almost half of all Kayayei children delivered at the Korle-Bu Teaching Hospital in Accra are abandoned by their moms" (Opare 2003). Inadequate incomes were cited as a primary barrier to individuals accessing appropriate health care, limiting their ability to pay for treatment.

Kayayei also encounter challenges when seeking medical attention is the NHIS's coverage and effectiveness. The Kayayei explain that the NHIS does not cover expensive vital drugs. As a result, even though they have a health insurance card, the program does not cover all vital drugs; as a result, even if they have a health insurance card, they still need money to pay for good health care. Furthermore, unlike people in the mainstream society, the Kayayei experience long waiting hours when they visit the hospital for healthcare services. The women who visit hospitals encounter the issue of having to wait for long hours of time before being attended to. To them, time is money. As such, they do not find it favourable to spend these hours they could have used to work, to sit at health facilities, if they do not deem the issue to be life threatening. In spite of their increased health needs, they do not seek professional healthcare and rely on self-medication (Kwankye et al., 2007). Unfortunately, some of these health behaviours are continued even in times of increase healthcare needs such as pregnancy and childbirth.

3.4 Selection of participants

The participants of the research were first of all selected based on their socio-economic status. The women must have been migrant Kayayei working in one of the markets around the CBD in the Accra Metropolis. This is because the informal market in that area is the busiest trading centre in the region where the head porting business is highly relevant. The second criteria for selection was that the Kayayei had to have at least spent some time in Accra during their pregnancy in order to allow the author to analyse how they were able to use maternal healthcare services while living in the urban area. Another criteria was that the participants should have given birth to their last child three years or less prior to the interview, so as to ensure that their pregnancy and childbirth experiences were still fresh in their memory and easy to recall.

The snowball method, which is a method where a participant links the researcher to another potential participant and so on, was employed to reach out to the head porters. Since the author had acquaintances with some female head porters prior to the research, with the help of family members who run a business in the informal markets, a mutual acquaintance who suited the eligibility criteria was contacted for the interview. Thanks to the previously established relationships with some Kayayei, there was already a level of trust built

with them and using them as contacts to find more participants reduced reluctance in participating in the interview because of the presence of a mutual connection.

The sample size required for the research was 10 female head porters. In all, 12 head porters were interviewed, however, two of the interviews were not taken into consideration because one of the participants did not meet the eligibility criteria and the other was unable to clearly articulate her thoughts to the interviewer, and therefore, the 10 remaining interviews were the final ones considered for this study.

3.5 Data collection

The data collection took place between the 17th of August and the 23rd of August, 2021. The use of primary data was considered the best option in acquiring recent information on the subject as well as providing direct interaction with the study participants. A questionnaire (Annex 2: Interview Guide) was prepared prior to the data collection to serve as a template which would frame the discussions. The interviews were semi-open; the participants had to answer to specific questions but were invited to answer the questions asked liberally.

Due to the researcher's inability to physically interact with the participants, they were contacted through WhatsApp audio call. It was most practical to interview them during their working hours because it was less difficult to find them. The interviews were recorded with Audacity for transcription purposes.

All interviews were conducted in the Ghanaian local language Twi, which allowed participants to express themselves with ease. The locations of the Kayayei who participated in the interviews were Tudu (Makola), Tema Station and Agbogbloshie markets.

3.6 Data analysis

The data obtained through interviews with participants were transcribed verbatim in English, while preserving filler words and exclamations that were useful in understanding the emotions conveyed at the time those statements were made. The audios were played repeatedly to ensure that they matched the transcriptions. The various themes identified in the interview were grouped under the topics of the Andersen Behavioural Model of Healthcare Service Utilisation as demonstrated in **Table 1*Table 2***. Since the focus of this study is on the social influences on the access to maternal healthcare services, the need was only analysed in terms of perceived need, and the evaluated health status under outcomes were not discussed. The transcribed interviews were then colour-coded in order to facilitate analysis and then analysed according to the identified main themes indicated in the adapted version of the conceptual framework.

Table 2: Classification of interview discussion points under the Andersen Behavioural Model of Healthcare Service Utilisation

Main Themes	Concepts	Determinants
Environment	Healthcare System	• Availability of health facilities • Availability of medical staff
	External Environment	• Place of residence • Sanitary conditions
Population Characteristics	Predisposing Characteristics	• Demographic factors • Social structure • Health belief
	Enabling Resources	• Personal factors • Community factors
	Need	• Perceived need
Health Behaviour	Personal Health Practices	• During pregnancy • After childbirth • Use of medication
	Use of Health Services	• Antenatal visits • Skilled delivery • Post-natal care • Child vaccination • Birth registration
Outcomes	Perceived Health Status	• Perceived state of health after maternal healthcare
	Consumer Satisfaction	• Attitude of staff • Communication • Waiting times

Source: Andersen, 1995

3.7 Ethical considerations

The data collected from participants was carried out in conformity with the Ethical Principles and Code of Conduct for research and publication of the American Psychological Association (APA), 2017. All participants received detailed explanation of the purpose of the interviews, after which verbal consent was obtained from each of them.

They were also made aware of the fact that participation was benevolent and they could decline without them bearing any consequences, however, none of the prospective participants contacted declined the interview.

Since the Kayayei were interviewed during their working hours, they were financially compensated for the opportunity costs incurred – this applied to both the eligible and ineligible. They were also encouraged to ask questions if they had any concerns or doubts.

Again, the author assumed a neutral position during the interview, making sure not to come across as judgemental against the participants for any health choices they claimed to have made as pregnant women or new mothers. This aimed to allow them to express themselves without subconsciously thinking of how the author would react.

Lastly, participants were made aware that the interviews were being recorded but solely for the use of the author who was going to use them for transcription purposes. Details of their identity, such as their names and images were not collected to ensure their anonymity and there was no third-party involved in the interviewing process or the transcription of the recordings.

3.8 Limitations and assumptions

3.8.1 Limitations

One of the limitations of this study is that there was no physical contact with the participants during the interviews. The use of virtual audio tools to conduct the interviews may have caused the author to miss physical non-verbal expressions that could have contributed to the interpretation of some responses provided by the participants.

Moreover, due to the limited amount of resources at the disposal of the author, the sample size was limited to 10 participants in only one territory, which is under-representative of the total number of Kayayei. As a consequence, results of this study, although may apply to most female head porters, are not generalizable to the whole population.

The snowball effect employed in the selection of participants could have also limited the diversity of the participants. The ethnic clustering of Kayayei could imply that earlier participants connected the author to others in their ethnic group, thus, possibly homogenising the women interviewed.

3.8.2 Assumptions

The following are the assumptions of the author prior to the study:

1. It was assumed that Kayayei would have little to no formal education because of the occupation does not require one to have any form of education and the income is relatively low.
2. The low level of education among the women was expected to cause lack of information on the importance of seeking maternal healthcare and consequently, the underutilization of maternal healthcare services.
3. The poor living conditions would have an effect on their health during pregnancy and after childbirth.
4. Their low income would serve as a barrier to their access of maternal healthcare services.
5. They perceived or experienced differential treatment in healthcare facilities because of their socio-economic status.

CHAPTER 4: PRESENTATION OF RESULTS

4.1 Introduction

This section presents the findings from field interactions held with the Kayayei at the Makola, Agbogbloshie and Tema Station markets in Accra. The chapter was organized consistently under major concepts of Andersen's Behavioural Model. This commences with the presentation of the sociodemographic characteristics of the participants, the environmental determinants of maternal healthcare during pregnancy as identified from the interviews, population characteristics of the participants, their health behaviour and outcomes pertaining to their perceived health status and their satisfaction with healthcare services received, which they derived from the uptake of maternal healthcare services.

4.2 Description of interview participants

At the end of the data collection, ten female head porters or Kayayei from informal markets in the Accra Metropolis were interviewed in total. All the women who took part in the interviews hailed from the northern part of Ghana: five of them were from Yagaba in the North East Region, three of them from Tamale in the Northern Region, and two of them from Walewale also in the North East Region.

A majority of the participants were still in their youth: the average age is 29.2 years with the youngest participant being 22 years and the oldest being 40 years of age. However, one of the women did not know her date of birth and therefore speculated that she would have already reached 30 years. This could affect the accuracy of the ages and the average provided.

Some of the characteristics all of the female head porters who participated in the interviews had in common were that they were all Muslims and married women. Overall, the level of education was very low: 8 out of 10 participants did not receive any form of formal education; 1 out of 10 completed secondary school level but did not pass her certificate examination; and 1 out 0f 10 only attended primary school for 3 years.

The average parity was 3.3. The participant with the highest parity had 6 children and the one with the lowest parity had 1 child. Also, one participant had a deceased child. The ages of the youngest children for all the participants were 3 years and below. The average daily income was between 20 Ghana cedis (GH¢), the equivalent of 2.87 euros, and GH¢35, which is also equivalent to 5.02 euros. They all carried out their head porting activities in informal markets in the Accra Metropolis; specifically, 6 of them worked in the Makola market, 3 of them in the Agbogbloshie market, and the remaining one at Tema Station market. Their places of work doubled as places of residence. All those who worked and lived at Makola market and Tema Station market were homeless and therefore slept outside in the open and those who worked and lived at Agbogbloshie market lived in rooms in informal settlements which they shared with several other head porters; two of them

reported that 10 people shared a room and 1 person reported that 30 people shared a single room. All of the women, whether homeless or living in rented rooms depended on public bathrooms and toilets which they had to pay for, when they needed to use sanitary facilities.

The average number of years the women have worked as Kayayei is 10.3 years, with the number ranging from 2 years all the way to 20 years. In **Table 3** below is a summary the characteristics of all the participants considered for this research. The participants are labelled P1 to P10, representing participant 1, and so on.

Table 3: Summary of socio-demographic characteristics of participants

Participants	**Age (years)**	**Origin**	**Religion**	**Marital status**	**Educational level**	**Parity**
P1	about 30	Yagaba	Muslim	married	none	3 (1 deceased)
P2	25	Yagaba	Muslim	married	none	4
P3	31	Yagaba	Muslim	married	none	4
P4	38	Yagaba	Muslim	married	secondary level	4
P5	22	Tamale	Muslim	married	none	2
P6	25	Yagaba	Muslim	married	3 years primary education	3
P7	26	Walewale	Muslim	married	none	3
P8	40	Tamale	Muslim	married	none	6
P9	30	Walewale	Muslim	married	none	1
P10	25	Tamale	Muslim	married	none	3

Source: Field Data, 2021

Source: Field Data, 2021

Participants	**Age of oldest child (years)**	**Age of youngest child (years)**	**Average daily income (GH¢)**	**Area of residence**	**Type of accommodation**	**Years in head porting**
P1	10	1	20	Makola	homeless	4
P2	10	1.5	30	Makola	homeless	2
P3	20	3	20	Makola	homeless	20
P4	9	2.5	20	Makola	homeless	20
P5	7	3	35	Agbogbloshie	shared room	6
P6	10	3	30	Makola	homeless	10
P7	8	2.5	35	Makola	homeless	8
P8	20	3	20	Agbogbloshie	shared room	18
P9	2	-	20	Tema Station	homeless	5
P10	9	1.5	20	Agbogbloshie	shared room	10

4.3 Environment

As part of the objective of this research, the paper sought to explore the influence of environmental factors on maternal healthcare among Kayayei in Accra. The goal is to ascertain the impacts of institutional structures and other enabling conditions on the readiness and capacity of vulnerable groups to access antenatal and postnatal care services in Accra. As a demonstration of Andersen's postulation of the Behavioural Model, the researcher explored the participants' experiences with healthcare systems and the perceived ease of access to these facilities as a function of external environmental conditions.

4.3.1 Health Systems

The characteristics of a functioning healthcare system tend to promote or inhibit broad-based access to maternal healthcare among excluded populations. The research utilised Andersen's concept to demonstrate how available health equipment, including trained and effective human resources, useful medication, and active regulatory architecture influence maternal healthcare access among minority groups. The results show that the majority of the participants desire to receive antenatal care during pregnancy. However, the lack of information on how the health system works had derailed the resolve of many to go to the hospital when pregnant.

> *"I wasn't taught to go to the doctor" (Participant 7)*
>
> *"There were many [hospitals] ... you would go to the one close to you and they would tell you to go to a farther one" (Participant 8)*

While a lot of them complained about the absence of maternal healthcare facilities nearby to enable access, others complained about the absence of medical professionals to readily attend to them whenever they visit the hospital. Some of the participants had this to say:

> *"If you go and the people are many, you had to wait… there are times you will come [early], around 12pm before you leave" (Participant 1)*
>
> *"If you went in the morning, you had to sit and wait until about 2:00pm before you got a doctor" (Participant 5)*

4.3.2 External Environment

According to Andersen, the external environment, which consists of factors in the physical surroundings of the place of residence, could influence health outcomes of individuals. In this case, the elements of the external environment taken into consideration are the living conditions of the Kayayei and the availability of sanitary facilities which could have an impact on their maternal health outcomes. When asked about the type of housing in which they live and whether or not their places of residence were equipped with sanitary facilities, the participants explained that they were either homeless or living in informal settlements and exposed to many environmental hazards; neither option provided access to sanitary facilities. Some of them explained their ordeals as follows:

> *"If you even look at where we sleep, when we are wet with rain, we have to stand to our feet ... when it rains, we just have to coil ourselves… the water drenches all our belongings" (Participant 3)*

"Yes, we all sleep outside… there are mosquitoes and other insects" (Participant 4)

"We are more than 30 [in a room] … we are a lot" (Participant 10)

"The ones [bathrooms] that people have built and take charges for, that's where we go and shower and pay one cedi" (Participant 3)

"We go to pay money in order to use the toilet" (Participant 8)

4.4 Population Characteristics

The study sought to verify the veracity of Andersen's postulation that health beliefs, enabling factors and perceived need for care significantly affect the likelihood that vulnerable populations with access maternal healthcare during pregnancy. The concept opined that the belief in the capacity of healthcare facilities, including the calibre of staff and service delivery module adopted, could either promote or inhibit the readiness of women to seek antenatal care. It further mentioned that personal conditions, including income levels and the number of children birthed by the Kayayei, among others, also affects access to maternal healthcare among women. Finally, Andersen argued that the perceived need for care is a vital consideration for anyone who contemplates the desire to go to the hospital for care. In this research, the population characteristics are operationalized to understand how the current income level of the participants and the existence of available medications create the need to seek antenatal care during pregnancy. The theme was explored under three subthemes, namely, predisposing factors, enabling factors and need.

4.4.1 Predisposing Factors

According to Andersen, predisposing factors comprised elements related to women's health beliefs and social structures. However, while these elements in themselves are critical in the determination of the likelihood that Kayayei will access healthcare during pregnancy, they do not stand alone. They comprise of sociodemographic characteristics which interact with the health beliefs of the participants to have the observed impacts. The researcher explored the participants existing beliefs about antenatal care and the perceived need for it maternal healthcare during pregnancy. As it can be observed from **Table 3**, the participants have a low level of education. The response gathered from the participants show that many of them demonstrated a strong belief in the effectiveness of maternal healthcare. At the same time, a few of them pointed out that in the absence of the hospital, traditional medicine is equally good. Below are the voices of some of the participants:

"If you go there [hospital] to give birth, it is better than to give birth at home. That is where they will take good care of you" (Participant 2)

"But if you are pregnant and you don't go to the hospital, you don't love yourself. ... if you are pregnant, you should make the effort to go to the hospital. Even if you don't have the means, you can borrow money to go and take care of yourself in the hospital" (Participant 3)

"As for traditional medicine you just take it, you don't drink it thinking that it will help you or not but if the doctor is giving you medicine, they know that the particular medicine will help you that's why they give it to you" (Participant 5)

"If you give birth in the hospital, it is better than the one at home… for that one you don't suffer, as for the home birth, you suffer" (Participant 8)

"There are some people who take the traditional medicine because they are convinced that the traditional medicine is better than going to the hospital" (Participant 9)

4.4.2 Enabling Factors

The theme examines the resources or the lack thereof, that either improve or reduce access to maternal healthcare among Kayayei. According to Andersen, this can be a personal, family or community factor. Along this line, the research assessed the availability of health personnel, facilities, health insurance, and strong social capital, among others, to the participants. Concerning health insurance, the majority of Kayayei interviewed complained about the ineffectiveness of the policy. While some indicated that consultation fees and the cost of some drugs were waived thanks to the insurance, many others pointed to the inability for some prescription drugs that the insurance covers, as well as the failure of some facilities, such as medical laboratories to accept it. Added to the health insurance scheme, many participants also alluded to other costs associated with accessing healthcare from the hospital. They argued that irrespective of a patient's status, she must pay for medical tests and ultrasound scans.

"As for the scan, you will pay. The lab too, you will pay for it" (Participant 1)

"Ah, they are the ones who told us to do it [health insurance] o … and after doing it too they tell you that unless you pay for the medicines before you receive them … is this free?"(Participant 2)

"When I got pregnant and came here, I didn't have any money to take to the hospital … so if I work a little to get my transport fare and purchase things for the baby, then I leave. So that's why I didn't go to the hospital. It's because of financial constraints. If you go to the hospital with a little money, it will not be enough, It has made us afraid of the hospital" (Participant 7)

"So as for the health insurance, it supports us a little but it doesn't do much. The benefits are that, if you go, you won't pay for someone taking care of you but if you have to buy medication outside, you have to use your own money" (Participant 8)

Moreover, as a result of the long distance from residence to healthcare centres, they had to spend a lot of time and resources commuting to-and-from the healthcare centre. While some of the female head porters who belonged to groups benefitted from contributions in cash and kind from their colleagues, others point to the lack of social capital as a precursor to their inability to afford orthodox healthcare. Some of the participants had this to say:

> *"The hospital itself was not far but the place where I had to make the health insurance and do the scan were far" (Participant 6)*
>
> *"It was far… The motor would take you there. On the day you don't get a motor, you go with a car… you would spend about 40 [cedis]" (Participant 8)*
>
> *"We the Mamprusis have a group… when someone gives birth, there is some support that we give to the person. We buy a specific cloth, baby clothes, and we add some amount of money and give to the person" (Participant 3)*
>
> *"Yes, they [the Kayayei] helped me madam… When I took the money, I used it to buy baby clothes and clothes for myself as well" (Participant 4)*
>
> *"My family, they didn't do anything… You had to struggle to take care of yourself" (Participant 7)*

4.4.3 Needs

Need, in this context of study, is described as the biological and the psychosocial drive for maternal healthcare services. It points out the reasons why the Kayayei may seek medical attention during pregnancy. Need is, however, a function of the characteristics of the population, and the socio-cultural and institutional structures with which people interact. During the interview, some of the participants mentioned that since healthcare centres can detect anomalies in pregnancies, it is always necessary to seek antenatal care during pregnancy. Others pointed to the proper diagnosis of pregnancy-related illnesses as critical to the survival of their babies. These were their comments:

> *"If the child is not in a good position, they can correct that" (Participant 2)*
>
> *"When you go to the hospital, it benefits a lot. They will take care of you to become strong so that the child in your womb will also be healthy. …when you go to the hospital, maybe something, the disease is in you. The hospital workers will diagnose it and treat you" (Participant 3)*

"There are times when you can't sleep at night ... so you go and they take care of you and give you medication that will benefit you during your pregnancy so you can also sleep well" (Participant 6)

4.5 Health Behaviour

Health behaviours comprise factors pertaining to what pregnant women do to stay healthy. This is influenced by their characteristics, health facility features and community factors, particularly, culture. In this study, health behaviour was explored using two concepts, personal health practices and the use of health services. These included the experiences of the Kayayei during pregnancy, during antenatal care, child delivery, and postnatal care, among others.

4.5.1 Personal health practices

Personal health behaviour comprises the set of activities that pregnant women undertake to maintain a healthy lifestyle. This includes the diets that pregnant women eat, the physical activities that they undertake and the self-care protocols they engage in. The research investigated the actions the participants took outside of the healthcare centres which could positively or negatively affect their overall maternal health outcomes. The findings show that they adopted certain behaviours which were hazardous to their health and that of their unborn child during pregnancy such as taking part in physically engaging activities, however, this was deemed necessary according to them because they had to raise funds to purchase items for themselves and the baby prior to delivery. Another health personal health practice was that they made sure to take the drugs prescribed to them - this was a positive health practice. It was only one participant who took traditional medicine. After childbirth, they usually took a long break from head porting as they had to care for the child and they also believed that women became weak post-partum.

"I continued with the kaya until the ninth month" (Participant 1)

"When you go to the hospital, they write everything for you to buy and when you are going to give birth in the hospital, you bring them… So if you don't continue the head porting, you won't be able to buy these things… when I stopped, I was seven months into the pregnancy" (Participant 6)

"The traditional medicine, they told us not to take some of those drugs in addition ... So we should take only the orthodox medicines" (Participant 2)

"As for me, when I was pregnant, I took traditional medicine" (Participant 7)

4.5.2 Use of Health Services

This section examines the facility factors associated with access to healthcare services among Kayayei in Accra. It explicates the perceived trust of the participants in the competency and capacity of healthcare

practitioners to meet their health needs and the degree to which organizational structures in healthcare centres grants access to minority groups. On the use of health services, the 9 out of 10 participants who used maternal healthcare services attended at least four antenatal care visits, had a skilled delivery in a healthcare facility, and attended post-natal visits. The remaining participant out of the term did receive any form of maternal healthcare at any point in her pregnancy

> *"When I get pregnant, I take it to the hospital. I went for about seven to eight [times]" (Participant 3).*
>
> *"You would go about six [times] before you give birth" (Participant 8)*
>
> *"Yes, I gave birth in the hospital" (Participant 4)*
>
> *"It was my husband's mother who helped me [with delivery]… When I got pregnant and came here, I didn't have any money to take to the hospital… so if I work a little to get my transport fare and purchase things for the baby, then I leave. So that's why I didn't go to the hospital" (Participant 7)*

Indeed, some of the participants still attended post-natal visits and informed the interviewer that they were going to continue until the child was three years old. Some of the issues encountered with the post-natal care visits were that on certain occasions, it was either mother or child that was examined, and not both. Other services they also benefitted from during birth in the facility and antenatal visits were baby vaccination and registration of birth. The following are some of the points raised by the participants.

> *"I was going there for my personal examination … As for the child, I didn't take them. I went alone … I went there about 8 or 9 times" (Participant 2)*
>
> *"They checked the child and me as well. Unless the child is three years before they stop the weighing [post-natal care]" (Participant 4)*
>
> *"They used to care for only the child…. Right now, they are three years, then I stopped" (Participant 6)*
>
> *"After you take them home and have the naming ceremony, then you will take them back… So they would write the name on the paper [birth certificate]" (Participant 8)*
>
> *"On the day the child was born, they received those injections on the same day" (Participant 2)*

4.6 Outcomes

The research aimed to ascertain the impacts of perceived health status, after the uptake of maternal healthcare, on women's readiness to continue the uptake of skilled healthcare services during subsequent pregnancies. It

assessed the participants' capacity to maintain and improve their health status with the assistance of healthcare professionals. The section is also focused on the satisfaction of the participants with the quality of care and the efficacy of continuous receipt of maternal healthcare services from skilled professionals in Accra. In terms of the perceived state of health after the uptake of maternal healthcare services, the participants mentioned that most of the complications associated with pregnancy and childbirth were not experienced as they attended antenatal care. In terms of service quality and satisfaction with the medical interventions received, the participants generally expressed gratification with the services received from the nurses, midwives and doctors, only two mentioned that it was possible to encounter a medical staff member with a negative attitude. They however expressed great displeasure with the waiting times:

> *"They were patient enough to give you the necessary care that you would be satisfied with… when I went and there was something wrong with me… I could explain it to them" (Participant 3)*

> *"I was more than content with it [care received]" (Participant 5)*

> *"They are all different … Some of them have the patience to attend to the pregnant women, some will also insult you… So we told everything to the radio journalists … So now, they don't raise their voices at us anymore. ...some people would say this woman bothered me and others would say she doesn't have a good character, yeah so if many people keep saying that, then they tell her to change her attitude because everybody is speaking ill of her so she should change" (Participant 8)*

> *"You could ask (questions) but there were some people you couldn't ask" (Participant 9)*

CHAPTER 5: DISCUSSION

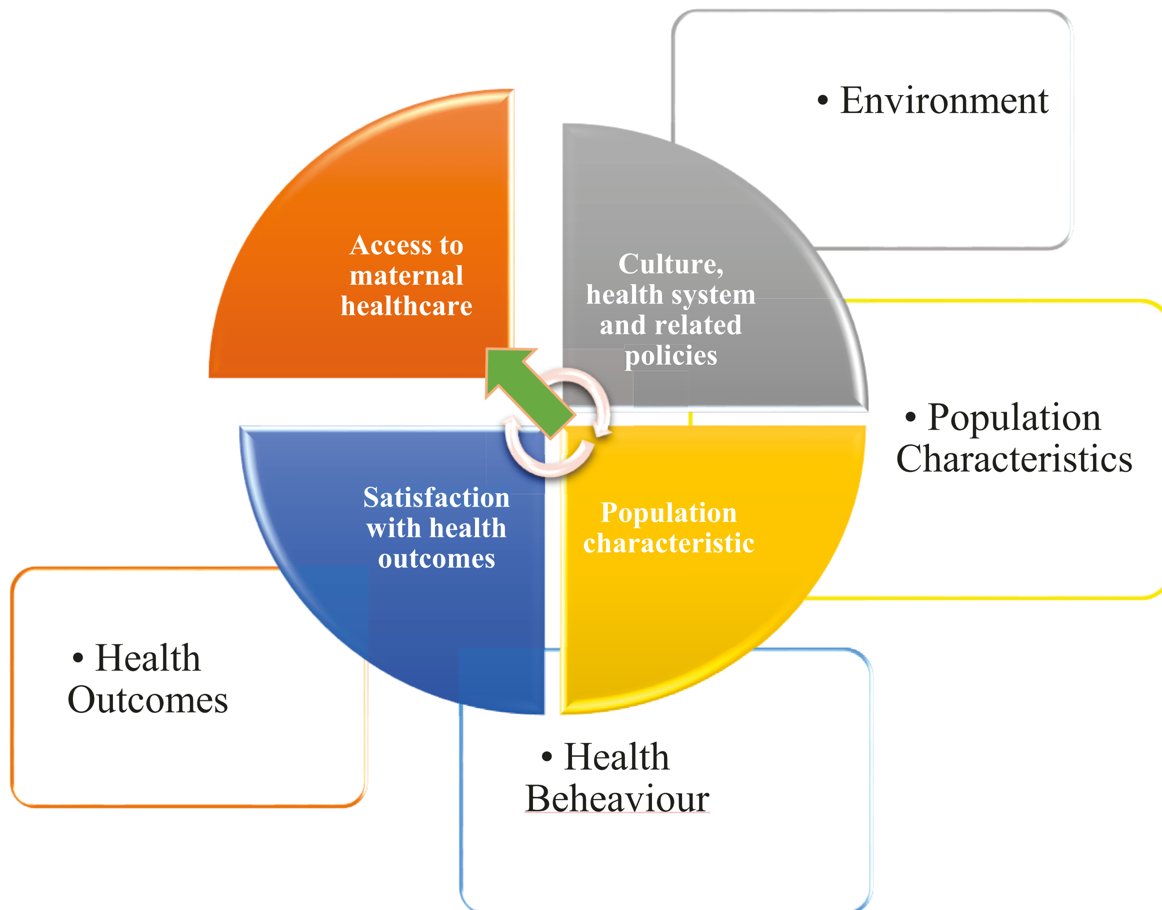
5.1 Introduction

This chapter discusses the findings of the study. The objective is to find suitable justifications for the research question. While Andersen's Behavioural Model formed the crust of the study's design, the information gathered from the participants was purposed to address the research objectives of the thesis. Accordingly, the study redesigned a thematic framework that abstractly expounds the meanings derived from a juxtaposition of the participants' experiences with what literature teaches about maternal healthcare among Kayayei in Accra. The remaining part of the section discussed the research questions, as follows: 1. What are the effects of culture, healthcare system and related policies on the health-seeking behaviour of Kayayei? 2. Does the population characteristics of Kayayei influence their health-seeking behaviour? 3. How do Kayayei evaluate their healthcare status following the uptake of maternal healthcare services? It is vital to mention, however, that while the demographic characteristics of the study participants indicated an age range between 22 years and 40 years, there are many Kayayei who fall below 18 years, which could be observed in the information collected on the number of years they have been head porting goods in Accra. Thus, although the researcher intended to interview some Kayayei in their teen years, none of them was available to be interviewed. This accounted for the range of people who were represented in the study. This notwithstanding, the purposeful selection of participants above 18 years of age was intended to ensure that potential interviewees are free to speak to the researcher without the need for authorisation from a guardian or parent. The ages of the last children born to the Kayayei.

5.2 Thematic Framework

The diagram is a matrix of Andersen's Behavioural model and the research objectives of this study. It illustrates how the research, namely (i) the influence of culture, policies, and health systems, (ii) population characters, and (iii) satisfaction with health outcomes are conditioned on the Behavioural model. There is a multidirectional relationship between all the concepts, but all culminating in the likelihood that the Kayayei will promote their healthcare conditions during pregnancy by seeking skilled maternal healthcare assistance from trained and qualified experts.

Figure 4: Thematic Framework



Source: Autor's Construct

5.3 What are the effects of culture, healthcare system and related policies on the health-seeking behavior of Kayayei?

Environmental influences are critical determinants of behaviour, according to the behavioural model. It proceeds to state that learning and unlearning of conducts and belief systems are the production of the social environment and the norms that the individual is exposed to (Andersen, 1995). It is on this grounds that this research was set to ascertain the effects both the health system and external environments of their settlements or residence have on accessibility to maternal healthcare among the Kayayei in Accra.

The healthcare systems comprises the institutional structure of Ghana's healthcare delivery, availability and equitable distributions of facilities, the design and effective adoption of relevant new-born tools and standards to promote the safety and wellbeing of mothers and their new-borns, the adequacy and competency of staff to carry out the mandates of new-born facilities, and the enactment and enforcement of enabling programmes and policies to ensure that the deprived and vulnerable population of society adequately mesh with the healthcare system. Consistent with Andersen (1995), the healthcare systems have had a significant impact on the healthcare-seeking behaviour of participants in this study. For the majority of participants, their behaviour towards seeking maternal healthcare services is largely influenced by the availability of healthcare facilities within the communities in which they live. Interviews with participants in the study show that inadequate healthcare centres that provide maternal services rendered it extremely difficult to access formal healthcare services during the maternity period. The women complain that having to walk long distances to access healthcare services is stressful and as a result, had to spend a lot of money on public transport and waste time commuting from their places of residence to the health centre. This finding is supported by Anderson behavioural model of healthcare service utilisation which posits that there is a direct influence of environmental factors on the healthcare-seeking behaviour of individuals. This was made evident in this study as one of the major influences on the healthcare-seeking behaviour of pregnant women is a scarcity of healthcare services within theory localities. Thus, if healthcare centres are located within the environment it is likely to have an impact on the health-seeking behaviours of those the system is targeting. Consistently, the participants in this study identified that the availability of healthcare centres within their living environment would have a positive impact on their health-seeking behaviour, particularly at the time of pregnancy. On the other hand, the study sought to suggest that even in some parts of urban areas where the Kayayei resided, the inadequacy of healthcare facilities may have had a negative influence on their attitudes towards maternal healthcare services. The same is true for the availability or the lack of health facilities in relatively poorer communities. Individuals tend to feel reluctant in making efforts to seek healthcare services, but instead, rely on herbal and traditional medications to treat pregnancy-related ailments (Yiran, Teye, & Yiran, 2015). Indeed, this could have been a reason why one participant did not benefit from any maternal healthcare services at all because there was none close to her to even make her curious to consider it in the first place, thus, her reliance on traditional medicine. The study also reveals that not only does inadequate healthcare facilities influence the maternal healthcare-seeking behaviour of Kayayei but also the absence of healthcare professionals to deliver the requisite care services to pregnant women. For the majority of study participants, an understaffed healthcare centre could discourage them from visiting the healthcare centres when they are pregnant. Some of the participants bitterly complained about the time spent when they attended antenatal care because of the fact that a few staff had to attend to a large number of people and expressed a desire to use different healthcare facilities as a result. According to Roiss et al. (2021), when the expectations of people are dampened consistently by a system, over time, they begin to develop negative attitudes towards that system. Although this was not the case, frustration

may cause them to abandon the pursuit of healthcare if after some time, they begin to judge that the costs outweigh the benefits. As noted by Kiross et al. (2021), the presence of skilled health professionals improves maternal health attendance and health outcomes among women. On the flip side, the absence of health professionals at the various health centres could negatively impact the health status of Kayayei during pregnancy.

The external environment of the participants' living conditions was also identified by the participants as a major determinant of some of their health behaviours during pregnancy, childbirth and after childbirth in Accra. These are policies and community norms that often influence the decision of Kayayei and other minority groups like them to seek maternal care. In Ghana, the National Health Insurance Scheme and the Free Maternal Healthcare were some of the most pregnancy-related policies advanced to enhance patronage of maternal care services. However, the coverage of these policies were not comprehensive so the Kayayei were still forced to heavily invest financial resources into maternal healthcare. Consequently, the lack of money to finance the cost of healthcare during pregnancy was mentioned as one of the main reasons why the participants of this research failed to seek maternal healthcare from qualified and skilled professionals during pregnancy and childbirth. For instance, Participant 7, who related that *"If you go to the hospital with a little money, it will not be enough, It has made us afraid of the hospital"* may never take the opportunity to benefit from the financial packages available to pregnant women to enable them to access quality care service free of charge (Yiran, Teye, & Yiran, 2015.). In addition to this, the lack of policies on affordable housing or the vulnerable resulted in the Kayayei not being able to participate in the housing market, hence, driving them into homeless conditions or making them dependent on the informal housing sector. This exposed them and their children to health hazards because these alternatives usually have poor hygienic conditions, lack sanitation facilities such as bathrooms and toilets, and render it more difficult to seek formal healthcare services. Finally, cultural norms that bar people from the uptake of orthodox medication during pregnancy has also impacted the patronage of antenatal care among Kayayei. According to Yiran, Teye, and Yiran, (2015), some ethnic groups consider the uptake of orthodox treatments during pregnancy as a bad omen. Such indoctrinations may significantly influence the readiness of participants who hailed from such regions to avoid maternal care services. For instance, Participant 7, one of the least educated participants had this to say: *"When I was pregnant, I took traditional medicine, I didn't go to the hospital, I wasn't taught to go to the doctor"*.

These challenges that the Kayayei face as a result of their environment bring to mind the notion of systemic exclusion propagated by McGranahan et al. (2016) which argues that people cannot fully participate in their society because systematically, cities were created to attract a specific class of people but when poor people moved from rural areas because of the opportunities that became available in cities, their needs were not taken into account and were deliberately abandoned by the government. The living conditions and the lack of basic facilities such as sanitation facilities and access to maternal healthcare are a prime example of what the author

attempts to explain that cities were not initially built with exclusion in mind but when there was an influx of rural-urban migrants, they were deprived of basic amenities that every member of society should have access to.

5.4 Does the population characteristics of Kayayei influence their health-seeking behavior?

This question discussed the definitive concepts employed by Anderson to explain the influences of population characteristics on maternal healthcare (Andersen, 1995). In his model, population characteristics describe the combination of all predisposing factors that encourage uptake of healthcare, the enabling factors and the needs of pregnant women. The study, thus, utilised the responses given by the participants to locate their needs based on their peculiar description and orientation.

Yiran, et al. (2015) opined that socio-cultural norms often affect the health decisions of people. He suggests that the orientation of women concerning pregnancy and childbirth, by parents, community activists, and the formal institutions they were exposed to, largely influence the trust they develop for healthcare centres and health professionals. For instance, Participant 7 in this current research failed to go to the hospital because according to her, that was not the kind of socialization she had from infancy. This reality may be the same for other women who grew up within similar environments and socialised with similar customs. Another prevailing factor that may account for the likelihood that the participants may attend antenatal care is their socioeconomic status. The Kayayei are extremely poor with the majority who are homeless. Often, they scramble for space on the streets to sleep. According to Poston (2009), when sustenance needs are not met, including food, and shelter, many people may not find the need to make healthcare a priority. It was not surprising therefore that some of the respondents pointed to needs on their priority lists, aside from antenatal care: *"If you even look at where we sleep, when we are wet with rain, we have to stand on our feet, we stand" (Participant 1).*

The study also explored the influences of the existence or absence of enabling factors as a precursor to the patronage of maternal care services. Enabling factors may be personal, familial or communal (Andersen, 1995). It also pertains to some of the programmes and policies advanced by the government to facilitate access to care services among the poor and vulnerable. According to the participants, the cost of securing healthcare is too expensive for them. They lamented about the money spent on prescription drugs, transportation to the healthcare centres and the cost of scans and other diagnostic procedures. This revelation is consistent with Maslow (1948) hierarchy of need, which places sustenance needs ahead of other priorities. Thus, it is right to mention that since the majority of the participants and their children are hungry, and have nowhere to lay their heads, the likelihood that they will use the money made from head porterage to go to the hospital will be below.

According to Yiran et al (2015), this situation is also a challenge in developing nations where no arrangements are made to provide the extreme poor emergency access to free transportation to their places of destination.

The implementation of the NHIS has often been touted as a good example for many developing countries, particularly Ghana. Largely subsidized through the taxes of citizens, the NHIS requires its subscribers to pay a modest annual premium. Despite this provision, it is worth mentioning that not all people are enrolled on it. A few participants from the study were not signed up for the NHIS. This was so because mothers who were not enrolled on the NHIS scheme mentioned that either it did not cover all maternal health needs, or it was not useful to them at the time. Again, the distance to registration and the time wasted demotivated some of the participants from registering. This was because participants felt it was going to affect their daily working hours as time meant to be spent working would be used at the centre.

Another finding that emerged from the study was transportation issues. The cost of transportation to health facilities and pharmacies to purchase prescribed medicines was recorded as a challenge for most mothers in this study. This could be attributed to limited economic resources and meagre income earned by Kayeyei often throwing them into having to prioritise their needs based on their income. Thus, the exorbitant cost to these facilities often deterred mothers from accessing maternal health facilities let alone travelling the distance of purchasing medicines from pharmacies. Again, participants lamented that they were financially constrained and, as a result, could not commute to the health facilities and reported that distance was a barrier to the patronage of these facilities.

According to the GDHS (2008:1), "the healthcare that a mother receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and her child." As a result, providing maternal health services, such as prenatal and postnatal care throughout pregnancy and after birth, is one way to improve women's health (Kiross et al., 2021).

Access to and use of health services by mothers is critical for the prevention of diseases and infections associated with childbirth. This is especially true with Kayayei mothers. This is because women's health is a key non-monetary indicator of poverty. As a result, improving women's health is one way to alleviate poverty. For example, the Ghana Poverty Reduction Strategy and the Ghana Shared Growth and Development Agenda recognise that strengthening the poor's health is critical for poverty reduction because declining health is both a consequence and a cause of poverty. Another issue raised by the findings of this study is that some mothers underutilise maternal health services, particularly post-natal care.

The study's findings in the instance of post-natal care appear to follow a pattern of low utilisation among some few participants. For example, mothers cited economic status, long wait times at hospitals, employment, and gender as causes for underutilisation. Other studies have revealed that economic status, occupation, gender,

migration, level of education, ethnicity and cultural background, religion, area of residence, and perceptions of healthcare facilities are among the individual and social characteristics that affect access to maternal services (Kifle et al., 2017). Thus, one of the assumptions of the author was that due to their low educational background and socioeconomic situation, maternal healthcare would be severely underutilised. However, the findings of this study demonstrated a high level of some form of maternal healthcare utilisation among participants. While a few of them managed to receive the full continuum of care from service providers, which includes the minimum of four antenatal visits, a skilled delivery and post-natal care for mother and child, many of the participants fell short on the utilisation of post-natal care; one mother attended post-natal care visits without her child and several others reported that only their children were examined and there was a complete non-use with one other participant. Although the situation was better than expected, there still remain gaps to be filled.

Again, postnatal care as revealed by this study's findings is an essential part of safe motherhood. For instance, Warren et al. (2006) particularly allude to the fact that postnatal check-up provides an opportunity to assess and treat delivery complications and to counsel new mothers on how to care for themselves and their babies, monitor the health of the baby and the mother and to provide periodic health examination. As seen from the study findings, a few mothers preferred to visit the hospital for post-natal care as they reported that doctors took their time to examine their health and that of their child hence giving them some level of satisfaction after visiting the health facility. Thus their perception that the doctor could examine them as opposed to seeking healthcare service elsewhere were justified. This is supported by the Andersen Behavioural Model of Healthcare Service Utilisation which suggests that the outcome after visiting a health facility by a service user should translate into some satisfaction for the user.

For all women, the transition to motherhood has been recognised as a significant developmental milestone. Social support has been highlighted as a resource that can come from a variety of sources, including family, friends, and co-workers. According to the study's findings, peer support was the most important source of social support for Kayayei mothers. This is because the majority of Kaya participants are first and foremost migrants, who may or may not have family members in Accra. All of the participants were married, according to the data.

Even though all the mothers were married, there was no evidence that their husbands supported them when they were in Accra. A majority of participants travelled back to the north for childbirth and returned after some months with their babies to continue head porting. It appeared that while these women were in Accra, the received no support either in the antenatal or post-natal period but when they were home, their husbands provided for them because their child had to be cared for. As a result of the foregoing, mothering is by no means simple, and it's crucial to remember that one parent cannot fulfil the roles of both mother and father. It is important to note that "single" parenting (in this case, because married women did not receive any form of

help from their partners) violates the spirit and letter of the Convention on the Rights of the Child and the Children's Act of Ghana. Indeed, the Children's Act of Ghana (Act, 560) of 1998 states among other things that a parent or any other person who is legally liable to maintain a child is under an obligation to supply the necessities of health and life, education and reasonable shelter for the child. In the circumstance of single parenting, one party usually takes custody of the children as with mothers in this study.

On the contrary, social relationships and strong bonds that exist between mothers, community members and colleagues played an important role for mothers. From the findings of the study, it was rather revealed that mothers received monetary contributions and items from colleagues and loved ones during and after pregnancy. This is also in line with the assertion made by Begeny et al. (2019) and the World Bank (2013) that people with similar attributes who are marginalised in society tend to cluster together as a self-help strategy and also to affirm their identity.

Finally, the uptake of maternal healthcare is influenced by the needs of the people. This points to the degree of sicknesses that the women are faced with and the imperativeness of seeking medical care under such conditions. It is important to mention that due to their low socioeconomic status, Kayayei is less likely to be attentive to their health, and thus, the need for periodic check-ups (Kaba et al 2018). As a result, although they may know the importance of antenatal care, some of them may not appreciate the need for antenatal care services as critical during pregnancy. As Andersen (1995) highlights, when the use of healthcare services is influenced by diagnostic factors rather than social factors, then there is equitable access but when the contrary is the case, then access to healthcare in unequitable. Indeed, to an extent, the health belief of a majority of the participants matched the diagnosed need that utilisation of maternal healthcare services was essential to pregnant women and mothers of new-borns. Nevertheless, it is arguable to assume that there was equitable access to these services because they had to overcome major barriers such as distance, high medical costs per their income and long waiting times.

5.5 How do the Kayayei evaluate their healthcare status following the uptake of maternal healthcare services?

The import of this research question was to ascertain how the perceived health status of the Kayayei influences their health-seeking behaviour. According to Kifle, et al (2017), self-care is important to staying healthy during pregnancy. Some self-care approaches that pregnant women may adopt to stay healthy include periodic bathing, eating nutritious food, having a good and safe sleep, cutting down on stressful activities, and most importantly, visiting the healthcare centre for antenatal care (Lincetto, et al, 2006). Albeit many of the participants are aware of these measures, their prevailing livelihood does not permit them to keep the rules.

For instance, instead of having a good sleep, pregnant Kayayei may scramble on the streets with other Kayayei. The scare of being attacked by robbers, raped, and the thoughts of getting food to eat the following day, make the sleep uncomfortable and stressful. In the same vein, instead of taking a break from head porterage, the women continue to carry heavy loads. In terms of personal hygiene, the women often sleep on the bare ground, which is not safe for the pregnancy, eat foods bought from street vendors that are cooked under less hygienic conditions because their living condition denies them access to kitchens where they can cook their own food, and lack the essential nutrients for the growth and development of the foetus, and do not often get the privilege of using private bathrooms. With this prevailing condition, the women may not consider frequent maternal care services to be critical.

The way people perceive their health is influenced by a lot of environmental factors and conditions. Perceived health status can simply be defined as the perceptions of a person's health. Based on the findings of the current study, the ability of the women to give birth in a health facility makes them perceive that their children are healthy. For instance, some participants according to the findings of the research believed their children are healthy because they delivered them in a health facility, unlike other women who delivered in their homes. Just as Andersen mentioned in his model, the availability of health facilities and the presence of skilled perceive influence the quality of healthcare patients may receive and vice versa. In the same vein, the availability of health personnel and health facilities also influences the perceived health status after maternal healthcare. Being given all the necessary maternal healthcare influences health satisfaction which eventually tend to impact health outcome. As a result, the availability of clinical tools, drugs, access to health-related resources, medical care sanitary conditions toiletries among others also explains why participants were content with the services they receive in the health facility which also influences the perceived health status. While the above-mentioned factors all contribute to perceived health outcomes, the decision to deliver in health facilities and receive all needed care is equally dependent on a lot of factors such as financial wellbeing (Lattof et al., 2018) and established gender norms (Van Der Land et al., 2018). As a result, perceived health outcomes could be particularly controversial in the health discourse.

The findings of the research also indicate that the severe complications after birth and the potency of prescription drugs influence perceived health outcomes. While having complications after childbirth is dependent on a lot of factors such as underlying health conditions of the mother and the foetus and other mediating factors, most respondents believe that being healthy is dependent on not having complications after childbirth. While this could be true, it is important to note that even women who perceive they are healthy even after may still experience other health challenges.

Also, consumer satisfaction just as Andersen (1995) mentioned influences health outcomes. The general attitude of medical staff could either influence a patient's decisions to use medical facilities or prevent a patient from using health facilities. Every patient expects that they are treated with respect, as a result, failure of

healthcare providers to give them the accorded respect creates disappointment in patients which may impact their decision to utilise health facilities.

The physician-to-patient interaction is an important factor to determine patient satisfaction. As a result, improving communication and interpersonal skills may expand the patients' satisfaction which is a positive effect on adhering to treatment, drug prescriptions, and health outcomes. Polite and respectful physicians are more likely to be liked by patients and this also impacts patient satisfaction and influences their decision to utilise healthcare or not. Communication between physicians- patients goes beyond face-to-face interaction. Ensuring that a competent and well-mannered person is placed to handle consumers' inquiries, the tone, and speech of the person and the manner to explain and convince consumers when a doctor is occupied or busy is also crucial in determining consumer’s satisfaction.

The number of time patients spends in a health facility determines the outcome of their satisfaction, as a result, patients who spend more time than they expect at hospital facilities may consider other options. With so many hospitals and health facilities sprouting out now, only a few people may stick to doctors or nurses who pay little or no respect to time. While longer waiting times deter patients from visiting health facilities, it is also necessary to consider the factors that lead to longer waiting times. This includes the availability and efficiency of supportive staff, the doctor's style of working, and the kind of patients the physician may be attending to. All patients have different situations, hence they may equally need different consultation times to attend to their needs.

While all these indicators affect consumers’ satisfaction, patient satisfaction is an attitude which is maybe very subjective. This is because, getting satisfied with health services does not guarantee that the patient will remain loyal to visiting the health facility or seeing the doctor frequently, however, it is still a strong motivating factor to satisfaction. As it can be observed from the findings of this study, many of the participants were content with the attitude and communication of healthcare service providers, even those who reported negative attitudes made no connection to their socioeconomic status as suggested in some literature (Moyer et al., 2014; Mumtaz et al., 2012; Patel et al., 2018; World Bank, 2013) and also acknowledged that the health facilities were dedicated to curbing the problem.

CHAPTER 6: CONCLUSIONS

6.1 Conclusions

In spite of the lapses in the maternal healthcare system in the Accra Metropolis, the cost of seeking maternal healthcare and the low level of education among the participants of this study, a majority of them had a positive view towards the health institution and its capacity to cater for their health needs, thus, there was an optimal utilisation among most of the female head porters who participated in this study – all but one attended antenatal care visits, had a skilled delivery in a healthcare facility, and attended postnatal care visits.

Nevertheless, they still possessed some hazardous health behaviours unsuitable and potentially threatening to the safety of the mother and child, such as sleeping on the streets, head porting until late into the final trimester of pregnancy, using shared sanitary facilities and using commercial motorcycles, which are illegal and unregulated, as means of transport to the hospital even during pregnancy.

These results do not however imply that there is an increase in the use of maternal healthcare services among female head porters because the sample size is not representative of the entire population of Kayayei – even if some participants indicated that this was the case, this research could not prove this. Also, the snowball method of recruiting participants could have limited the diversity of the participants.

In light of these findings, the researcher holds the view that the Kayayei, experience some forms of social exclusion with regards to their access to maternal healthcare services. This is because firstly, they face higher health risks as a result of their exclusion from accessing decent housing.

Secondly, the financial implications of seeking maternal healthcare services, though many not be enough to completely bar all of them from accessing these services, place a higher financial burden on them as compared to the average urban resident in the Accra Metropolis, thus, compelling them to continue making risky decisions such as engaging in head porting until the last trimester in order to afford hospital bills and buy stuff for their new-born children.

Thirdly, taking into account the situation of the participant who neither had the knowledge nor the financial resources to seek any form of maternal healthcare, there may still exist women like her in the city who experience total exclusion from access to healthcare services. However, the extent to which such cases exist is unknown.

This research has proven the multidimensional nature of social exclusion which can still be discovered even in the analysis of a single dimension of it. Indeed, besides the effects that personal characteristics such as migrant status and poverty had on access to maternal healthcare services, exclusion from other domains of

society such as the housing market and educational services contributed to the exclusion from maternal healthcare services and the increase in health risks.

Therefore, in the context of the Accra Metropolis, the implementation of the National Health Insurance policy and the free maternal healthcare policy had limited impacts on the access to maternal healthcare services. It is suggested that a social inclusion/exclusion analysis be employed in order to target groups of vulnerable women, in this case, the Kayayei, to assess their problems and address specific policies to promote their participation in healthcare services, and in society as a whole, in lieu of treating the whole population of excluded persons as a homogenous mass and expecting a single intervention to solve all the challenges they face.

To ameliorate their situation and improve access to maternal healthcare services, the participants suggested that the health insurance registration be brought closer to them. If the female head porters had the opportunity of registering in the markets, there would be a wider outreach to people who are unable to leave the market to get this done.

Another policy suggestion was that the cost of the maternal healthcare should be reduced. Currently, the services covered by the National Health Insurance Scheme are few and the financial burden is still unbearable by some women. Therefore, an expansion of coverage to cover more medications and services such as laboratory tests and ultrasound scans would benefit more women.

Furthermore, public education and raising awareness was another intervention recommended by a participant. Taking into account the high level of illiteracy among the Kayayei, public education is a useful tool for changing the attitude of these women towards maternal healthcare services and maternal health in general.

Finally, many of the participants lamented over the deplorable living conditions in the city and demonstrated a strong desire for government intervention in this domain. If affordable housing is implemented and made available to the head porters, it will have a major impact on their maternal health because their risk of contracting diseases such as malaria and the sanitation problems would be reduced.

6.2 Recommendations

From the foregoing discussions and the conclusions drawn from the findings of the study, recommendations were advanced to address some of the systemic and knowledge deficits that this research identified. In the subsequent paragraphs, recommendations for policy improvements and research were discussed.

6.2.1 Policy and Practice

In response to the influence of culture, the health system and its related policies on how the Kayayei utilize maternal healthcare services, the specific practices they engage in, such as the use of traditional medicines and childbirth at home should be targeted and addressed through interventions such as market outreaches. Medical staff should also be able to take advantage of antenatal and post-natal care visits to educate the women on aspects of their way of living which could be detrimental to their health as well as that of their child. The problem of long distance of healthcare facilities from informal settlements could be addressed through the provision of maternal healthcare facilities in these areas. With the help of Civil Society Organisations, they could draw more attention to this issue and pressure the government to provide these facilities.

The health policies in place, which have not succeeded in having the desired impact on the lives of the vulnerable could be improved through the collaboration between public institutions and relevant non-state actors to plan interventions which will facilitate access to maternal healthcare services.

The characteristics of the Kayayei group such as poor living conditions and lack of financial resources have implications on their maternal healthcare access and their maternal health in general. Their situation can be improved by financially empowering them through cash transfers or equipping them with skills which will enable them pursue a more lucrative and decent work. This will put them in a better position to make better health decisions and utilize maternal healthcare services.

To tackle the anomalies in the healthcare system which take away from a positive experience in the healthcare setting, there should be more medical staff available to attend to these women in the shortest possible time. Moreover, a system should be put in place to facilitate the reporting of unprofessional attitudes by medical staff and perpetrators should be held accountable. This will reduce the incidents of negative attitudes of staff towards patients.

6.2.2 Further Research

The findings of this research, though have shed light on the issue of social exclusion in the maternal healthcare system in an extremely polarizing context such as the Accra Metropolis, are not conclusive and leave more questions to be answered.

This topic needs to be further explored in terms of scale and scope. The researcher recommends a quantitative study be carried out with a larger sample which is representative of the entire population of female head porters will determine the extent to which this form of exclusion is experienced. The themes evoked in this research present a good foundation for the execution of surveys and other forms of large scale research on the topic.

As pertains to the scope, it would be interesting to explore how other layers of personal identity or attributes could influence the exclusion of these female head porters from accessing maternal healthcare services. The

questions on whether single motherhood, some form of physical or intellectual disability and the like, would influence the exclusion of these Kayayei in the access to maternal healthcare services, still remains to be explored.

Furthermore, this study does not include the views of some key informants on this matter. The opinions of Non-Governmental Organisations, medical staff, government institutions such as the Ministry of Health, Ghana Health Service, the National Health Insurance Authority and the Ministry of Gender, Children and Social Protection on this topic would complement findings from the female head porters and help to better address the problems in the healthcare system as well as the factors accounting for some inefficiencies among public institution from the point of view of experts.

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ANNEXES

Annex 1: Interview Transcripts

Individual Interviews with Kayayei

Interviewee: Participant 1

I: I have started recording now. So how old are you, please?

P: As for my age, when my father gave birth to me, he didn't tell me but I should be about 20- I should have reached age 30.

I: Oh okay, okay. Mm, are you married please?

P: Yes please.

I: Okay. And, um, where in the North do you come from?

P: I am from Yagaba. {okay}. After Bolga.

I: Oh okay, okay. So your religion, are you a Muslim or-?

P: I am Muslim.

I: Muslim?

P: Yes.

I: Okay. And, please did you attend school?

P: No.

I: Okay. So, um, when you do the head porting, a d- a day how much do you earn?

P: Oh as for that, when you get something little, the little that you get, that's all.

I: I see. Could you please give me perhaps, uh, the amount?

P: It could get to about 20 cedis a day.

I: Okay. So apart from the kaya, do you do something else? Do you do another work or only that?

P: No, only that.

I: Oh okay. How many children do you have please?

P: Three, one of them is no longer here.

I: Oh okay. And when you gave birth to your first born, around what age were you? Okay, how old is your first born?

P: She is uh 10 years.

I: 10 years? Okay. And your last born also, how old is she? [name]?

P: [name]? One year.

I: She is one year?

P: Mhm.

I: So um, um, you work in Accra, Makola. Do you live in the same place or you live elsewhere?

P: That's where I live.

I: Oh okay. And uh, have you rented an apartment or- you, you live outside?

P: It's outside that we sleep.

I: Oh okay. And when you came to Accra to start the kaya, how many years has it been?

P: I started, four years.

I: Four years, okay. Uh, so now I am going to ask you some questions on, like, pregnancy and childbirth. So, um, in English, when we say 'maternal healthcare', do you understand?

P: No oo.

I: Ah okay. I will try to explain it in Twi. So maternal healthcare is uh, um, when you realise you are pregnant, and after childbirth, uh, those- things you do to take care of yourself. Yes, so, your health (laughs), your health when you and soon after you have given birth. That is what we refer to as maternal healthcare. So within that pe- um, with regards to maternal healthcare, do you think that when a woman is pregnant, and um after she gives birth, in your understanding, what is she supposed to do

P: She should go to the doctor.

I: She has to go to the doctor. Okay. (Laughs). So please, when I say antenatal visits too, do you understand?

P: No. [5:00]

I: Okay. That is also um when a woman is pregnant, she going to the doctor to do check-ups and others. That is also the antenatal visits. So with that, what do you think are the benefits of it?

P: When you give birth?

I: No, when you are pregnant and you go to the doctor. What are the benefits? Is it important?

P: Aahh, when you go to the doctor, he takes care of you and he gives you drugs.

I: He gives you what?

P: He gives you drugs that when you take you become strong.

I: Oh okay, okay, okay.

P: Mm.

I: Uhh, and umm, okay, question- and- do you know that this maternal care that I am talking about, in the hospitals, it is free? Please do you know if it is free or you-

P: Please the question?

I: What did you say please? - Please I was saying that, do you know that it is free when you are pregnant and you go to the hospital, you are taken care of for free, or?

P: No, if you don't have the health insurance, they will take money.

I: Oh okay.

P: But for the scan, you will pay.

I: Ah okay.

P: Yes.

I: So, do you have insurance or not?

P: If you don't have one, they will take the money.

I: I- I am asking if you yourself, you yourself, do you have one or you don't?

P: I have one.

I: You have one? Oh okay. And, normally, apart from going to see the doctor when you are pregnant, is there any other thing you can do or it is only the doctor you are supposed to see?

P: No, you don't do another thing. You will go and see them and they themselves will come and examine you to see how your body is.

I: Okay, and what about the person who has maybe decided not to go to the doctor? What do they do?

P: Somebody says she will not go to the doctor?

I: Yes.

P: Hello?

I: Hello.

P: Ah, if you will not go to the doctor, you will take traditional medicine.

I: Oh, traditional medicine. So in Accra, are they able to get someone who makes traditional medicine?

P: Yes.

I: Oh okay. And, after you found out you were pregnant with your last born, [name], for how long did you continue with the kaya?

P: I continued with the kaya until the ninth month.

I: Oh okay. And after you gave birth as well, euh, how many months, days or weeks did you wait for before starting the kaya again?

P: I waited four months before starting the kaya again.

I: Oh okay, okay. So, umm, you said you went to the doctor during the pregnancy, umm, how many times did you go before you gave birth?

P: I went four times (simultaneous speech).

I: Oh okay, okay. And when you went to the hospital, was it close to you? Was the hospital close to you? Which hospital did you go to? Sorry.

P: The one that's just around here. The one at Makola.

I: Oh okay. So are you able to walk there or you had to take a car?

P: Mmhm.

I: Okay. And, umm, with the health insurance, did you do everything for free or they took money from you despite having the health insurance? [10:00]

P: As for the scan, you will pay.

I: Scan? Okay.

P: The lab too, you will pay for it. As for the insurance, it seems like only the medicines and their card that you use it for.

I: Okay. So, umm, when you gave birth to [name], did you give birth to her in the hospital?

P: Mmhm.

I: Okay. And umm. When you went to the hos- what made you decide to go to the hospital?

P: As for that, (laughs). What did you say?

I: I said what made you, want to go to the hospital?

P: Hello? Umm, the hospital is good so -

I: Oh okay. And when you went too, how the nurses and doctors attended to you, were you content with how they took care of you?

P: Yes please.

I: And umm, umm, how they also spoke with you, did they speak to you well and-?

P: Yeah, the way they talk is nice.

I: Oh okay, okay. And did you feel- when you went, did you feel that the way you were treated, that's the same way everyone else is treated or there was a difference?

P: Yes please.

I: Okay, so that's how they treated everybody. Okay. And, umm, when they took care of you, when you per chance had any questions, were you able to ask these questions?

P: Yes Please.

I: Okay. And umm, when you- you went to the hospital as well, umm, did you have to wait for a long time before they attended to you or when you got there, when you went, you didn't wait too much?

P: If you go and the people are many, you had to wait.

I: Mm, okay. So let's say for instance, how many minutes or hours?

P: As for the hours, sometimes you could go around- there are times you will come around 12pm before you leave.

I: Mm, wow.

P: Yeah.

I: Okay. And after you gave birth too were you going to the hospital to do stuff like weighing, etc.?

P: Yes please.

I: Okay. So, umm, when you went, umm, did they take care of the child only or they tookay care of you too?

P: They tookay care of all of us.

I: Okay. Was your child registered in the birth registration when you gave birth to her?

P: Yes please.

I: Okay. And umm, was she injected (vaccinated)? [laughs]

P: Yes please. She was injected.

I: And with that as well, was it free?

P: Yes please.

I: Oh okay. And also when you went to the doctor, did you and them- apart from the time that you had to wait, when you got to the doctor, around how many minutes did you spend with spend with the doctor themselves? [15:00]

P: Yes please.

I: I meant how many minutes do you spend with the doctor? Around how many minutes?

P: As for that, I-

I: You can't tell?

P: As for that, I don't check.

I: Okay. But in your opinion, does it take time or once they start taking care of you, it doesn't take too much time?

P: No.

I: Okay. So if maybe you had a different option, let's take for instance there was another hospital, would you go to the other one?

P: If there were another one, we would go to that one.

I: Ah. And why?

P: [laughs] Because of the time we waste over there.

I: Mm, alright. So the time?

P: Yes.

I: Okay. Now I have some questions on, umm- So are you part of either a union or something of the like? Like maybe the kayayei you have a group?

P: I don't know.

I: I mean that, the kayayei, do you have a group that meets and has discussions?

P: Yes please.

I: Okay, so when you were pregnant and after you gave birth, did they assist you in any way?

P: No.

I: And what about your family?

P: Umm, my family-

I: Did they help you in any way or what?

P: Yes, they helped me.

I: And, umm, when you decided to give birth at the hospital, was it something they were happy about or they were not happy about it?

P: Umm, they were-

I: Were they happy, in other words, were they supportive of your going to the hospital or if they could, they would have you do something else?

P: Umm, hospital.

I: Did you hear my question, please?

P: What did you say?

I: I said did you hear my question? I was saying, umm, so your family, did they support that you go to the hospital or they would have wanted you to do something else?

P: No, they were all accepting of me going to the hospital.

I: Where did they say you should go?

P: Hospital.

I: Hospital? Okay. And for your spouse too, was it the same?

P: Yes please.

I: Okay. And- umm- normally- you said you were Muslim, so do Muslims perhaps have any teaching which tells you that when a woman is pregnant, there are certain things you should do or-? [20:00]

P: No.

I: And do they talk about maternal issues in the mosque or they don't say anything about it?

P: No they don't.

I: Ah, okay. And, umm, among the kayayei, among yourselves, do you talk about this?

P: Yes please.

I: Okay. And among the other kayayei, do they also go to the hospital? Do you know some of them who go there and some of them who don't?

P: Mm, I know some of them who go.

I: Oh okay. And do you know why they go?

P: Yeah.

I: Oh okay. Because they also believe it's good for them?

P: Yes please.

I: Mm okay. What about those who don't go? Do you know some people who when they are pregnant and when they are giving birth, they do not go to the hospital?

P: Yes, some of them use traditional medicine.

I: So, why do they use the traditional medicine? Is it as a result of financial issues or maybe cultural imperatives or something?

P: It is because of financial issues.

I: Okay. You said that if you have the health insurance, they umm, it is free apart from the scan and the lab. So is it because they do not have the health insurance that's why they don't go or they have it but maybe because of the little amounts of money you have to pay, that's why they don't go?

P: For some people, if they don't have the insurance, they can't go.

I: Mm, okay. So I'll ask some few questions on certain things that can be done to improve, umm- knowledge- So, with the groups, do you think there is something that the groups you have created can do to encourage people to go to the hospital when they are pregnant?

P: Yeah.

I: So what are some of the things that they can do?

P: We make some 'susu' to support each other.

I: And, umm, the hospitals too, is there something they can do so that they could perhaps make those who don't want to go to the hospital go?

P: Yes.

I: Okay. So, umm, what sorts of things can they do?

P: When we do the 'susu', we assist them with that.

I: Umm, I am saying the hospitals, they too, is there anything they- they can- is there anything they can do so that those who don't go to the hospitals can go? Like, as hospitals, what can they do?

P: When we give them the money, they will then go to the doctor to take care of them.

I: Umm, it seems you didn't get my question please. I said what can the HOSPITAL do, so that it will encourage the kayayei who don't go to the hospital to go? Like what can the doctor and the hospital staff do, not the kayayei?

P: Umm, if they come and do the insurance for free for them, they can go.

I: Okay, okay. Umm, and, you mentioned that it was quite close to you so you could all walk there.

P: But the scan and the lab are not close to here.

I: Mm, okay, okay. Thank you for making time to speak to me and answering my questions. God bless you.

P: I’m also grateful to you.

I: Okay, bye bye.

Interviewee: Participant 2

I: How old are you, please?

P: I- I am 25 years.

I: Oh okay. And are you married?

P: What did you say?

I: Are you married?

P: I have three children.

I: I said are you married? [laughs]

P: Oh okay. I am married.

I: Okay. And where are you from, please?

P: Umm- I am from the North.

I: Where in the North?

P: I'm from Yagaba.

I: Yagaba? Oh okay.

P: Yeah.

I: And are you a Muslim or you do not have a religion?

P: I am a Mamprusi woman. Oh, I am a Muslim.

I: Mus- okay, okay. And have you ever been to school?

P: Please no oo.

I: Okay. And please, when you do umm- the kaya work, how much do you earn a day?

P: A day I can gain about 30 cedis.

I: Okay. And apart from the kaya, do you do any other work or that's the only thing you do?

P: That's the only work I do.

I: Okay, okay. And could you please mention how many children again you said you have again, please?

P: Three.

I: Okay. So how old is the first one?

P: They're about 10 years.

I: Okay, and your last child as well, how old are they?

P: They are twins, they are also 8 years.

I: Your youngest children? Okay.

P: Ah this one? This one is one and a half years.

I: Your last born is one and a half years? Okay, okay.

P: Yes.

I: Okay. And do you live in Makola too or you live elsewhere?

P: I'm at Makola.

I: And umm, where you stay, is it a rented place or you sleep outside?

P: I sleep outside.

I: Oh okay. And since you sleep outside, what do you do to- where do you take a bath and do you use public toilets or something?

P: We pay before we go.

I: Ah, okay. And how many years has it been since you started the kaya?

P: It's been about a year.

I: Oh okay. So please, in English- do you speak a little English or you don't really understand it.

P: I don't understand it.

I: What did you say, please?

P: I didn't go to school at all so I don't understand.

I: So you don't speak at all?

P: No.

I: Okay, then I want to ask you some questions on maternal healthcare so I will explain it in Twi then I will ask for your opinion on issues that pertain to it. So um, regarding maternal healthcare, it is how umm- a pregnant woman takes care of herself until the time she gives birth- how she cares for herself, yeah. So in your own understanding, when a woman gets pregnant up until she gives birth, what are some of the things she is supposed to do? [5:00]

P: What are the things I do?

I: In general, not like you specifically, but in your point of view, what should an expectant mother do to take care of herself?

P: Umm-

I: You did not understand the question?

P: Not exactly.

I: When you are pregnant what do you do?

P: Oh, I go for them to give me medication.

I: Okay, okay. So umm- in- do you think it is something that everyone is supposed to do or apart from the hospital, someone can decide to do something else?

P: Yes they- no, I will go to the clinic.

I: Okay, so everyone is supposed to go to the hospital? Okay. So, umm- you- do you have the National Health Insurance Card?

P: Yes, I have everything.

I: Okay. And during your pregnancy, were you still doing the kaya, when you were pregnant with your last born?

P: Yes please.

I: So how many months did you do it for before you gave birth?

P: I was about- 7 or 8 months into the pregnancy.

I: Okay so approximately 8 months?

P: Yes.

I: Okay.

P: Yes. Before I give birth.

I: Okay. And you- after you gave birth as well, how many months did you wait for before you started again?

P: About three or two months.

I: And concerning that, when you went to the hospital, did the doctor talk to you about it, like the time that you could resume, did they speak to you about that they said nothing and you had to use your own discretion?

P: They said nothing.

I: Ah okay.

P: They didn't talk about it.

I: Okay, okay. So umm- antenatal, sorry, the time that you were pregnant and you were going to the hospital, how many times did you go?

P: I went about five times.

I: You went five times? Okay.

P: Yeah

I: When you went for the first visit, you, umm, how many months was the pregnancy?

P: One month.

I: Okay. And which hospital did you attend?

P: I don't know the name of the place.

I: Okay. And is it close to where you stay?

P: No.

I: So what do you do to get to the hospital?

P: I usually pick a car.

I: You pick a car? Okay.

P: Yes please.

I: So is it trotro?

P: Yeah.

I: How many minutes does it take when you pick the trotro? How many minutes do you spend?

P: I could leave at 7:00am or 8:00am and I will get there at 10:00am or 11:00am.

I: Then it's quite a distance. So- [10:00]

P: Yeah.

I: So umm- when you went to the hospital, did you pay some amounts of money or everything was free?

P: I used to pay.

I: Oh okay. So approximately how much did you use to pay?

P: What did you say?

I: About how much were you paying? The money they were taking from you, how much was it? Like, maybe 50 cedis or how much?

P: Yeah, or 40 cedis.

I: Okay, 40 cedis. So every time you went they took this amount of money?

P: Yes please.

I: So was that for the medicines or tests or what?

P: For medicines.

I: Oh okay. But you said you had the health insurance card, right?

P: Yes please I have it.

I: Ah, okay. So, you having the health insurance and still being charged money, then what benefit is the health insurance of to you?

P: Ah, they are the ones who told us to do it oo.

I: [laughs]

P: And after doing it too they tell you that unless you pay for the medicines before you receive them.

I: Oh, okay. Then I don't see what is free about it.

P: Mhm, is this free?

I: Awww. And when you gave birth as well, did you do that in a hospital?

P: Yes I gave birth there.

I: Was it the same place where you were going for the antenatal care?

P: Yes please.

I: Okay. You said it was far from where you stayed so-

P: Yes it's far.

I: So with that, what did you do to get there?

P: What did you say?

I: I said, what did you do to get there when you were going to give birth? Which means of transport did you use? Did you still go with the trotro or you went with a taxi?

P: I boarded a taxi to get there.

I: Oh okay you went with a taxi. So umm- is it- information- I don't know how to say this in Twi, umm- so why did you decide that you would go to the hospital and maybe didn't rely on traditional medicine or something else?

P: The traditional medicine, they told us not to take some of those drugs in addition.

I: Mm okay, okay.

P: So we should take only the orthodox medicines.

I: Oh okay. I know that some people also give birth at home, among other things so why did you find it beneficial to go to the hospital to give birth and not at home?

P: If you go there to give birth, it is better than to give birth at home.

I: Okay, okay. So how- when you went to the hospital, the way they attended to you and all, were you happy with it? Like the treatment they gave you, the doctors and the nurses, their attitude and how they took care of you?

P: Yeah, I was happy with it.

I: And you didn't find any problem with it?

P: No.

I: Okay. So if you had any questions were you able to ask them? Were you able to ask them freely or you weren't really comfortable to speak to them?

P: Oh no. [15:00]

I: Oh okay, okay. So when you went to the hospital as well, was there someone available to attend to you at the same time you arrived or you had to wait again for a while before you were attended to?

P: Sometimes when you go, they will attend to you quickly but there were other times when it took long – you would go and meet a queue.

I: Mm okay.

P: You will sit down for a very long time and by the time you return, it's already in the evening.

I: Oh okay. So when it happens that way, does it affect you, for instance in your work and other things?

P: Uh huh.

I: Mm, okay. Umm- so umm- after you gave birth, were you still going to the hospital for check-ups and weighing and other things or you weren't going?

P: Yeah I still went.

I: Okay. So when you went, they- did they examine you yourself?

P: Yes please. I was going there for my personal examination.

I: Oh okay. And what about your child?

P: As for the child, I didn't take them. I went alone.

I: Okay. And usually when a child is born, it receives some vaccinations. So as for your child, they didn't get- they didn't take those vaccinations?

P: On the day the child was born, they received those injections on the same day.

I: Oh okay. So that was it after that. Umm- So for that, how many times did you go? After you gave birth?

P: When I was going to give birth?

I: After you gave birth. How many times did you go to the hospital?

P: I went there about 8 or 9 times.

I: 9 times?

P: Yes.

I: Okay. So- umm- sorry, just a moment- So for that as well, did you have to wait or when you went, you were attended to in a short time?

P: Also for that I had to wait for a while.

I: Oh okay.

P: They would tell me to have a seat for a while.

I: Okay, okay.

P: Yeah.

I: So if perhaps there were a different place you could go to, would you go there or the one you went to was okay for you?

P: Wherever you go, it's the same thing.

I: Everywhere you go? Mm, okay. So the kayayei, do you have a group that, like a group that meets and has some discussions or you're not a member of any such group?

P: Oh yes, we meet.

I: Oh so you have a group? Okay. And when you were pregnant, did you receive any support from the other kayayei or you had to do everything on your own?

P: I had a sister here who was helping me.

I: Oh so you had support from a sister?

P: Yes please.

I: Okay. So is your family in the North? Are they also in the North?

P: Yes please.

I: So during your pregnancy, were you in contact with them?

P: Yes please.

I: So did they know that you were going to the hospital to take care of yourself and stuff? [20:00]

P: Anytime I went, I called them.

I: You called them? Okay. So-

P: The day I go, I would tell them.

I: Okay, okay. So was it something they were happy about and were they supportive of you goingto the hospital?

P: Yeah.

I: Oh okay, okay. And please did you say you were married? I have forgotten if I asked you or not.

P: Yes please I'm married.

I: So was your husband also happy with you going to the hospital?

P: Yes please.

I: Okay. So being a Muslim, umm- is there anything in your religion that teaches you that as a pregnant woman or a new mother, you should do certain things or there's nothing like that?

P: Mm, I've been doing it.

I: [Laughs] Please I think you didn't understand my question. In your Muslim religion, do they teach you about maternal health issues?

P: Yes please they teach us.

I: So please, what are some of the th- things that they- they have been teaching you?

P: The things are a lot.

I: Mm- So please give me some examples.

P: They are a lot. [Laughs]

I: Okay, okay. So- so let's say for example, you go to the hospital and umm- maybe it's a male doctor that is supposed to attend to you, is it something that your religion umm- speaks against or you do not really bother about the fact that you might be attended to by a male doctor?

P: Mm- at times you go and it is a male and other times you go and it is a female.

I: Ah okay. And was it a problem or it- it wasn't a problem?

P: It's not a problem.

I: Okay. Umm- so within your group, the other kayayei that you know who have also given birth, do you know some of them who went to the hospital and maybe some of those who did not go to the hospital? Do you any people like that?

P: Yes I do.

I: So those who, did not go to the hospital, what is the reason why they don't want to go?

P: Yes that's true, there are some people who go and some who don't go. Even if you talk to them, they don't mind you.

I: Mm, okay.

P: Sometimes some of them, when they are pregnant, they don't go for weighing [antenatal visits].

I: Mm, okay. So for people like that, do you know the reason why they don't go or what- or you don't know?

P: I don't know what they are doing. If you ask them, they don't want to respond.

I: Ah okay. So do you think maybe it could be because of financial constraints or what?

P: Yeah- financial issues.

I: That also plays a part, right?

P: When they go, they tell them that they have to pay for the scan [ultrasound] that they do. You pay money before you do the scan and the money is not a small amount.

I: Mm- okay.

P: The scan could cost about 300 [old cedis] or 30 cedis or 40 cedis or even 50 cedis.

I: Ah, yeah, yeah. Okay. Umm- so, umm- your- what do you think that your group, among yourselves, you can do to help each other? So that maybe if someone is pregnant, she could go to the hospital or she will take umm- she will have that umm- she will get the care that she is supposed to get from the hospital? What can you do? [25:00]

P: Umm- if you go to the hospital, it is better than the- other one-

I: Oh okay.

P: That is where they will take good care of you.

I: Mm.

P: If the child is not in a good position, they can correct that.

I: Okay. So, let's say you have a sister who doesn't go to the hospital- who doesn't want to go to the hospital, what do you think you can do, like maybe advise her or there is something you can tell her that will make her go to the hospital? What will you do?

P: When you tell them, they ask you a lot of questions, that's why you can't-

I: Mm.

P: You know.

I: So maybe you don't know how to respond to their questions.

P: [laughs]

I: And what else do you think the hospitals can do to make more people go?

P: People to go what?

I: For instance, so that those who don't go will go?

P: Yeah.

I: What can the hospitals or the government do so that people will go?

P: They should raise awareness.

I: Oh okay. So maybe they will come around and talk to your peers. So, um- maybe the money that you have been paying, even though you have the health insurance, do you believe that if they remove this fee, those who don't go will do so?

P: I don't know, maybe they will go or maybe not.

I: Mm, okay, okay. Then, if there is anything that you would like to say, you can please do so.

P: Umm-

I: Maybe something you want to say in addition.

P: No, I have nothing to say.

I: Oh okay. Thank you then, for getting the time to speak with me. Thank you, God bless you.

P: I also thank you for spending time to discuss with me. God bless you.

I: Amen. Bye then.

Interviewee: Participant 3

I: How old are you please? - Hello? Hello? How old are you please?

P: I am 31 years.

I: 31?

P: Yes please.

I: Oh okay. And are you married please?

P: I am married.

I: Okay. And umm- where in the North do you come from please?

P: Yagaba please.

I: What did you say please?

P: Yagaba.

I: Yagaba? Okay.

P: Yes please.

I: Mm. Umm- and umm- and are you a Muslim?

P: Yes please.

I: Okay. And did you go to school for a while?

P: I didn't go to school please.

I: So when you do the kaya, how much money do you earn per day?

P: When I do the kaya, I earn about 20 cedis.

I: About 20 cedis? Okay. And apart from the kaya, do you do any other work or that's the only one?

P: Plea- please it's only the kaya that I do.

I: Okay. And how many children do you have please?

P: My children are four.

I: And how old is your first born?

P: The first born is now going on 20.

I: Almost 20? Okay. And what about your last child?

P: My last child also is turning 3.

I: Ah okay. And where in Accra do you stay, please?

P: I live in Tudu.

I: Tudu? Okay. And you- where you live, do y- you sleep outside or you- you have rented a place or you live with someone?

P: Please I live outside oo.

I: Okay. So- what do you do to use- like, where do you take a shower, you use- if you want to use- the toilet as well, what do you do?

P: Please, the ones that people have built and take charges for, that's where we go and shower and pay one cedi.

I: Okay, okay, ah. And since you started the kaya, how many years has it been please?

P: Okay, since I started the kaya, it's getting to umm- umm- about 20 years now that I've been doing it, because when I come, I don't stay for long, then I go back home to look after those at home.

I: Okay. So when you started, how old were you, when you started the kaya?

P: Umm- I was saying-

I: I said when you started the kaya, how old were you? Were you 20?

P: Ah- when I started the kaya I was almost 20 years.

I: You were 20? Okay.

P: But I don't stay for long.

I: Okay, okay. And umm- when we say umm- for instance- [stuttering] pregnancy and childbirth, how umm- a woman takes care of herself, what is you understanding about this? Like, if a woman is pregnant and also just had a child, what are the things that she is supposed to do?

P: Umm, please, when I have a new born, I stay at home.

I: Mm

P: Because the work- if you are going to work and you don't have enough strength, madam, when we do any work, we suffer. When you have a new born, there is no strength on you.

I: Oh okay.

P: So because of this, we stay at home and when the strength increases, we come and do the kaya.

I: Okay so if you are pregnant, wh- what do you do to take care of yourself? Do you do self-medication or you go to the hospital or what are you normally supposed to do? [5:00]

P: Ah- when I get pregnant, I take it to the hospital.

I: You go to the hospital?

P: Yes please.

I: Okay, okay. So umm- do you think you obtain any benefits from going to the hospital during pregnancy- they go to the hospital? What are some of the benefits of that?

P: When you go to the hospital, it benefits a lot. They will take care of you to become strong so that the child in your womb will also be healthy.

I: Mm, okay, okay. So umm- when you went to the hospital, was it free? When you went to the hospital, were you paying some amount of money or it was free?

P: When I went, I would pay some money because they would write the prescription for me to go and buy drugs to take that will make me healthy.

I: Okay, okay. And please, do you have the health insurance card?

P: Mm- the health insurance I used to have it.

I: Ah okay. So when you were pregnant with your last child, did you have the health insurance or at that time you didn't have one?

P: Ah, when I gave birth to my last child, I had one.

I: You had one?

P: I made one there. That's when I did it.

I: Okay, okay. So umm- maybe I know that umm- umm- some of your peers are there who have decided that, they- they have decided that they won't go to the hospital, so those of them who don't go to the hospital, normally, what- what do they do? What do they do?

P: But if you are pregnant and you don't go to the hospital, you don't love yourself.

I: [laughs]

P: Because when you go to the hospital, maybe something, a disease is in you. The hospital workers will diagnose it and treat you. If you stay at home with it, you don't love yourself.

I: Mm.

P: So if you are pregnant, you should make the effort to go to the hospital. Even if you don't have the means, you can borrow money to go and take care of yourself in the hospital. So yeah, as for going to the hospital, it is very good. It gives strength to you yourself and the child will also be healthy and strong.

I: Yeah, mm- okay. And umm- you- when you were pregnant, were you still doing the kaya?

P: Mm- I came here with it and I was head porting little by little to get things for the child and then I left.

I: Okay.

P: So later I came back.

I: Okay. So for how many months did you do that before you stopped to go and give birth?

P: When I was pregnant, I was working until it was about seven months then I stopped and left.

I: Okay. And you- after you gave birth as well, umm- for how- umm- how many months did you wait for before you resumed the kaya?

P: Ah, when I gave birth I stayed at home for about umm- nine months getting to ten. When I could carry the child at my back then I returned.

I: Okay, okay. Umm- so umm- when you went- when you were pregnant and you went to the hospital for them to give you drugs and for other things, how many times did you go?

P: I went for about seven to eight when I had finish taking the prescribed medication then they told me that my due date is near so I didn't need to go again so they changed the time and when it was getting to the ninth month then I would go again.

I: Okay, so umm- the hospital that you were going to during your pregnancy, was it close to where you stayed?

P: I had to pick a car to get to the place I used to go to, it was a bit far.

I: Okay, okay. So were you picking a trotro or a taxi?

P: I used to pick a taxi please. [10:00]

I: Okay, mm. So with that, were umm- you seeing it as a problem that every time you are going to the hospital, you pay that money to pick a taxi and- the price, was it something that you could handle or it was a bit of a problem?

P: Okay, maybe- the time that I used to go to the hospital, when I left early, I would join the queue, also considering that it is far, I would go early so that time would be available and that it would be fast for me, that's why I used to pick a car to go there.

I: Okay, okay. Mm. So umm- when you went to the hospital, the way umm- umm- the nurses and doctors communicated with you, was it something that you appreciated? Were you happy with- for instance the time that they- they had for you? Did you think it- [stuttering] was 'enough' [laughs] as it is said in English. Did they have your time? When you went to the hospital, did the doctors have time for you?

P: Yes please.

I: Mm, okay.

P: When you join the queue, once it gets to your turn, they had- they always had a lot of patience for you, that's the way it was. They were patient enough to give you the necessary care that you would be satisfied with so with regards to that, yes.

I: Okay, okay. So umm- you mentioned that you had the health insurance when you were pregnant.

P: Yeah.

I: So having the health insurance and still having to pay some money, that- what then did you think were the benefits of the health insurance to you?

P: As for this insurance, when you take it [the pregnancy] there and they receive you, during the maternity period, [mm] that's what they- they took into account to make one for us. [Okay] But now if you make one and takes a long time, they tell us that it can no longer be used. The childbirth umm- once you give birth, you cannot use it anymore.

I: Okay, okay. And umm- umm- did you say you went to give birth in the North or in Accra?

P: I went to give birth in the North please.

I: Okay. So in the North as well, did you give birth in the hospital?

P: Yes please.

I: Okay. And also, was that hospital close to where you were staying or you had to get there with a car too?

P: It was not close at all, it was not close. [Mm] It was distant.

I: Ah okay. So if you compare it to- umm- let's say how far it was from where you lived, and the way it was in Accra, would you say the hospital in Accra was more distant or the one in the north was more distant in Accra?

P: As for the one in the North, I don't intentionally get myself there, but rather the one in my hometown is the one I used to go to that's why when the time was almost due, I decided to go back there.

I: Mm, okay. So that one, was it close to where you were staying in the North too?

P: Yes please.

I: Mm, okay, okay. And also in the North, the way they took care of you- were you content with the way the doctors and nurses attended to you?

P: Oh they too were-

I: They also took good care of you? [15:00]

P: Yes please.

I: Okay, okay. And umm- and- whenever you had questions, were you free to ask?

P: Yes please. When I went and there was something wrong with me, for instance, I couldn't fall asleep the previous night until daybreak, I could explain it to them [mm] how- yeah.

I: Okay. Mm- So umm- you- okay - you said when you went, you sometimes had to wait for a while before it got to your turn.

P: Yes please.

I: So with that, with that, how many minutes or hours did you use to wait before your turn?

P: Umm- please sometimes- if I went early, I could get there and when it was around 2:00pm or 3:00pm and the people were many so I will queue.

I: Ah okay, okay. And after you gave birth, were you going to the hospital? Were you taking the child for weighing and stuff?

P: Yes please.

I: Okay.

P: After I gave birth, I was taking them for weighing.

I: Okay. And also, was it the hospital in the North or umm- it was the one in Accra?

P: Ahh, in the North I used to take them and after I came here as well, I still took them and they would take- they would take- they would do the weighing for them.

I: So umm- usually did they do- were you also examined yourself or it was only the child?

P: Umm- please-

I: Okay, okay.

P: Please when I-

I: What did you say please?

P: When I took the child, they carried out a general examination on them.

I: Okay. And- and what about you? Were you attended to as well or it was only the child?

P: Oh no, no. Just the child, when I took them for weighing, it was only the child they took care of.

I: Okay, okay. Mm- so, and umm- the in- injections that they give to new-born children, did they give some to your child?

P: Yes please they gave them to the child.

I: Okay. And you- you- when you gave birth as well, your child, did they register their- was the child registered? As in the name was written, the place of birth, did they do that registration?

P: When I had my child and I took them there they did the, umm-

I: Was their name written?

P: Yes please.

I: Okay.

P: On a document.

I: Okay, okay. So umm- when you look at- in English we say 'experience', let's take for example, if you decide that you will- you will give birth again, will you go back to the same hospital you went to or you would prefer to another place- another hospital or another place?

P: Madam please I won't give birth again.

I: You won't give birth again? [Laughs]

connection problems

I: So please, umm- if you could go to another place for maternal healthcare elsewhere, would you go there or it's the same hospital that you would still go to?

P: Okay madam, that's where I had always gone to but I said I wouldn't give birth anymore. However, if I am not feeling well, I will still go there.

I: Okay, okay.

P: You said if I would give birth again, but I won't anymore. I am already struggling with the 4 children.

I: [Laughs] okay. [20:00]

P: Even when you get bread and they don't get their share, they become upset and the children keep calling you to say mum, give me this and that and it's a struggle for me. So having 4 kids, God has done well, God has done His part so with these 4 children, I'm okay.

I: Mhm, okay. And please, umm- you- are you part of a group or something, like the kayayei do you have a group?

P: Yes please, we the Mamprusis have a group.

I: And umm- do you get some assistance from that group if for instance, you are regnant, do you get some help from your peers?

P: Umm- when the person gives birth, there is some support that we give to the person. We buy a specific cloth, baby clothes, and we add some amount of money and give to the person.

I: Okay, okay. So umm- is your family also in the North?

P: Yes please.

I: Okay. So you, were you going to the hospital for childbirth as well as the regular visits, was it something they were happy about?

P: Yes please.

I: And was it the same with your husband? Was he happy that you were going to the hospital?

P: Yes please.

I: Okay. And umm- I- how do I say this? Does your religion also advise you to go to the hospital? Like the Muslims- you should go to the hospital or- was t something they advised you to do?

P: Oh we go, we go to the hospital.

I: Okay, okay. And usually, umm- issues concerning pregnancy and childbirth, in your group, do you speak about these things or you do not really talk about them?

P: Okay, we do. When we talk about pregnancy issues, it concerns the assistance.

I: Okay.

P: If for instance I get pregnant, yeah.

I: And umm- do you know those umm- like- those who- who say that they wouldn't go to the hospital, do you know why they don't want to go or you do not really know why they don't go?

P: Mm, as for the hospital, I myself- madam, please, there are certain medicines that require money. If the person doesn't have the means, then they go to the hospital and they are told that they will be charged this amount and you cannot afford, it bothers you. You understand?

I: Yeah.

P: If you go to the hospital with nothing, they won't attend to you [mm-], you get it? As for the hospital, even if you go without the money, what are you using to pay?

I: Mm, yeah.

P: They have nothing. If they won't accept you, you have to stay at home. If you want to go, even with the insurance is there and you want to go, they will tell you, "bring this amount" [mm-]. Madam, if you have nothing what will you make the payment with? That's the issue. Yes please.

I: Mhm, oh okay. So umm- since you have realised that it is because of financial constraints and things like that, what umm- can the doctors or the government, what can they do to make those who do not go to the hospital go?

P: Mm, some people, if they are lucky, they can give birth at home when they go into labour, you see. But the unlucky ones who can't give birth at home must definitely go to the hospital. Even at the hospital, if God does not intervene and you must be operated on, it is all about money, you see. So right now, everyone is saying many things about the childbirth. Also if you go to the hospital and they

have to discharge you, it's also about money. So if you have nothing, you must do everything to go far. [25:00]

I: So if- okay - so if it were possible for the government to help with, for instance, the money that they have been taking could be waived, would more people be able to go?

P: Mm- when you go, they tell you the fees will be waived but when you go to the hospital to give birth to the child, after giving birth and when it is time for you will be discharged, the bill that will be written for you, madam, if you are not careful, they will say they want to admit you again in order to make you pay the money [oh] before you are discharged.

I: Mm-

P: I have witnessed something like this myself, not by hearsay. So if you go and give birth and you are confronted with such a situation, then unless- if you don't pay, they won't let you go.

I: Mm- so-

P: If you have no helper, this is what you will face.

I: So with regards to this, how much money could it be?

P: The money?

I: Yes.

P: Hmm, as for the money, there are instances- I personally, who didn't have any helper, 12 million (old Ghana cedis, equivalent of 1,200 new Ghana cedis or 171 euros)-

I: 12 MILLION?!

P: -is what they charged me.

I: Ei! Wow. Then the money is a lot.

P: The money is a lot, madam. This is part of the reasons why we are saying that we won't give birth anymore oo.

I: [Laughs]

P: If I do the head porting and roam about a lot, when will I manage to raise 12 million?

I: Mm- yeah.

P: Eh? Hmm.

I: This is an issue. Okay, okay. Then- and- how you also mentioned that the hospital is far from where you live, so you also have to board a taxi to get there, umm, that also, what do you think umm, maybe the hospitals can do to help you- so that you don't spend a lot?

P: Mm- you have to go with a car, madam.

I: And when you get there, you have to spend a lot as well.

P: The hospitals must- the hospitals that we go to, if they had a car, so that after you give birth they can give you a ride [yeah] but you have to make expenses on all this. If you are going back home, you must board a car to take you home [yeah] so if you don't have help, after childbirth, you must hold the child in your arms and walk on foot back home. All these are disturbing.

I: Yeah, okay. And please, umm- now I have asked all my questions so if there is something you want to add- you can say it please.

P: Madam, all we request for is assistance, that's all we need. If not- if you even look at where we sleep, when we are wet with rain, we have to stand on our feet, we stand. It would be good if the government is able to build a shelter for us. Currently, when it rains, we just have to coil ourselves and for those who don't have- the water drenches all their belongings. And also, we don't sleep on a proper mat, it's not a real mat. Umm, boxes that are used to pack goods, that's what we tear up and lie on [mm-], hm. So if the government could help us with that, it's even okay.

I: Yeah.

P: It would really help us.

I: Mm- okay, okay. So thanks a lot, God bless you for spending time to speak with me.

P: God bless you too and whatever you do.

I: Amen.

P: May He really bless you and grant you strength and long life.

I: Amen.

P: I'm really thankful, God bless you.

I: Don't mention.

Interviewee: Participant 4

I: How old are you please?

P: I am 38 years.

I: 38? Okay. And are you married please?

P: Yes, I have done Amelia

I: Okay, okay. And where in the North do you come from please?

P: North

I: Umm, where? Your hometown, how is it called?

P: My hometown is Yagaba.

I: Yagaba? Okay.

P: Yeah. Should I spell it for you?

I: Yes please.

P: Y-A-G-A-B-A

I: Okay, okay. Thank you. And are you a Muslim please?

P: Yes I'm a Muslim.

I: Okay. And did you ever go to school?

P: Yes.

I: Okay. And which stage did you get to?

P: JSS (Junior Secondary School), umm- SSS (Senior Secondary School.

I: SSS?

P: Yes but madam, my paper wasn't good (didn't pass the exam).

I: Oh so you went to SSS but didn't pass the final exam?

P: Exactly.

I: Okay. Umm- and when you do the kaya, about how much do you earn in a day?

P: A day I can earn 20 cedis and sometimes I earn 150 or 250 (old Ghana cedis, equivalent of 15 and 25 cedis respectively) or 30 cedis.

I: Oh okay. Mm- okay. And umm- apart from the kaya, do you do another work in addition or just that?

P: No, no, only the kaya.

I: Okay, and please how many children do you have?

P: Umm- children? I have 4.

I: You have 4? Okay. And-

P: Yes.

I: Okay. How old is your first child?

P: The first child is 9 years.

I: 9 years? Okay. And your second chi- your- your last child, sorry. How old is your last child also?

P: The last child is two and a half years.

I: Okay. And please in Accra, do you live in Tudu or you live elsewhere?

P: Tudu, Tudu.

I: Okay. And where you stay at Tudu, do you sleep outside, have you rented a place or you live with someone?

P: I sleep outside.

I: Okay. And since you started kaya, how many years has it been?

P: Mm- since I started the kaya, it's been up to 20 years because I came here after I got married.

I: Ah, okay. So do you mean it's been 20 years since you started the kaya or when you started, you were 20 years?

P: Umm, 20 years-

I: When you started, were you 20 years?

P: Umm, it should be.

I: Okay, okay. And when- I will ask you questions related to umm- maternity.

P: Okay.

I: So when a lady is pregnant until she gives birth, what are the things you believe she should do to take care of herself?

P: Umm, they tell you to buy a cloth and diapers.

I: Umm- oh-

P: Or that's not right?

I: No that's not what I was referring to, I mean, how you will take care of yourself when you are pregnant, yeah.

P: Mm-

I: For instance, will you take medicines or you must go to the hospital?

P: Yeah I took drugs.

I: Mm- okay. And umm, did you go to the hospital?

P: Yes I went.

I: And with regards to that, when you are pregnant and you go to the hospital, what are the benefits?

P: [Laughs]

I: Benefits, as in is it important? Is it important that when you are pregnant you go to the hospital and why is it important? [5:00]

P: Oh, when you go there, you become healthy and strong, at the hospital.

I: Mm, you become strong.

P: Yeah.

I: Okay. And umm- is it also free? When you went, was it free?

P: No, it's not free.

I: Oh okay. And do you have the health insurance?

P: Mm- I have the health insurance. When I go, sometimes I had the health insurance and sometimes I didn't have the health insurance.

I: Okay, and when you were pregnant with your last child, did you have the health insurance?

P: Even my last child doesn't have health insurance so even when they are sick, - hospital is where I came from.

I: Ah okay. Do you believe that it is because you didn't have the insurance that when you went to the hospital you had to pay?

P: Umm-

I: Did you not understand please?

P: I understood but it's the health insurance, or that isn't what you said?

I: Yeah, I said umm- is it because you didn't have one that you made payment?

P: Yeah, I don't have the health insurance, they told me that it had expired.

I: Okay. So- so when you went to the hospital, because of that, they took money from you?

P: Yeah. At that time, there was something wrong with my genitalia so-

I: What did you say was wrong with you?

P: There was a problem with my genitalia.

I: Ah, okay, okay, mm. So when they were treating that for you, did they take money for it?

P: At that time, I hadn't yet given birth and I had the health insurance so they didn't charge me for that.

I: Okay, okay, Ah, okay. And umm- umm- if umm- you if someone says she wouldn't go to the hospital, what else can she do? If she decides not to receive care from the hospital, is there anything else she can do?

P: Yeah she will take-

I: What did you say she would do?

P: She will use traditional medicine.

I: Okay.

P: Yeah.

I: Okay. And umm- when you were pregnant with your last child, how many months into the pregnancy did you do the kaya for before you stopped?

P: I didn't do kaya with the last child I had.

I: Okay, so when you were pregnant, you weren't doing it?

P: No, I didn't do the kaya.

I: Okay, okay. And after you gave birth, were you- how many months did you wait before you started- you started again?

P: Six months.

I: Six months? Okay.

P: Yes please.

I: Okay. And umm- the time you were pregnant, how many times did you go to the hospital? About how many times?

P: So many times, I can't even count.

I: Mm, but were you going often?

P: Yeah.

I: Okay. And the hospital you were going to, was it close to you or not?

P: Yeah.

I: Okay. So were you able to walk there?

P: Yeah, sometimes I could walk to the hospital but in my hometown, I had to go with a car.

I: Oh okay, okay. And umm- so when you- you went to the hospital and they were charging you, about how much was it? How much money was it approximately?

P: I took my last child to the hospital in Kumasi. [10:00]

I: Okay okay, you took it to-

P: I had 15 million (old Ghana cedis, equivalent of 1,500 new Ghana cedis or 212.61 euros).

I: Ah, okay. So is that what you paid,

P: I used to pay by myself please.

I: Okay. And also, when you went to the hospital, umm- the way they attended to you umm- did they take their time to care for you? As in, the time that they had for you, did you perceive it as umm- the necessary time they should have spent with you, or they did not have time for you?

P: Madam, please say it again so I understand it better.

I: Okay. I was saying that when you went to the hospital, when you went to the hospital for check-ups during your pregnancy, did the doctors and nurses have enough time for you?

P: Yeah.

I: Mm, okay. And umm- your- your national health insurance, what benefits were you getting from it?

P: Huh?

I: When you were pregnant, how did your health insurance benefit you?

P: It allowed me to get a doctor to attend to me.

I: Okay. But you still had to pay?

P: Yeah.

I: Okay.

P: The medicines.

I: Oh the medicines? Okay. Umm- also, when you went to give birth, you did that in a hospital, right?

P: Yes, I gave birth in the hospital.

I: Okay, okay. And umm- how was it like? The way they attended to you? How was it?

P: It was very nice, madam.

I: Mm- okay. And were you happy with the attitudes of the doctors and nurses?

P: I didn't encounter any problems with them.

I: Okay, okay. And also if you had any questions, were you able to ask them freely without problems? Or should I-

P: Yes madam.

I: Okay. After you gave birth as well, umm- were you taking your child for weighing?

P: We've been going.

I: Okay. So umm, when you went for the weighing, were they taking care of the child only or they also examined you as a new mother?

P: They checked the child and me as well.

I: Okay.

P: Both of us.

I: Okay. And was your child's name registered? As in, was your child's name written at the hospital?

P: Yeah, they wrote the name.

I: Okay, okay. And the vaccinations that are given to babies, did umm- were they administered to your child?

P: Yeah, they did.

I: Okay. And did you have to pay money for that as well or-?

P: No, no.

I: Okay. Could you precise as well, how many times you went for the weighing?

P: The weighing? Every Thursday, weighing was available.

I: So let's take it that-

P: The Thursday of every month.

I: Every Thursday?

P: Yeah, there was weighing.

I: How many months was your child when you stopped going for weighing?

P: My child?

I: Yeah, as in how many months did you take them to weighing?

P: They are one year.

I: Okay. I mean, with the weighing, how old was the child when you stopped?

P: Unless the child is three years before they stop the weighing. [15:00]

I: Okay, so you still take them?

P: Exactly.

I: Okay. And umm- did you also have to wait for a long time before it got to your turn or as soon as you got there, you got someone to attend to you?

P: It took a while.

I: It took a while? Okay. Umm- were you-

P: The people were many.

I: Okay, so for instance, how many minutes or how many hours?

P: One hour.

I: Oh okay. And when you were pregnant and you were going to the hospital, was it also the same or-

P: Yeah it was the same.

I: Okay, okay. And umm- are you part of any kayayei group or umm- or you don't know any group like this?

P: Yes- we- hello?

I: I was asking if you were part of any group.

P: Yeah-

I: Okay. So within the group, if someone is pregnant- the time you were pregnant, were they assisting you in any way?

P: Yes, they helped me madam.

I: Mm- okay so in what kind of help did you receive from them- your peers?

P: I don't understand.

I: As in, in which way did they help you? What did they do for you?

P: When I took the money, I used it to buy baby clothes and clothes for myself as well.

I: Oh okay, okay. You said you had your child in Kumasi-

P: Yeah, Kumasi-

I: Oh okay. And do you have family there or they are in the North?

P: I don't have any relation there, just me.

I: Okay, okay. But you do the kaya in Accra?

P: Yeah.

I: Okay. So why did you go to Kumasi?

P: When I got pregnant, as I said already, I had a disease so they told me to go there.

I: Okay, okay.

P: Yeah.

I: Okay, okay, mm- So when you went there, was your family happy about it? Did they know that that's where you were and when you told them, were they happy about it? Did they support you?

P: Yeah.

I: Okay, okay. And what about your husband, was he also happy?

P: Yeah.

I: Okay, mm, okay. And, as a Muslim, is- is there something in your religion that- umm- that- how do I say this in Twi- that encourages you to go to the hospital or umm- not? Did you not understand the question?

P: No I didn't understand the question.

I: Okay, I said that, being a Muslim, in your religion, is there something umm- is there something umm- that teaches you to go to the hospital or maybe umm- umm- for instance, that it is good or it is bad?

P: They teach us to go to the hospital.

I: Mm- okay, okay. And usually, do you and umm- the kayayei- do you talk about maternal issues sometimes? [20:00]

P: Yes madam.

I: Oh okay. So what kind of things do you say?

P: [To another person] let's go? Hello?

I: Please, did you say I should talk?

P: Yeah.

I: I was asking what kind of things you talk about concerning maternity.

P: Our lives.

I: Mm- okay. And umm- do you know some people, as in the kayayei who weren't going to the hospital? Or do all those you know go to the hospital?

P: Yeah I know a few.

I: You know some who didn't go to the hospital?

P: Yeah.

I: Okay, so for people like that, do you know the reason why they don't want to go to the hospital?

P: No.

I: You don't know? Okay. So- so umm- if umm- being in a group- you, you being in a group, what do you think you could do to make those who don't want to go to the hospital?

P: Yeah-

I: Umm- please I asked that in your group, what- what can you do to make your peers who do not want to go to the hospital to go?

P: -

I: Or you didn't understand?

P: Yeah I understood. Umm- madam, but the hospital is good, mmhm.

I: Ahh, so you would speak to them.

P: Yeah.

I: Okay. But when I spokay e to some of your peers, they said for some people, it's as a result of financial constraints.

P: Really?

I: Yeah. They said for some people it's as a result of their finances, so for such people, maybe they would like to go but they have no money, so what could the government do to support you?

P: Umm- they could give us a place to sleep because we sleep outside.

I: Mm, okay. So where you sleep, do you sleep there with the children as well?

P: Yes, we all sleep outside.

I: Mm, okay.

P: There are mosquitoes and other insects.

I: You don't have mosquito nets?

P: No, no.

I: Mm, okay. So is there anything you would like to say in addition please?

P: No madam.

I: Okay then.

P: Tell the government to come to our aid.

I: [Laughs] yes please. Thank you, thank you for making the time to speak to me.

P: Okay.

Interviewee: Participant 5

I: How old are you please?

P: 22 years please.

I: Ok. And are you married please?

P: Yes please.

I: And, you- where do you come from?

P: I come from Tamale.

I: Tamale?

P: Yes.

I: Ok. What language do you speak? What is your native language?

P: I am a Dagomba.

I: Dagomba? Ok. And did you go to school for a while?

P: No please.

I: Ok. And when you do the kaya, how much do you earn in a day please?

P: I could get 30 or 40 (cedis).

I: ok. And apart from the kaya, do you do something else in addition or that's the only thing?

P: No, I do nothing else in addition.

I: Ok. And how many children do you have please?

P: Two please.

I: And how old is your first child?

P: They are seven.

I: and what about your last child?

P: They are three.

I: Three? Ok. And you- what time did you come to Accra please?

P: I've been here for more than one month?

I: More than one month? Oh ok. So meaning you had your last child in the North?

P: Yes.

I: Ahh. And at that time you hadn't started kaya?

P: Yeah.

I: Oh ok, thanks. Oh I mean how many years has it been since you started the kaya?

P: It should be- it should be about six years now.

I: Oh about six years? Ok.

P: Yeah.

I: And Accra, where in Accra do you stay please?

P: I'm at Agbogbloshie.

I: Agbogbloshie? Ok. And please, where you live, is it an apartment you have rented, do you live with someone or you sleep outside?

P: I rent a place.

I: Ok. So at this apartment, where you are living, do you have, umm- your own bathroom and toilet?

P: Yes.

I: Ok. And do you live alone or you and your peers have rented together?

P: I have rented together with my peers.

I: Ok, so about how many are you?

P: We are about ten people.

I: About 10 people? Ok.

P: Yeah.

I: So the apartment you have rented, about how many rooms do you live in?

P: It is one space but with a lot of people.

I: Oh ok, ok. And do you speak some English please?

P: No please, only the Twi.

I: Ok, ok. So if umm- a woman is pregnant, umm- in your own understanding, what are some of the things that she is supposed to do to take care of herself?

P: What exactly do you mean?

I: As in, if a lady is pregnant, what is she supposed to do to take care of herself, for instance, will she go to the doctor and the like?

P: You must take medicines.

I: You take medicines?

P: Yeah, so you become strong.

I: Ok.

P: The medicines will protect the child.

I: And the medicines, are they traditional medicines or those prescribed by the doctor?

P: Yeah, the doctor's medicines.

I: Ok. And please, umm- if you go to the doctor, if you are pregnant and you go and see the doctor from time to time, what are the benefits?

P: What are you talking about?

I: As in-

P: I can't hear what you are saying.

I: I said what are the BENEFITS of going to see the doctor when you are pregnant? [05:00]

P: There are many benefits.

I: Ok so some-

P: For instance, if you go [mhm]- if you go- as for traditional medicine you just take it, you don't drink it thinking that it will help you or not but if the doctor is giving you medicine, they know that the particular medicine will help you that's why they give it to you. That is why we like the doctor's medicine.

I: Mm- ok. And when you- you go to the hospital, is it free?

P: When we go?

I: Yeah. Do you pay or-?

P: We pay.

I: And do you have the health insurance? The health insurance card?

P: Yes I have one but usually if I go, you have to pay money before you get drugs.

I: Ah, ok. So the care from the doctor is free but if you want to receive medication you have to pay?

P: you make payment, yes.

I: Ok, ok. So umm- after you- you found out you were pregnant, were you still doing the kaya?

P: Yeah.

I: Ok so how many months did you do it for before you gave birth?

P: Six months.

I: You did it for six months? Ok. So after the six months then you went to the North to give birth right?

P: Yeah.

I: Ok, ok, so after you gave birth, did you wait for a while before starting the kaya again?

P: Yeah.

I: Ok, ok. Umm- so- how many months with that as well?

P: As for that- because I stayed at home for about 2 years.

I: Oh ok. So with that- mhm, were you saying something please?

P: No, speak.

I: Ok, ok.

P: You know that when you give birth, you don't have a lot of strength so I stayed at home for a while before I started working.

I: Ok, ok. So in that case, was it your husband and your family members that were providing for you at that time?

P: Yeah.

I: Ok, ok. And please, when you gave birth, did you do that in a hospital?

P: Yes I gave birth in a hospital.

I: And umm- the hospitals you were attending, both in Accra and in the North, were they close to you?

P: Yeah.

I: So were you able to walk there or you had to go with a car?

P: I could walk there.

I: Ok. And umm- ok- so the money you were paying, about how much were the doctors taking from you?

P: Hmm, as for the money, hmm, for instance, if they are giving me medicine, then I pay an amount before they give it to me it could be about- the medicines and the weighing card inclusive could cost about 4 million or 4.5 (old cedis, equivalent to 400 and 450 new Ghana cedis or approximately 57 and 64 euros respectively).

I: Mm, ok. And umm, so having the health insurance and being charged all that money, what then do you thing was the importance of the health insurance?

P: Hmm, if you don't have the health insurance, the money you will spend will be more than if you have one. If you have one, it could help you, for just fluids for instance. There are these fluids that are administered by drip to us.

I: Mm, ok.

P: And the thing- where you will sleep in the hospital.

I: Mm, ok.

P: Those are the things that the health insurance covers but with the medicines, you will pay with your own money.

I: Mm, ok. Umm, and when you delivered at the hospital, were you content with how they took care of you?

P: I was more than content with it.

I: Oh, ok, ok. Then we thank God for that [laughs]. And umm- umm- were the attitudes of the doctors and nurses positive? [10:00]

P: Yes.

I: Ok. So if you had any questions, were you able to freely ask them?

P: Yes.

I: Ok. Umm, so when you went to the hospital, did you have to wait before someone attended to you or you didn't take long?

P: The people were many so you w- you will have to wait before you get a doctor.

I: So around how many minutes or hours?

P: If you went in the morning, you had to sit and wait until about 2:00pm before you got a doctor.

I: Ei! Ah, ok. So did you also go for weighing? After you gave birth, did you go for weighing?

P: Yes.

I: Ok. That was in the North, right?

P: Yes, that was in the North.

I: Ok. With that also, about how many times did you go?

P: As for that, if you go in the morning, because it is weighing, when it is about 12 noon, you could finish everything.

I: Ok, ok. Was that also free or you had to pay something little?

P: It was free.

I: So when you took your child for weighing, was it only your child who was examined or they also examined you?

P: If for instance you had a problem, they would examine you but if you don't have any problem, it's only the child they would examine.

I: Oh ok. And umm- the injections that are given to new-born children, did your child also receive them?

P: Yes they received them.

I: Ok. So umm- let's take for instance if you decide that you will have another child, will you go to these same hospitals or you will search for other ones?

P: Oh I will go to the same hospitals.

I: Ok, Ok. So umm- do you the kayayei have a group or-

P: As in?

I: As in a group which organizes meetings and talk about specific issues concerning your lives or-?

P: No.

I: You have no group like this?

P: No we don't have such a group.

I: Oh ok, ok. And, you and- you and your peers stay together, right?

P: Yeah.

I: So when you were pregnant, did they help you in any way?

P: Yes they could help me.

I: And what kind of help did they give you?

P: For instance, the day- you know that the day that you go into labour, you don't feel good so they would help take you to the hospital. If you wanted something, they would do it for you.

I: Ok, ok. Umm, and when you were going to the hospital, was it something your family encouraged that you would go to the hospital?

P: Yeah.

I: Ok. And was it the same with your husband?

P: Yeah.

I: Oh ok. So if- are you a Muslim please?

P: I said I am a Dagomba.

I: I mean your religion. Are you a Muslim?

P: Yes, I'm a Muslim.

I: You're a Muslim?

P: I'm a Muslim.

I: Ok. So umm- is there something in the Muslim religion that umm- umm- in English I would say 'encourage' umm- that encourages you to go or it doesn't say anything about it or maybe umm- it discourages you? I don't know how I will say it in Twi but did you understand?

P: Did you say there is something in the Muslim religion that would- what are you trying to say?

I: As in, do they advise you to go to the hospital or- or [yes, yes] that you shouldn't go or they don't say anything about it?

P: Every Muslim is advised that if something is wrong with them, they should go to the hospital and receive help.

I: Mm, ok. And usually, do you and the other kayayei talk about maternal issues or you don't really discuss them? [15:00]

P: We are able to discuss and talk about these issues because you know childbirth is painful.

I: Mm-

P: So when we chat, we could say- one person will say that, I am about to have a child and this is how it feels and others share their experiences so we can discuss it.

I: Mm, ok, ok. Umm- so- so if there's anything umm- the government could do so that those who don't like to go to the hospital could go? Do you think there's something they could do?

P: There's something they can do because if you have a home birth, if you take it, you know that sometimes they would ask you why you didn't come to the hospital.

I: Mm, ok.

P: So if you are afraid of such stuff, no matter what, you will go to the hospital.

I: Mm- yeah, ok, ok. So if there's anything you would like to say in addition, you can do so please.

P: No please.

I: Ok then. Thank you for making time to speak with me.

P: Ok. And tell the government to come to our aid, we are struggling.

I: Yes please. Ok, bye.

P: Thank you.

I: Thank you too. Bye.

Interviewee: Participant 6

I: Ok, my first question is- how old are you please?

P: Please I am 25 years.

I: Ok. And are you married please?

P: Yes.

I: Ok. And where do you come from?

P: I am in Accra now, or my hometown?

I: Yes please, your hometown.

P: I am from the Walewale area, Yagaba.

I: Ok. Umm- and are you a Muslim please?

P: Umm- please I practice all of them but my father is umm- Christian [oh ok] and yeah- so when I got married, my spouse was also a Muslim.

I: Ok, ok. So you practice the two?

P: Yeah.

I: Ok. So did you go to school for a while please?

P: Please, I went to school but it has no value.

I: What did you say please?

P: I didn't stay long in school.

I: You didn't stay long?

P: I went to school but I didn't stay for long so I know nothing.

I: Ok, but what level did you get to?

P: I got to class three.

I: Oh ok. Umm, so if you do the kaya, about how much do you earn in a day?

P: Please there are times that I can earn 20 [cedis], times I can get 30 cedis and other times, 35 [cedis].

I: Oh ok, ok. And apart from the kaya, do you have any other work or that's the only thing?

P: It's only the kaya please.

I: And how many children do you have please?

P: I have 3 please.

I: And how old is your first child?

P: Umm they are twen- umm- ten years.

I: Ok, and what about your last child?

P: That one also turned three years recently.

I: Ok. And where in Accra do you live now?

P: I am at Tudu, inside Makola please.

I: Ok. And umm- the place where you live, is it outside, a rented apartment or you live with someone?

P: What did you say?

I: Please I said where you live, do you live outside or- [background] hello? So I was asking that the place you live, is it a place you are renting or do you sleep outside or do you live with someone?

P: I sleep outside please.

I: Ok. How many years has it been since you started the kaya?

P: It's been about ten years since I started the kaya.

I: Ten years? Ok. So in your own understanding, if a woman is pregnant, what is she supposed to do? What are the things she is supposed to do?

P: Please, when we conceive, we go to the hospital.

I: Oh ok. Is that the only thing or there are other things that you can do?

P: Umm- please if we go to the hospital, [mhm] and the nurses will give you drugs. If you are sick and you go there, they will give you medicine. And they will write a paper for you- if you have health insurance, they will- if you don't have health insurance, they will ask you to go make on and come back.

I: Mm- ok.

P: So after you go and make the health insurance, they give you a weighing card. [Ok]. So they give- or? [05:00]

I: Hello? Please talk, I'm listening.

P: When they give you the weighing card, they will tell you to do lab.

I: Oh ok. So-

P: So if you go and take the lab, then they will now give you access.

I: Ok, ok. So please, what are some of the benefits of using the hospital when you are pregnant?

P: Umm- there are times when you can't sleep at night [mm] so you go and they take care of you and give you medication that will benefit you during your pregnancy so you can also sleep well.

I: Ok. Mm, so you think in general, it is good that you go to the hospital?

P: Yes please.

I: Ok. So please, if you have the health insurance, is it free?

P: Yes, it is free.

I: Ok, so they didn't take any money from you?

P: As for the medicine, umm- if-. They will give you some of the medicines, the hospital, so some of them will be written on a paper for you then you will go and buy them.

I: Oh ok, ok. Mm, so, umm- apart from the hospital, umm- you- let's take it that you went to the hospital but I know that there are some people who don't really go to the hospital so for the ones who don't go to the hospital, what are some of the things they do? - Did you hear my question please?

P: I don't understand what you are saying please. Say it again.

I: Ok. I said, there are some people, they decide not to go to the hospital, so for such people, what do they do?

P: They do traditional medicine.

I: Ok, so for such cases, do you know why they don't go to the hospital?

P: Huh?

I: Do you know WHY they don't go to the hospital?

P: Yeah.

I: Ok, so why-

P: Usually, they don't have money.

I: Oh ok.

P: If they don't have money, they can't go to the hospital so they will go and take traditional medicine.

I: Oh ok, ok. And when you got pregnant, were you still doing the kaya?

P: Yeah.

I: So for about how many months did you do it before you gave birth?

P: But when I'm pregnant, I do the kaya because if I do the head porting, children's items are there, children's soap, and other things. When you go to the hospital, they write everything for you to buy and when you are going to give birth in the hospital, you bring them.

I: Mm.

P: So if you don't continue the head porting, you won't be able to buy these things.

I: Oh ok. So how many months did you do that for before you gave birth?

P: Please, when I stopped, I was seven months into the pregnancy, then I would take two months to rest.

I: Ok. Umm, and after you gave birth, did you wait- did you wait a little before you started again?

P: Yes. Whenever I gave birth, I would wait, when the children begin to walk, then I would resume the kaya.

I: Ok, ok. So umm, the hospital you went to, was it close to you?

P: What did you say?

I: Was the hospital you were going to close to you or it was far?

P: Umm- it was far.

I: Mm, ok. So how were you getting to the hospital – were you picking a car or-?

P: My husband would get a motorcycle to take me to the hospital.

I: Ok, ok. And was it something that was problematic or you were ok taking a motorcycle to the hospital? [10:00]

P: What did you say?

I: Was it worrisome to go with a motorcycle to the hospital or you saw no problem with that?

P: No, I didn't have any problem but if the bump hurt me, I couldn't walk.

I: Mm- ok.

P: So if I couldn't walk, that was when he would get the motor but it's far.

I: Mm, ok.

P: So if he didn't take me there, I couldn't go.

I: Mm- so you would have wished it were a bit closer, right?

P: Yeah.

I: Ok, so, is your husband in Accra or in the North?

P: No, he's in the North.

I: Ok, ok. But, when you were pregnant, were you in Accra for a while?

P: Yeah, I bring the pregnancy from the North to this place.

I: Mm, ok, ok. So when you were in Accra, was the hospital you were going to far as well or it was close to you?

P: Well, the hospital itself was not far but the place where I had to make the health insurance and do the scan were far.

I: Ok, mm, ok. Umm- so were the costs you incurred on the pregnancy a lot? When you were going to the hospital?

P: Yeah, the drugs. They could prescribe certain drugs that exceeded one million (old Ghana cedis, equivalent of 100 new Ghana cedis or 14 euros) but some of the medicines would not be up to one million.

I: Oh ok, ok. So the health insurance that they required you to make, what were its benefits?

P: But with the health insurance, the medicines that were covered, the common medicines, were given to us for free [mm] but the medicines for the blood were those written on a paper for you to go to the drugstore to get them.

I: Ok, ok. So did you give birth in a hospital?

P: Yes.

I: In the North?

P: Yes, in the North.

I: Ok. So umm- with that, when you- when you went to give birth at the hospital, were you happy with the way the doctors attended to you?

P: Umm, please when I went to the hospital, they used to give me fluids-

I: I mean-

P: Please- I-

[background]

I: I was asking if YOU WERE HAPPY with how they took care of you.

P: Yes.

I: So their attitude and everything was ok?

P: Yeah.

I: And umm- was everything they had to use in taking care of you available at the hospital? Did they have everything?

P: Yes.

I: Ok, so umm if you had any questions were you able to ask them freely? Umm- could you ask in a- could you ask them or you didn't have any question when you went to the hospital?

P: Yeah, I used to ask the doctor.

I: Ok. And when you went to the hospital, both when you were pregnant and when you were in labour, did you have to wait for long before someone attended to you or someone could attend to you quickly? [15:00]

P: No, it was at dawn, getting to 6am then I would take the lead. When I got there, there were no nurses so I would wait for them at the hospital.

I: Mm, ok, ok. So about how many minutes or hours did you wait for before you got someone to attend to you?

P: It could take about seven- s- umm- [please] it could take about umm- seven umm- seven- please say it again oo.

I: Ok. I was saying that do you wait- when you got to the hospital, how much time were you waiting for, as in one hour or 30 minutes before someone attended to you?

P: One hour.

I: One hour, ok. So umm- after you gave birth, were you taking your child to the hospital for check-up and weighing?

P: Yes.

I: Ok. So umm- when you went, were they examining you as a person who just gave birth or just the child?

P: They used to care for only the child please.

I: Ok. And after you gave birth to your child, was their name written? Was their birth registered- or?

P: Yeah.

I: And did they give your child the injections that are normally given to newborns?

P: Yeah.

I: Ok. So umm- about how many times did you go?

P: The people were many.

I: Mm, ok. So, for instance, were you going every month, as in did you go for weighing three times- can you say the number of times you went?

P: Umm, for that, we went every month.

I: Ok. So how many months was your child when you stopped?

P: Right now, they are three years, then I stopped.

I: Oh so you went until they turned three years? Ok. And so, sorry, the time you were pregnant, how many times did you go for check-ups as well? [Background] Did you hear my question please?

P: Yes, about six.

I: About six times? Ok.

P: Yeah.

I: And umm, so the way the hospital was, will you return there if maybe you get pregnant again or you will go to a different place?

P: That's the same place I will go to if I get pregnant again.

I: Ok, ok. So do the kayayei have a group that maybe you meet and you- you speak- you speak about things that are going on or you don't have anything of that sort?

P: No.

I: Ok. And umm- you are on good terms with some of your peers right?

P: Yeah, we're around.

I: Ok, so, when you were pregnant and staying in Accra, were they helping you in any way?

P: Yeah.

I: Ok. So what were the things they did for you?

P: They used to take money. [20:00]

I: Ok. So, when you went to the hospital, was it something that your family was happy about – that you would go to the hospital?

P: Yeah.

I: Ok. And your husband- ok you said your husband used to take you so by all means he was happy with it. [Laughs]

P: Yes.

I: So umm- do you and the other kayayei talk about maternal issues?

P: Yeah

I: So umm- what were some of the things you spoke about?

P: Mm-

I: Which things? Do you not remember?

P: Ahh, everyone says how they feel.

I: Oh ok, ok. And please, do you know any of your peers who may have decided not to go to the hospital?

P: Yeah, it is not good but if they tell you and it is within your capacity, then you help them so they can also go.

I: Oh ok. And please, umm, what- what are the things that the hospital can do to help those who cannot go to the hospital?

P: Before- when we used to go previously, we weren't paying money but they take money for the scan so if they go and they are told to go and have a scan, if they don't have money, they can't go.

I: Mm ok, so if they are able to take away this money, everyone will be able to go, right?

P: Yes.

I: Ok.

P: And the lab. So with the lab, if you don't have insurance and you go, they will take a lot of money from you but if you have insurance, they won't take money from you.

I: ok, ok. Mm. Thank you then for making the time to speak with me. God bless you.

P: Ok. I am also grateful.

I: Don't mention. Bye bye then.

Interviewee: Participant 7

I: How old are you please?

P: I am 26 years please.

I: Ok, and are you married please?

P: Yes madam.

I: Ok. And where do you come from please?

P: I am from Walewale please.

I: Walewale? Ok

P: Yes.

I: Umm- and- umm- are you a Muslim or a Christian?

P: I am a Muslim please.

I: Ok. And did you go to school for a while?

P: No please, I didn't go to school.

I: Ok, so when you do the kaya, about how much do you earn in a day?

P: Umm- in a day, I could earn about 40 cedis or 30 cedis.

I: Ok.

P: Or even sometimes 50 cedis – what God- [ok] yeah-

I: Ok, ok. And please, apart from the kaya, do you do any other work in addition or it is just the kaya?

P: It is only the kaya that I do please.

I: ok. And how many are your children please?

P: I have 3 children please.

I: Ok. And how old is your first child?

P: They are 8 please.

I: And what about your last child?

P: They are 6-

[Background]

I: Your last child.

P: Ahh, the youngest is 3- they are not yet 3- two- two and a half.

I: Ok. And where in Accra do you live please?

P: I live in Tudu please.

I: And umm- where you live, do you sleep outside, rent an apartment or you live with someone?

P: I sleep outside please.

I: Oh ok. And about how many years has it been since you started doing the kaya?

P: When I was doing the kaya?

I: Yes please.

P: Since I am not educated, I cannot calculate but it's been a while.

I: So let's say when you started, had you already given birth to your first child or?

P: No, I hadn't given birth yet.

I: You had not yet given birth? Ok. So it should be more than 8 years right?

P: Yeah.

I: Ok, ok. So umm- if umm- if a lady gets pregnant, what are some of the things she can do to take care of herself so that she becomes healthy – both she and the child?

P: I didn't hear you well please.

I: I said umm if a lady gets pregnant what are some of the things she would do so that she and the child in her womb will become healthy?

P: When I was pregnant?

I: Yeah- like umm- it's not just you but like if any woman is pregnant, what are the things she is supposed to do so that she and her child will be healthy?

[Background]

P: As for that, it will be difficult for me.

I: Mm-

P: As for me, when I was pregnant, I took traditional medicine, I didn't go to the hospital, I wasn't taught to go to the doctor.

I: Ok, so you didn't go to the hospital for them to check the pregnancy?

P: Exactly.

I: Ok. And do you have the national health insurance please?

P: I don't have one please.

I: Oh ok. And when you were pregnant, were you still doing the kaya?

P: Yes, when I was pregnant, I was still head porting.

I: Ok so you didn't go to the hospital with any of your three pregnancies?

P: No I didn't.

I: Ok, for about how many months did you do the kaya before you stopped to go and give birth?

P: Umm, when it [the pregnancy] is two months old, I come back here with it and when it is about five or seven months then I return [to the North]. [05:00]

I: Ok, ok. Umm, so after you gave birth as well, about how many months did you wait for before starting the kaya again?

P: Umm- I could wait till the child was about 7 and for the other 4 (months)

I: So- umm- you- when you gave birth- getting pregnant and not going to the hospital, what were some of the things you were doing?

P: Umm- I did nothing please, it is God who has taken care of me. I didn't take anything.

I: Oh ok. Ahh, and when you had a home birth too- you gave birth at home right?

P: Yeah.

I: In the North or in Accra? Your last child-

P: I gave birth in the North.

I: Ok. So umm- with that as well, umm- umm- someone- was it someone who assisted you in delivery – like a traditional birth attendant came to help you or you gave birth on your own?

P: Ahh, it was my husband's mother who helped me.

I: Your husband's mother? Ahh, ok. So with regards to that, were you happy with the care, did you encounter any problems with that?

P: I had no- nothing happened to me please.

I: Ok, so umm- could you please explain why you didn't go to the hospital but rather gave birth at home?

P: Mm-

I: Is it tradition or financial issues or you didn't know much?

P: When I got pregnant and came here, I didn't have any money to take to the hospital [ok] so if I work a little to get my transport fare and purchase things for the baby, then I leave. So that's why I didn't go to the hospital.

I: Oh ok, ok. So umm, after you gave birth to your child, did you take them to the hospital to receive medical care? And like, maybe, the vaccinations that newborns receive, was it also something you were able to provide or you did nothing of that sort?

P: Oh I did nothing like that please.

I: Oh ok, ok, mm. So if you- you- if you had the opportunity, would you go to the hospital?

P: Hospital? If maybe I were sick, I would have gone but the money [inaudible]

I: Mm, ok. So is it because of financial constraints?

P: It's because of financial constraints. If you go to the hospital with a little money, it will not be enough.

I: Mm, ok.

P: It has made us afraid of the hospital.

I: Did you say you were afraid please?

P: Huh?

I: Did you say you feared hospital matters?

P: Mm-

I: [laughs] Ok, ok, so that's what makes going to the hospital scary.

P: Yeah.

I: Ok, ok. So umm, with that- you- are you part of any group, as in the kayayei in Accra, do you meet occasionally to discuss or there is nothing like that?

P: We have nothing like that oo.

I: Ok but you stay with some of your peers, right?

P: Yeah.

I: Mm, ok. So staying with them during your pregnancy in Accra, what were some of the things they did to help you? [10:00]

P: The goods I was carrying?

I: Umm- I mean were they doing something to help you or what? As in, your fellow kayayei who were around you during your pregnancy?

P: No, they didn't help me in any way, I did everything on my own.

I: Ok, ok. So what about your family? The time you were in the North- when you took the pregnancy to the North, in what ways were they assisting you?

P: They didn't help me please. I went about my business on my own.

I: Ok.

P: My family, they didn't do anything.

I: Ok, ok.

P: You had to struggle to take care of yourself.

I: Mm- ok, ok. So please umm- do you and the kayayei discuss maternal issues or there's nothing regarding pregnancy that you usually talk about?

P: We- because of the head porting we do, we don't get the chance to sit together and talk much. Everyone goes to do the kaya and when it's late they just sleep.

I: Mm.

P: We can't talk much.

I: Ok, ok. So do you know someone- the kayayei who went to the hospital?

P: Yeah but-

I: Ok, ok. But you don’t talk about it – you only know they went to the hospital, right?

P: Yeah.

I: Mm- ok. So you mentioned that you not going to the hospital was also because you didn’t know much about it-

P: Exactly-

I: -and also the money was a bit of a problem. So having realized this, what can the hospitals and the government do to encourage people to go to the hospital?

P: They should make- [laughs] the hospitals should reduce the cost so that we can also go.

I: Ok ok. So umm- if you have something you could say in addition, you can say it please. Or you have nothing more to say? [Laughs]

P: I have nothing to say.

I: Ok, then. Thank you for making the time to speak to me, God bless you for the time you’ve had for me.

P: I’m also grateful, God bless you.

I: Amen. Thanks.

P: Sure.

I: Bye.

P: Bye.

Interviewee: Participant 8

I: How old are you?

P: I am forty years.

I: And are you married please?

P: Ys please, I'm married.

I: Ok, and where do you come from?

P: I'm from Tamale.

I: And please, umm- are you a Muslim or a Christian?

P: I'm a Muslim.

I: Ok. And did you go to school for a while please?

P: No, I didn't go to school.

I: And [mm] how much do you earn after a day's work please?

P: The work? I do

I: Please when you work-

P: Mm-

I: About how much do you earn in a day?

P: Umm- in a day, sometimes I get 1.5 (million old Ghana cedis, equivalent of 150 new Ghana cedis) or 1 million.

I: Oh ok.

P: One week, one week is what I'm referring to.

I: One week? Oh ok.

[Background]

P: Ahh, in a day I don't make that amount.

I: Mm-

P: In a day, sometimes 20 (cedis)

I: Oh ok.

P: Yeah, 20, sometimes 30.

I: And apart from the kaya, do you have any other job please?

P: No, I don't do any other work in addition.

I: Ok. And how many children do you have please?

P: My children are six.

I: You have six children?

P: Yeah

I: Oh ok.

P: Yes please.

I: And how old is your first child please?

P: They are 20 years.

I: Ok, and your last child?

P: And what about your last child?

I: That one is 10 years.

P: Your last child is 10 years? [Background] Ahh, the youngest is three years.

I: Three years? Ok. And where in Accra do you live please?

P: I live at Agbogbloshie.

I: And where you stay at Agbogbloshie, is it an apartment you have rented, do you live with someone or you sleep outside?

P: I rent a place.

I: Ok, and in this case are you renting it alone oryou and some of your fellow kayayei-

P: Yeah, I stay there with them.

I: Ok, ok. So about how many are you at the place you stay?

P: We are- we are 10.

I: Ok, ok. And-

P: Mm- we are 10 people sleeping there, yeah.

I: And is the place equipped with a bath and toilet please?

P: No, there is no toilet at the place.

I: Ok, so what do you do to use the toilet?

P: [Laughs] we go to the place where money is taken for that.

I: Ok, ok.

P: Yeah, that's where we go to pay money in order to use the toilet.

I: Ok, ok. But as for a bathroom there's one in the house, right?

P: Yeah, that one is not far from us.

I: Ok, ok.

P: Yeah, it is not indoors but it is a big house where we go to take our shower.

I: Ah, ok, ok. So about how many years has it been since you started the kaya please?

P: When I started the kaya? [Laughs]. It- it's been quite a while.

I: Ok, but had you already had your first child or you hadn't given birth yet?

P: I had my first child and then came to start the kaya.

I: Oh ok, ok. So let's say how old was you child- your first child when you started the kaya?

P: They were two years.

I: Oh ok, ok so I'd say it's been 18 years since you-

P: Exactly.

I: Ok, so please, if a woman is pregnant, not just you [05:00] but if any woman is pregnant, umm- what are the things she's supposed to do for good health?

P: Mm- [Inaudible]

I: No, I said if umm- a lady is pregnant, what is supposed to do- what is she supposed to do so that she and her child stay in good health?

P: As for me, I give it tuo-zaafi-

I: Umm- no [laughs] I mean that if you are pregnant, if a lady is pregnant, what are the things she will do to make her and her child healthy?

P: You will eat good food- [laughs]

I: Oh ok, so you would eat good food and what else, like medicines-?

P: Mhm-

I: What did you say please?

P: And medicines for the blood, you have to drink those in addition [laughs]

I: Ok. And where will you get those medicines from?

P: The medicines?

I: Yeah.

P: The hospital will give me these medicines.

I: The hospital will give you the medicines?

P: Yeah.

I: Oh ok. And if a lady goes- if a pregnant lady goes to the hospital to see the doctor, which benefits does she derive from them?

P: Ei [laughs]

I: Oh you can say anything, nothing is wrong- as in-

P: I don't know the benefits

I: [Laughs]

P: Umm, if I take the medicines, they will give me strength.

I: Mm, ok. And what about the doc- doctor? If you go to the hospital, the doctor examines you as well, so if the doctor examines you, what are the benefits of that too?

P: If they check me, it helps me.

I: In which way?

P: Umm- if the child is not in a good position, they will make the child lie in a good position so I could also walk well.

I: Aha! Ok. Mm, so- so if you go to the hospital, is it free please?

P: No.

I: Mm, really?

P: It's not free.

I: And what if you have- you have- the health insurance?

P: Yeah I have the health insurance.

I: Mm- but it's still not free?

P: No, it's not free, if I take that one there, they will tell me to go and do lab-

I: Ahh-

P: -and when you go to the lab, you pay 30 cedis-

I: Oh ok

P: -before they attend to you, mhm.

I: Ahh, ok, ok.

P: And the scans.

I: Oh ok.

P: Yeah. So as for the health insurance, it caters for us a little but it doesn't do much.

I: Mm, ok.

P: Yeah, the medicines, they will give you some medicines to take, if you have low blood count, they will prescribe the medicines you should go and buy so you will go and buy those ones.

I: Ah ok, so what is the use of the health insurance then?

P: The benefits are that, if you go, you won't pay for someone taking care of you but if you have to buy medication outside, you have to use your own money.

I: Ok, ok.

P: Yeah, they wouldn't give you money for that. Yeah, you will look for money to go and buy it. Even if you don't have money, you have to go back home first.

I: Mm, ok. So umm- I know that there are some people who don't go to the hospital, some of the kayayei don't go to the hospital when they are pregnant. So for such people who say they won't go to the hospital, what else do they do to take care of themselves?

P: Ei, nowadays everyone goes.

I: Now everyone goes? [10:00]

P: Yeah.

I: Oh ok.

P: Now everyone goes so I don't know who doesn't go.

I: Mm, ok.

P: Yeah, everyone goes now.

I: So when you were pregnant with your last child, how many months did you do the kaya for before you gave birth?

P: [Laughs] As for the kaya, I did it for [inaudible]

I: What did you say please?

P: Months- months- I can't speak the language well- I know it in my language- [background] I went for six months, yeah.

I: Is- is it six?

P: Yeah six months is how long I did it for.

I: Are you sure?

P: Yes please, I am sure about that.

I: Oh ok, ok. And after you gave birth, did you wait for some months before you started again?

P: Mm, after I gave birth, I waited for about two years-

I: Oh ok-

P: Yeah, so that the child could grow.

I: Ahh, ok. So-

P: That way, someone else could care for them before I resumed the head porting.

I: Oh ok. So in such a case, you don't work so umm- was it your husband who was providing for you at that time or you had saved some money or- what do you do to cater for yourself?

P: At that time, my husband would do everything. While I was at home, he did everything.

I: Ok. So please, the hospital you were going to get examined by the doctor, was it close to you or it was far?

P: Mm-

I: Was the hospital close or distant?

P: Mm- there were many so some of them, you would go to the one close to you and they would tell you to go to a farther one.

I: Ok, but-

P: Yeah so it's not just one that I went to. Some of them would tell you they don't have a certain drug so go to a more distant one, so whether you like it or not, you'd go.

I: Ah ok. But was the place you went often far or you didn't go to one hospital?

P: It was far.

I: It was far? Oh ok.

P: It was far from my house.

I: So what were you doing- what were you doing to get there? Were you picking a car or a trotro or a motorcycle?

P: Mm- motor.

I: Oh ok.

P: The motor would take you there. On the day you don't get a motor, you go with a car.

I: Mm, ok. So in that case you- in that case how much money were you spending on picking the motor and the car? As in for a return trip.

P: For the money, you would spend about 40 (cedis).

I: Mm, ok, ok. So with that-

P: Forty cedis.

I: Oh ok. So how many times did you go for the doctor to examine you?

P: As for that, you would spend a long time there. Sometimes you would go at 8am and finish at 1pm.

I: Mm, ok.

P: Because when you go, there are a lot of people [mm]. Then we will join a queue.

I: Yeah, ok.

P: Yeah, you will stay for long, yeah.

I: Yeah. Ok. So umm, in that case, I meant throughout the entire period of your pregnancy, did you go to the hospital for like two, three or four times? As in, how many times did you go and see the doctor before you gave birth?

P: You would go about six [times] before you give birth.

I: Oh ok, ok. Ah, ok. Did you give birth in Accra or you went to give birth in the North?

P: As for me, I give birth in the North.

I: Mm, ok. So did you also give birth in a hospital in the North?

P: Yeah.

I: Ok.

P: When I go, I don't give birth at home. [15:00]

I: What did you say please?

P: I said that when I go, I give birth at the hospital, I don't give birth at home.

I: Ok, ok. So did you perceive that giving birth at the hospital is better than giving birth at home or umm- you had a different reason for going to the hospital?

P: Umm- If you give birth in the hospital, it is better than the one at home.

I: Mm, ok.

P: For that one you don't suffer, as for the home birth, you suffer.

I: Ah, ok. And also, when you went to the hospital, were you satisfied with the attitudes of the doctors and nurses?

P: Mm, they are all different [laughs].

I: Mm, ok, ok.

P: Some of them have the patience to attend to the pregnant women, some will also insult you.

I: Oh!

P: Yeah, it's not good. So we told everything to the radio journalists-

I: Mm. Ah, ok.

P: So now, they don't raise their voices at us anymore.

I: Oh ok, ok. Then we thank God that things have changed.

P: Yeah- they have changed.

I: Mm, ok. So do you think the way you were treated was the same way everyone else was treated?

P: Mhm [laughs] mm- yeah, when we step out, some people would say this woman bothered me and others would say she doesn't have a good character, yeah so if many people keep saying that, then they tell her to change her attitude [mm-] because everybody is speaking ill of her so she should change, then you would realise she has changed her attitude.

I: Mm, ok.

P: Yeah- yeah.

I: So, for instance, if you went to the hospital and you had any questions, were you able to ask any questions that were probably on your mind? If you didn't understand anything, were you able to ask the doctors?

P: [Laughs] If it is someone who won't raise their voice at you, then you could also ask the questions you may have.

I: Oh ok, ok. Yeah.

P: They would tell you to ask questions if you had any, then you would see that the person has a good heart and if they wouldn't get angry at your questions, you could ask them any question and they would answer you.

I: Oh ok, ok. So umm- after you gave birth, were you going to the hospital with your child for weighing and check-ups and the like?

P: Mm- yeah, we go and do it.

I: Oh ok.

P: We go every month. They would call us.

I: Oh ok.

P: Yeah. They will call you and the motor will take you there.

I: Mm, ok. So do you still go- do you still take them or you have stopped for now?

P: Now I go less often, they are grown, they are three years so I don't go many times.

I: Oh ok. So when you went to the hospital, when you took them to the hospital, after you gave birth and you started taking your child to the hospital, they- did they only examine the child or they examined both you and the child?

P: No, it was only the child they would attend to.

I: And you-

P: If you ask them, they will examine you too. [20:00]

I: Ok, ok. And after you gave birth, was your child's name registered?

P: Yeah, yes please. After you take them home and have the naming ceremony, then you will take them back.

I: Ah, ok.

P: So they would write the name on the paper (birth certificate).

I: Oh ok. And did your child receive all the vaccinations usually administered to newborns?

P: Yes please, they were vaccinated.

I: Oh ok, ok. And also with that, was it as time-consuming- did you stay there for as long as your visits during your pregnancy or this one didn't take that much time?

P: No, it doesn't take long.

I: Ok, mm. So [laughs] umm- and so umm- if you had the opportunity, would you still go to the same hospital or you would like to go elsewhere

P: No, that's the same place you would go to.

I: Mm, ok. So do the kayayei have a group or- that meets or you have nothing like that?

P: That- where- those of us here?

I: Yes.

P: Yeah we have a place we go to at the hospital-

I: Oh no, I meant that do you and your fellow kayayei in Accra have a group that meets and discusses things or you have nothing like this?

P: No, only when we go home.

I: Oh ok.

P: When we go to the room, then we are able to chat [laughs].

I: [Laughs] Oh ok. And when you were pregnant and doing the kaya, do they have any help- were they helping you in any way?

P: Mm- as for that [laughs] as for that, you would go and stay with a sister then she would receive you. In that case you will chat.

I: I mean ASSISTANCE. Were they helping you? As in, did they give you money, were they helping with laundry or something like this?

P: No. They don't help much.

I: Oh ok.

P: You will do everything by yourself.

I: Oh ok. And were they happy with you going to the hospital to give birth? Was it something they were happy about?

P: Yeah, they all accept it.

I: Oh ok.

P: They are all happy with that thing.

I: Oh ok.

P: Yeah.

I: So umm, when you and your fellow kayayei were talking, umm, were you talking about maternal issues?

P: Yeah we talk about it [laughs].

I: Ok. What were some of the things you were saying?

P: Huh? We would say- one person would say "when I was pregnant, I really suffered" [both laugh] and another person would say "same here" and others would ask about the symptoms then another person would say "my waist" and the other, "my back", and then another, "my head". Yeah so when we sit together we talk about these things then we share with others where we don't feel at ease [25:00] [both laugh].

I: Ok, ah. So do you know- ok you said now all your peers go to the hospital so-

P: Mm- yes please, everyone goes.

I: Ok. So, as you said that you live with some of your peers and they don't really do anything to help you, if- how do you think you can help each other if one of you becomes pregnant- how can you help her?

P: Mm, we have nothing exactly we can do to help.

I: Mm, ok. And what help can the government give to you? For instance, the way some of the hospitals are far and you have to go with a motor and stuff like that? What can the government do to help you so that you can be comfortable with this respect?

P: [Laughs] Umm- we want housing.

I: What did you say please?

P: We want housing.

I: You want housing? [Laughs] oh ok.

P: [Laughs] Where we are now, mosquitoes are biting us so that's what we need [laughs].

I: Mm- ok. So if there's anything you would like to say in addition to umm- umm- you would like to add, you can do so please.

P: [Laughs]. I have nothing to say.

I: Ok [laughs]. Then-

P: The government- it is the housing that we want.

I: Ok then, thank you so much for making time to speak with me, God bless you.

P: Ok, I thank you as well and God bless you.

I: Amen.

P: Then let me give the phone back to mum so you speak with her.

I: Yes please.

P: Ok, bye bye.

I: Bye.

[Background]

Interviewee: Participant 9

P: So speak.

I: Ok. So how old are you please?

P: Huh?

I: How old are you please? Your age?

P: I am umm- 30.

I: Ok. And are you married please?

P: Yes I'm married.

I: Ok, and where do you come from?

P: I'm from the North.

I: Ok. Where exactly?

P: Walewale.

I: Ok. And please umm- are you a Muslim or a Christian?

P: I am a Muslim.

I: Ok. And did you go to school for a while please?

P: No.

I: Ok. So when you work, about how much do you earn in a day?

P: The work?

I: Yes please, the kaya.

P: The kaya?

I: Yeah.

P: Sometimes I earn 20 (cedis).

I: Ok. And apart from that, when you put the kaya aside, do you have another job in addition or it's just the kaya that you do please?

P: It's just the kaya I do.

I: Ok. So you- how many children do you have please?

P: Just one.

I: Ok and how old are they?

P: They are two years.

I: And also in Accra, where do you live, in Accra?

P: I stay at Tema Station.

I: Ok. And at Tema Station, where you sleep, is it an apartment you rent, do you sleep outside or you live with someone?

P: We sleep outside.

I: ok. And how many years has it been since you did the kaya please?

P: Huh?

I: For HOW MANY YEARS have you been doing the kaya? As in, how many years?

P: It should be up to 5 (years)

I: Five years?

P: Yeah.

I: Ok. So- now I would ask you some questions concerning maternity. So if a wom- woman is pregnant, what are the things she's supposed to do so that she's strong and the child in her womb is also healthy?

P: What work?

I: No not work, but rather things she will do to take care of herself.

[Background]

P: Things?

I: Yes, like would she take medication, would she go to the doctor or what- what would she do?

P: Yeah, we will go to the doctor.

I: Oh ok. And when you go to the doctor as well, why is it good to go to the doctor?

P: Well, if you do not feel well, you can go to the doctor to take medication.

I: Mm, ok. So I- I- so when you are pregnant and you go to the doctor, what does it do to help you the pregnant woman and the child in your womb? What would it do for you?

P: Usually they give us medicines.

I: Mm, ok.

P: And if you take those medicines, they will give you some help.

I: Mm, ok. So umm- when you go to the hospital, is it free please?

P: No.

I: Oh ok. And do you have the National Health?

P: Yeah I have it.

I: Ok, but- but when you went to the hospital, they took money from you even when you had the National Health?

P: They would give you some drugs for free but you will pay- they will write a paper for you then you will go and buy the drugs.

I: Ah, ok, mm. And please, umm- ok- a moment please. The time that- umm- you - ok- umm- [05:00] you know there are some people who don't want to go to the hospital or due to some reasons, they can't go so what do such people normally do to take care of themselves?

P: They usually take traditional medicine.

I: Oh ok, ok. And also, when you were pregnant, how many months did you do the kaya for before stopping to go and give birth?

P: Ahh-

I: Please how ma- about how many months- when you were pregnant?

P: Umm-. when it gets to [inaudible] months then I will go and have my child- then I'll come back.

I: What did you say please? How many months did you say please?

P: Yeah-

I: How many months please? As in two or- when you're pregnant, do you work for about 5 months or what before you stop?

P: I work for seven months.

I: Seven months? Ok.

P: Yeah, then I break.

I: Mm, ok. And after you gave birth as well, for that too you- how many months did you stay home for before you started the kaya?

P: When I gave birth?

I: Yeah.

P: Umm- it got to about five months before I came to work.

I: Ok, so was the hospital you were visiting close to you a bit or it was far?

P: Hospital?

I: What did you say please?

P: What did you say again?

I: I was asking if the hospital was far or it was close.

P: Ahh, It was a bit far.

I: Mm, ok. So what were you doing to get there? Were you picking a car or what?

P: No, they used to pick us up with a motor.

I: Oh ok, ok. Mm, so with that, was it something that umm- that was problematic or it was ok?

P: What?

I: Umm- the act of taking a motor to the hospital.

P: Yeah-

I: Did you think it was something problematic or bad or it was good for you?

P: But it- that one- that one, they can't find a car so they go there with a motor.

I: Mm- ok, ok, mm. So with that as well, about how much money did you use to pay to ride a motor?

P: The car?

I: Umm- umm- the motor since you said you went with one so about how much did you use to pay to board it?

P: The motor? You could pay about 10 cedis or- then you go with it.

I: So was it the same thing on your way back – 10 cedis?

P: Umm- it wasn't far.

I: Ok. So as you said that the National Health- when you went- if you possess the National Health, they would still take money from you, what then do you think were the benefits of the National Health?

[Background]

I: What was the importance of the National Health?

P: Sometimes when they wrote the drugs for you, [mm] you wouldn't give money to the doctor.

I: Ok, ok. Mm, ok. So, umm-

P: But you will go and buy the medicine, yeah. [10:00]

I: Ok. So when you were going to the hospital to do umm- umm- the check-up, when you go and see the doctor, when you got there, did you get someone to attend to you quickly or you had to queue and wait for a long time?

P: You will join the queue and wait for a while- [mm] then they would attend to you.

I: So about how many minutes or how many hours was it?

P: It would take about ten minutes before you go.

I: Did you say ten minutes?

P: Yeah.

I: Mm, ok. You- why did you- ok when you- you went to the North, did you give birth in the hospital?

P: Yeah.

I: Ok, ok. So why- what made you go to the hospital to give birth?

P: In our hometown, in the North, if you want to give birth, you have to go to the hospital, some people also give birth at home.

I: Oh ok. So why did you decide that the hospital was good for you?

P: Because that one is beneficial to us. If you have your child at home, it will not help you.

I: Ok. So when you went to the hospital, were you content with the way you were taken care of?

P: Yeah, it was a bit ok, it was better than giving birth in the North.

I: Mm- ok. So were you also happy with how the doctors and the nurses spoke to you?

P: Mm.

I: Did they talk nicely to you?

P: Yeah, they spoke well.

I: Ok. So do you perceive that the way you were treated was the same way they treated everyone else? The way you were attended to, was it the same thing they did for everyone else or there was a difference?

P: No, there are differences, some people will not be treated in such a way.

I: Mm, ok, ok. So why do you think there were differences?

P: Because some people would complain that they weren't attended to properly and others are treated well.

I: Mm- ok. But you don't know why it turns out to be this way, right?

P: No.

I: So, when the doctors were taking care of you and you had some questions you wanted to ask, could you ask- could you ask them?

[Background]

P: You could ask but there were some people you couldn't ask.

I: Mm, so why couldn't you ask them?

P: They are not friendly, that's why you couldn't ask.

I: Ah they are not nice? Ok, ok. So umm, when you went to give birth- when you went to give birth at the North, did you get a doctor to attend to you as soon as you got there or you had to stay there for a while before someone came to you?

P: I laid down for a while before I gave birth.

I: Oh ok, and after you gave birth, did you go to the hospital with your child to do the weighing and other stuff?

P: Yeah I went.

I: [15:00] Ok, so about how many times- did you go?

P: Mm-

I: As in, how many times- how will I say this in Twi? How many times?

P: About two months, then you will go again.

I: Ok. So do you still take your child or you have stopped now?

P: I still take them, even here, we still go.

I: Oh ok. Mm- and was their name written? When you gave birth to your child was their name written?

P: Yes it is written.

I: Ok. And umm- di they receive the vaccinations that newborns are given?

P: Yes, they have done that.

I: Mm- ok. So with that also, did you have to pay money or it was free?

P: We paid no money, that one was free.

I: Ok. Did you have to wait- did you have to wait for long before a doctor attended to you or- or you didn't wait for long?

P: You would wait.

I: Mm, ok. Also-

P: We wait before they attend to us.

I: How much time could you spend there also? Like 30 minutes or 1 hour or-?

P: Umm- it would be about one hour.

I: Mm, ok, ok. So umm- umm, the time you were pregnant and went to the doctor to examine you too, how many times did you go also?

P: The time I gave birth [umm] or the time-

I: No, when you were pregnant, yeah. How many times did you go to the doctor?

P: Umm-

I: How- how many times?

P: I went for about 6 months.

I: Oh ok. So umm- if you decide to give birth again, would you go to the same hospital or- or you would go elsewhere?

P: I would still go to that hospital, that's what's ours.

I: Ok, ok. So do the kayayei have a group that meets and discusses various issues or you have no group like that?

P: Huh?

I: Mm?

P: What did you say?

I: I was asking if you had a group that meets occasionally and organizes discussions.

P: Yeah, we have one.

I: Oh ok. So in that case, if one of you gets pregnant, what do you do to support each other, if maybe someone is pregnant?

P: We would gather money little by little to support them.

I: Mm, ok. So with that- umm- ok. When you decided to go and give birth in the hospital, was your family supportive of it?

P: Yeah, some of them would support and others would prefer birth at home.

I: Mm, ok. And was your husband also happy that you went to the hospital to give birth?

P: Yeah, he was happy.

I: Ok. So umm- do you and your fellow kayayei talk about maternal issues?

P: Yeah, we usually talk about them.

I: Ok. So what were some of the things you were talking about?

P: We usually say that, when you are pregnant and your husband cannot take care of you, we could- we could contribute money to help that person.

I: Oh ok. And umm, [20:00] do you know some people who don't go to the hospital?

P: Mm, there are some people who take the traditional medicine because they are convinced that the traditional medicine is better than going to the hospital.

I: Ahh-

P: Some people as well are not happy with it.

I: Mm, ok, ok. So umm- what do you think the government and the hospitals can do to help the kayayei during pregnancy and childbirth, so that those who don't want to go to the hospital would be able to go?

P: Us the kayayei?

I: I mean what can the hospital staff- the hospitals and the government do to help you so that everyone can go to the hospital?

P: A relative of ours or us the kayayei?

I: You the kayayoo, do you think there is something the government can do to help you so that everyone goes to the hospital?

P: As you have gone ant it was beneficial to you, you could also tell them about it so that they would also go.

I: And what about the government? For instance, how distant some of the hospitals are, among other things, what can they do to help those who maybe, have no money?

P: What they will use to help them?

I: Yeah, like the hospitals or the government.

P: Mm- they could tell them to construct good roads and maintain them.

I: Mm, ok, sure. If there's something you could say- you would like to say in addition, you can do so please.

P: Something I could say?

I: If you would like to say something in addition.

P: What I would like to say is that they should help us so that we get housing so we could also stop sleeping outside and stay in a decent place where you could sleep after work.

I: Mm, ok, ok. Thanks a lot then for making time to speak with me. God richly bless you.

P: Ok, I'm also grateful.

I: Don't mention.

P: My child also wants to speak.

I: [Laughs] bye bye.

Interviewee: Participant 10

I: So how old are you please?

P: 25.

I: Ok and are you married please?

P: Yes I'm married.

I: Ok. And where in the North do you come from?

P: I'm from Tamale.

I: Ok. So are you a Christian or a Muslim please?

P: I'm a Muslim.

I: Ok. And did you go to school for a while please?

P: No please.

I: Ok. Umm- And when you do the kaya, about how much money do you earn in a day?

P: Please- normally-

I: Yeah- when you do the kaya, how much do you earn in a day?

P: I earn 20 (cedis) please.

I: Ok, ok. And umm- apart from the kaya, do you- you have another work in addition or that's the only thing you do?

P: No please, that's the only thing.

I: Ok. And how many children do you have please?

P: I have three children.

I: Ok. And umm- how old is your first child?

P: They are nine years.

I: And what about your last child?

P: They are also three years.

I: Ok. And where in Accra do you stay please?

P: Oh the youngest one? Ah the youngest is t- one and a half.

I: One and a half? Ok.

P: Yeah, yeah.

I: And where in Accra do you stay please?

P: I live at Konkomba.

I: Ok. Umm in Accra?

P: Yes.

I: Oh ok. And where you live, is it a place you rent, do you sleep outside or you live with someone?

P: I live in a building.

I: And umm- are you renting it or you live with someone?

P: We are a lot there.

I: Ok. And you- so you divide the rent and pay together?

P: Everyone is working.

I: Ok. So umm- where you live, does it have a bathroom and toilet please?

[Background]

P: Ah, we bath outside.

I: You bath outside?

P: Yes.

I: Ok so- umm- th- this- so does that mean that the landlord didn't construct any bathroom?

P: No, no.

I: Ok. And what about a toilet?

P: No, that also, we go outside.

I: Ok, ok. So umm- when you started the kaya, how many years has it been? [Background] How many years?

P: It should be up to ten years.

I: Is it up to or it's more than?

P: It's up to.

I: Oh ok, ok.

P: Yeah.

I: So umm- if a woman becomes pregnant, if a woman conceives, what can she do to take care of herself- so that she will be healthy?

P: You will eat well-

I: Yeah, ok-

P: And you will take medication.

I: And the medicine, where will you get it from?

P: From the doctor.

I: From where please? Where did you say it will come from please?

P: From the doctor.

I: Oh ok, ok. And umm- if you are pregnant and you go and see a doctor, what are the benefits of that? [05:00]

P: It- they will examine your pregnancy well than they- they will prescribe medicines for you to purchase. They will look into your womb and prepare the baby well for you.

I: Oh ok.

P: As for the medicines, they will write them for you, then you'll purchase them yourself.

I: Oh ok, ok. So please umm- if umm- you go to the hospital, do you pay some money or it is free?

P: Umm- you will pay. You will pay money- for the medicine.

I: Ok. Do you still pay even with your health insurance?

P: That's all and- umm-

I: I mean that if you have the health insurance, if you have the health insurance card-

P: Oh, you only pay for the medicines.

I: Only the medicine?

P: It's only the medicine you'll pay for.

I: Oh ok.

P: Yeah.

I: Ok, ok, mm. So umm- what then are the benefits of the health insurance? What don't you pay?

P: The care, that's the only thing you don't pay for. Everything else, you'll pay for it.

I: Ok, ok. And umm, for those who don't want to go to the hospital, what are the things they do to take care of themselves when they are pregnant?

P: Trad- trad-

I: Traditional medicine?

P: Home remedies, yeah.

I: Oh ok. So umm, when you were pregnant, were you still doing the kaya, as in after you found out you were pregnant, did you continue the head porting?

P: Yes please, I still did the kaya when I was pregnant.

I: Ok. So how many months did you do that for before you stopped to go and give birth?

P: Eight months.

I: Oh ok, ok. And umm after you gave birth too, umm- in that case as well, how many months did you stay at home before you- before you started-

P: Five months.

I: Ok. And umm- how many times did you go to the hospital before you gave birth?

P: I went for six times.

I: Ok. And umm, the hospital you visited, was it close to you or it was a bit far?

P: It was far.

I: So how were you getting to the hospital?

P: I would walk.

I: Mm, ok. So when you walked how many minutes did it take before you got there?

P: Thirty minutes.

I: Oh ok. So umm- ok, umm- a moment please.

P: Ok.

I: So when you got to the hospital, did a doctor attend to you immediately or you had to sit and queue before someone attended to you?

P: They would take care of me.

I: Yeah but did it take long? Did it take long before-

P: Ahh, it would take a little while.

I: So about how many minutes or hours?

P: Two hours.

I: Mm, ok. Umm, ok. So umm- now- [10:00] did you give birth in the North or you gave birth in Accra?

P: I went to give birth in the North.

I: Ok. And there also- did you go to the hospital or you went to give birth at home?

P: Also the same thing.

I: Mm, ok. So, was the hospital where you delivered your child close to where you lived in the North or it was also far?

P: It was far.

I: Mm, ok, so how were you getting there too?

P: In that case, they would get a car for me to take there.

I: Ok, ok. So umm- why did you decide to give birth in the hospital rather than give birth a home like some others do?

P: It is good, that's why I prefer to give birth there.

I: Mm, ok. So umm, were you content with how you were taken care of by the doctors?

P: Yeah.

I: And were you happy with their attitudes and how they spoke to you as well?

P: Yeah.

I: Ok. And umm- if you had questions to ask, were you able to ask them?

[Background]

I: Or you didn't-

P: Yes.

I: Ok, and over there, at the hospital in the North, when you went into labour and you got there, was there somebody to take care of you at that time or you were busy so you had to wait?

P: There was someone available.

I: Mm, ok. So umm- you- after you gave birth, were you going for weighing, were you taking the child to the hospital for examination?

P: Yes,

I: Mm, ok. And umm- that also- when you went, did they examine only the child or it was both you and your child?

[Background]

P: Yeah-

I: Was it you and the child or just the child please?

P: Both of us were examined.

I: Both of you? Ok.

P: Yeah.

I: After you gave birth to the child, was their name registered?

P: Yeah.

I: Ok. And were the vaccinations that are given to newborn children given to your child also?

P: Yeah.

I: Ok. So you still go for weighing, the weighing, do you still take your child or- or you have stopped?

P: I still take them.

I: Ok. And is that also free?

P: Yeah,

I: Oh ok. And when you went for that, did you wait for long before someone attended to you or you did not take much time?

P: I don't take much time.

I: Ok. So if- so if you could change something, would you go to another hospital or you would go to the same hospital?

P: I would go to the same place.

I: Ok. So-

P: They are very good so that's where I'll go.

I: Ok, ok. So umm- are you part- are you part of a specific group which- maybe do the kayayei have a group which meets and discusses or you don't know of any such thing?

[Background]

P: No. [15:00]

I: Ok. And if someone is pregnant, you- usually you- do you support each other in any way if one of you becomes pregnant?

P: They collect money.

I: Oh ok, ok. And umm you- when you decided to give birth in the hospital, was it something that your family was happy about?

P: Yeah.

I: And what about your husband?

P: Yes, he was happy.

I: Ok, ok. And umm- when- you said umm- you and other people live together, where you live. Are they also kayayei?

P: Yeah.

I: So about how many people are you living with?

P: We are more than 30.

I: Ok.

P: Yeah, we are a lot [laughs].

I: So- hello? So do you talk about maternal issues?

P: Yes we do.

I: Ah, ok so what are some of the things you talk about?

P: Some people say they have waist pains, [ahh] others say they have leg pains and another person, the tummy; wherever they felt pains, they would say it.

I: Mm, ok, ok. So do you know umm, some people who decided that they wouldn't go to the hospital? As in, do you know anyone who didn't go to the hospital during pregnancy?

P: No, I don't know.

I: So everyone- everyone you know went to the hospital right?

P: Yeah. I know nobody like that.

I: Ok, ok. So umm- you- what can the hospitals or the government possibly do to help you so that if you get pregnant, umm- umm- everything will be easy for you?

P: They should please help us to get a shelter to sleep.

I: Mm, ok. So umm- and- with regards to the distance, you said you had to walk for about 30 minutes to get there so what can the hospitals also do so that those of you who are not close will be able to go without having to struggle a lot?

P: Ahh, they should get a car for us.

I: Ah, ok, ok. So if there's something you could- you- you would like to say in addition, you can please do.

P: The government should help us- they should help us.

I: Ok then, thank you for making the time to speak to me, God bless you.

P: Thank you, God bless you.

I: Amen [laughs]. Ok, bye bye.

P: Thanks.

Annex 2: Interview Guide

Topic: Urban Poor and Social Exclusion: Exploring Accessibility to Maternal Healthcare Services among Female Head Porters (Kayayei) in the Accra Metropolis

Section A: Socio-Demographic Characteristics

1. Age: ………………………………………..........................
2. Marital status: ……………………………………………..
3. Place of origin: ……………………………. ………………
4. Ethnicity: ……………………………………………..………
5. Religion: ……………………………………………………….
6. Level of education: …………………………………………...
7. The average income per day: ……………………………………..
8. Sources of income (Specify) ……………………………...........
9. How many children do you have? ……………………………
10. Age at first childbirth: …………………………………………
11. What is the age of the youngest child? ………………………………………………………
12. Where do you stay in Accra? ……………………………………...
13. Type of settlement in Accra? (a) Rented apartment (b) Family home (c) Friends (d) homeless (e) Other ………………………………….
14. How many years have you been staying in Accra as a kayayoo? ……………………………………

Section B: Knowledge on Maternal Healthcare

15. What is your understanding of maternal healthcare?
16. How important do you perceive antenatal visits?
17. What is your general perspective on receiving maternal healthcare from the hospital/clinics?
18. Are you aware of the free maternal services (even without the NHIS card)? (Explain)
19. To the best of your knowledge, what maternal healthcare service options are available to you?
20. How long did you work as a head porter during pregnancy? Until delivery, or did you stop earlier?
21. How soon did you return to head porting after birth? Narrate the advice you received, if any (and from whom), on how soon you could return to work.

Section C: Access to Maternal Healthcare

PRELIMINARY QUESTION: Did you have access to Maternal Healthcare? When? (Antenatal visits, delivery, post-natal checks?)

If yes→ continue with question 22

If no→ Why? [Related to questions 15-19]

22. Describe your means of transportation to the hospital or clinics (walking, taxi, minibus, etc).
23. Explain the challenges you encounter with each of the means of transportation you described.
24. Explain the cost involved in accessing maternal healthcare (How does cost affect your health-seeking behaviour during pregnancy?)
25. Do you receive the needed care any time you visit the hospital for maternal care services? (Explain)
26. Describe (if any) some of the benefits you derived from the National Health Insurance Scheme (NHIS) during pregnancy.
27. Describe (if any) some of the challenges you encountered with the use of the NHIS.
28. If you are not currently a registered member of the NHIS, explain why.

Section D: Experiences with Maternal Care Services

29. Did you give birth in a hospital or with the assistant of a skilled birth attendant? (Narrate your experience with any of these if applicable).
30. What informed your decision to give birth in the hospital or with the assistance of a traditional birth attendant? (If applicable)
31. How will you describe the quality of services you received in the hospital (if applicable)?
32. How will you describe the attitude of service providers towards you? (Explain)
33. In your opinion, do you sometimes feel that you are treated differently because of your sociodemographic characteristics? (Explain).
34. Did you feel comfortable asking questions if there were any? (Explain)
35. Were staff readily available to attend to you or you had to wait for a long time? (Explain)
36. If you did not receive postnatal care, explain why.
37. Describe, if applicable, your post-natal visits to the hospital/clinic?
    a. What type of care did you receive as a mother who just had a child?
    b. Was the birth of your child registered?
    c. What vaccinations did your child receive?

d. How many times did you go? Did you pay any user fees?
e. How long did it take during your visit to get attended to and how much time did you spend with the health professional?

38. If you had the means, would you choose a different option or go to a different hospital? (Explain)

Section E: Influence of Social Capital on Maternal Health Choices

39. Are you a member of any union or group of any kind?
40. What type of supports did you receive from these unions or groups during pregnancy?
41. What was the reaction of your family members concerning the decision to access maternal healthcare services from the hospital? (If applicable)
42. What was the reaction of your spouse/partner concerning the decision to receive maternal care services from the hospital? (If applicable)
43. What does your religion teach about maternal healthcare services?
44. Have you ever talked about Maternal Healthcare with the other female head porters?
45. Did other head porters you know receive Maternal Healthcare Services? (Yes/No, why?)

Section F: Recommendations

46. In what ways can unions and other social groups aid the patronage of maternal healthcare among the Kayayei?
47. In what ways can healthcare facilities promote access to maternal healthcare to the Kayayei?
48. How can the problem of cost be tackled to promote patronage of maternal healthcare among the Kayayei?
49. Explain, in your opinion, how the problem of distance can be resolved to encourage hospital attendance among pregnant and lactating kayayei?
50. Any further comments?

THANK YOU FOR YOUR TIME