KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

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DEPARTMENT OF COMMUNITY HEALTH

ENROLLMENT IN NHIS AND ACCESS TO HEALTHCARE: A CASE STUDY OF MIGRANT FEMALE HEADPORTERS AT THE CENTRAL BUSINESS DISTRICT OF KUMASI, ASHANTI REGION, GHANA

EVELYN AMOAH

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A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH IN PARTIAL FULFILLMENT OF THE AWARD OF DEGREE OF MASTERS IN PUBLIC HEALTH IN HEALTH SERVICES PLANNING AND MANAGEMENT

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MASTERS IN PUBLIC HEALTH (HEALTH SERVICES PLANNING AND MANAGEMENT)

APRIL 2014

DECLARATION

I hereby declare that this script is my own work and that, to the best of my knowledge, it contains no material previously published by another person, nor material which has been accepted for the award of any other degree of the university, except where due acknowledgement has been made in the text.

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(HEAD OF DEPARTMENT)

DEDICATION

This work is dedicated to my dear daughter Nana Abena Serwaa Dwomoh.

ACKNOWLEGEMENT

I wish to thank several individuals for their contributions to the research work. I would like to thank my able supervisor Dr. (Mrs.) Agatha Bonney for not only guiding me through this process with her keen insights and advice, but has also taught me many valuable lessons along the way. I would also like to thank Dr. Peter Agyei-Baffour for his suggestions throughout the dissertation process.

I greatly appreciate the contributions of Mr. Samuel Arkorful Odzefo and Mr. Prince Amoako. Additional thanks go to everyone who helped me in the collection of the data for this study, especially co-operation from all the headporters. Special thanks to Dr. Awudzie Yeboah (Kumasi Metro Health Director-Ashanti Region-Ghana) and the management staff for their encouragement and support of this study. I also appreciate the assistance of my friend Dominic Nyarko. Finally, the greatest of all appreciations go to the Almighty God for taking me through the journey.

TABLE OF CONTENTS

CHAPTER TWO

CHAPTER THREE

LIST OF TABLES

LISTS OF FIGURES

ABBREVIATIONS/ ACRONYMS

CBHI: Community Based Health Insurance Schemes

CDCP: Centers for Disease Control and Prevention

CIA: Central Intelligence Agency

DMHIS: District Mutual Health Insurance Scheme

DWMHIS: District-Wide Mutual Health Insurance Scheme

DWS: District-Wide Schemes

GES: Ghana Education Service

GHS: Ghana Health Service

GSS: Ghana Statistical Service

ILO: International Labour Organization

KATH: Komfo Anokye Teaching Hospital

LGAs: Local Government Areas

LI: Legislative Instrument

MOH: Ministry of Health

NGO: Non – Governmental Organization

NHIA: National Health Insurance Authority

NHIC: National Health Insurance Council

NHIS: National Health Insurance Scheme

NHP: National Health Policy

OHCHR: Office of the High Commissioner for Human Rights

OICI: Opportunities Industrialization Centre International

OPD: Out-Patient Department

PCHIS: Private Commercial Health Insurance Scheme

PHCR: Population and Housing Census Report

PMHIS: Private Mutual Health Insurance Scheme

PPVA: Participatory Poverty and Vulnerability Assessment

SAP: Structural Adjustment Program

SHI: Social Health Insurance

SPSS: Statistical Package for Social Sciences

SSNIT: Social Security and National Insurance Trust

UN: United Nation

UNCTAD United Nations Conference for Trade and Development

UNPF: United Nations Population Fund

USAID: United State Agency International Development

VAT: Value Added Tax

WB: World Bank

WHO: World Health Organization

WIEGO: Women in Informal Employment, Generalization and Organization

WMR: World Migration Report

ABSTRACT

The purpose of the study was to assess the female migrants' enrollment in NHIS and their access to healthcare in the Kumasi Metropolis using a descriptive cross sectional study design. A total of 665 migrant female headporters were selected using a snowballing sampling method from Kejetia, Adum shopping centre, Kumasi Central Market, Bantama market and Asafo market for this study. The study used questionnaire for collecting data. The data were then analyzed using SPSS (version 16.0). It was realized from the study that migrant female headporters had some level of knowledge about the NHIS and majority of them heard about NHIS through radio advertisement from various FM stations. The study found that not all migrant female headporters in the Kumasi Metropolis were enrolled in NHIS and 17.4% of the non- subscribers had made up their minds not to enroll in the scheme. Educational attainment and income levels were found to influence enrollment in NHIS. The majority of migrant female headporters did not visit health facility at their first sign of sickness and NHIS had increased access to healthcare among the migrant female headporters in the Kumasi Metropolis. The major challenge facing the migrant female headporters in accessing healthcare was financial factor. Some of the migrant female headporters went to hospitals without their NHIS cards and preferred to be treated under the "cash and carry" system. It is recommended that the NHIA should intensify educational programmes on the scheme and its benefits among the migrant female headporters. The NHIA should conduct free NHIS registration for all migrant female headporters to enable them first appreciate and accept the actual benefits of the scheme. The NHIA should work towards improving the healthcare under the scheme.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Current State of Knowledge

Headporters (*kayayei*) are people who carry or transport goods for shoppers or traders in and around commercial centers at a negotiated fee (Awumbila, 2005; and Yeboah, 2008). In Ghana, migrant female headporters have been tagged with different names within the social context that they operate their "*kaya"* business. In Ashanti region of Ghana, these migrants are called *"paa-o-paa"* and in Accra, they are referred to as *"kayayoo or kayayei".*

"Kayayoo" is a Ga terminology and it is used to describe a woman who carries head loads for a negotiated fee. Etymologically, "*kayayoo"* comes from two languages (Hausa and Ga). In Hausa, *''kaya"* means wares or goods whilst "*Yoo*" in Ga means woman. Hence, "Kayayoo" means a female headporter in Accra and other parts of Ghana (Awumbila, 2007; Yeboah, 2008; Yeboah & Appiah –Yeboah, 2009).

North-south migratory stream has been the unprecedented growing phenomenon of migrant female headporters in Ghana's commercial cities of Accra, Kumasi and Takoradi. Some migration literature mentioned that lack of social infrastructure and employment opportunities, dehumanizing socio-cultural practices (genital cutting, early marriage, widowhood rites), and ethnic conflicts are some of the factors that contribute to the north-south migratory stream (Nabila, 1985; Opare, 2003; Anarfi et al, 2003,; Anarfi

& Kwankye, 2005; Awumbila et al, 2008). According to the World Bank (2008), economic constraints push rural dwellers to migrate to the cities in search of non-exiting jobs.

Ghana Statistical Service (2007) and Wrigley-Asante (2008) also reported that poverty levels in northern Ghana are high and that poverty is feminizing. Majority of women in the northern Ghana and elsewhere in the world are poor and their disproportionate share of poverty rises relative to men (Chant, 2006). More women suffer the incidence of income poverty than men. Chant (2006) was of the view that women who suffer the incidence of income poverty could resort to migration. Thus, according to Ellis (2000), migration is used as a means of livelihood diversification to cope and escape poverty. Contrarily, some migration scholars have disagreed that poverty is a major cause of migration. Sabates (2013) and Omelaniuk (2005) contended that, it was not always the poor who migrated due to poverty, but because of other associated costs and other opportunities involved.

A number of governments of developing countries have been combating poverty and boosting development through providing adequate access to healthcare (Yuansheng, 2004). The United Nation in its convention on economic, social and cultural rights recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and required governments to create conditions which would assure all medical services and medical attention in the event of sickness (Richardson, 1996). Healthcare should be justified in economic terms through its benefit in improving

the health of the entire communities leading to conditions that favour economic growth (World Bank, 2005).

Ghana is one of three African countries along with Rwanda and Tanzania, which have implemented a national health insurance scheme. This National Health Insurance Scheme (NHIS) is based on the Social Health Insurance (SHI) model and it had been used before by some other African Countries (Atim et al, 2009). This conventional SHI model depended largely on the ability of governments to enforce compulsory membership through the deduction of payroll taxes, and was therefore most suited in context of high levels of well paid and well regulated formal employment (Cichon et al, 2007). Undoubtedly, this stands in stark contrast to the African context, where labour markets tend to be dominated by poorly paid and unregulated informal workers including these female headporters. The environment in which many of these informal workers work is unconventional and unprotected from a variety of different hazards and the absence of labour protection means that there are few ways for informal workers to ameliorate the risk and access to healthcare becomes a problem. Informal work in Ghana is no exception to this rule. Job and income insecurity are prominent features of the Ghanaian labour market (Apt and Amankrah, 2004).

1.1.1 Overview of the problem

The migrant female headporters' (*kayayei*) presence and the kind of suffering that they go through in the commercial cities of Ghana have become a grave concern to many

Ghanaians. In reality, almost all of these headporters are from the northern parts of Ghana. According to Ghana Statistical Service (2007), Ghana's northern regions are poor and women bear greater brunt of poverty as Yeboah (2008) reiterated that poverty is indeed feminizing. As a way of escaping poverty, women from these northern parts of Ghana migrate to southern cities to engage in portering which requires no qualification to enter in the informal sector (Yeboah, 2008).

The "*kayayei"* have become the most commonly cited north-south migrants in the bigger cities (Participatory Poverty and Vulnerability Assessment (PPVA, 2011). It has thus become a direct result of Ghana's internal migration, as a result of decades of economic deprivation in the north. According to Awumbila (2005), north-south migratory stream has been practiced greatly within Ghana for centuries. Twumasi-Ankrah (1995); McGregor and Nsiah-Gyabaah (2004) were of the opinion that migration in general could be rural-rural, rural-urban, urban-rural and urban-urban. The most dominant migratory stream particularly in the northern Ghana is the rural-urban migration. Omelaniuk (2005) was of the view that migration in general is a problem everywhere in the world. According to the World Migration Report (2010), 214 million people worldwide were on the move and 49% were women. Out of 190 million migrants in the world today, almost 50% are females, majority having migrated from and within developing countries (Omelaniuk, 2005).

Stressful economic conditions, poverty and unemployment, protracted ethnic conflicts, income disparities and living standards, landlessness, effect of environmental change,

technological revolution, social network amongst other factors have been cited as motivation to inform the households decision to migrate (Adu-Gyamfi, 2001; Adepoju, 2005; 2008; Anarfi & Kwankye, 2005). Under these conditions, migration remains an important livelihood strategy for migrants to deal with declining socio-economic conditions (Manuh, 2001).

The introduction of trade liberalization and Structural Adjustment Program (SAP) were to have improved the situation in the north. However, it rather seriously affected the development in the north and the subsequent removal of subsidies on agriculture and health, and other important social services compounded the problems in the north especially access to healthcare. The result was that the poor and the destitute could not afford the cost of healthcare services which was then known as "cash and carry" system. The net result of this could be the current trend of North-South migration to major cities in Ghana to engage in portering as occupation to earn a living and seek healthcare as well.

Again, the introduction of the NHIS (in placement of "cash and carry system") was perhaps one of the other social mitigating economic factors in solving north – south drift and also inequalities in healthcare. This was seen as a relief to northern migrants since it sought to make access to healthcare affordable and accessible. However it has been witnessed in practice that most often the theoretical postulate do not commensurate with what actually happens in practice. It is not everyone who could access this new healthcare system. The question is "is the health insurance scheme really for the poor?

Do the poor easily get access to healthcare as a result of the introduction of the NHIS? In the case of "*kayayei's*", do they face challenges in trying to access healthcare?" These are the questions that this study seeks to find answers to. In retrospect, there could be a low level of knowledge of people such as these female migrants on the NHIS, or that they face some challenges in their effort to seek healthcare or the way(s) these female migrants access healthcare.

1.1.2 Knowledge on the NHIS

The National Health Insurance Scheme is a form of national health insurance established by the Government of Ghana, with a goal to provide equitable access and financial coverage for basic healthcare services to Ghanaians. Ghana established NHIS to enhance the performance of its health system, paying particular attention to the poor. The scheme therefore focuses heavily on meeting the needs of the poor and providing social health protection based on the principles of equity, solidarity, risk sharing, cross-subsidization, reinsurance, client and community ownership, value for money, good governance and transparency in the health care delivery. It is a system that took off the "cash and carry" system of health delivery. Like many countries in the world, Ghana's health insurance was fashioned out to meet specific needs of Ghanaian citizens. NHIS coverage is thus highest in the most disadvantaged districts, where there is higher incidence of poverty, lower levels of female literacy and lesser healthcare facilities, and where the needs of pregnant women and the elderly may not be met. NHIS is therefore a growing known phenomenon in some African countries and in Ghana NHIS is by law being practiced by every government health facilities.

A study conducted by Adeniyi and Onajole (2010) in Nigeria on the knowledge and perceptions of Nigerian Dentists to the National Health Insurance Scheme (NHIS), using a cross-sectional descriptive survey of 250 dentists was employed in private and public Dental Clinics in Lagos State, Nigeria with a total of 216 dentists (response rate of 82.4%). The study revealed that most 132 (61.1%) of the respondents had a fair knowledge of the NHIS, while 22 (10.2%) and 62 (28.7%) had poor and good knowledge respectively. Majority of the dentists involved in this study had some knowledge of the NHIS and were generally positively disposed towards the scheme and viewed it as a good idea.

1.1.3 The Enrollment in NHIS

Act 650 technically requires all Ghanaians to enroll in the NHIS or in another health insurance plan. Specifically, Section 31 of Act 650 requires a person resident in Ghana other than a member of the Armed Forces of Ghana and the Police Service to belong to a health insurance scheme licensed under this Act. Again the act requires a person resident in a district, who is not a member of a private health insurance scheme or any other district scheme registered under this Act, to apply to be enrolled as a member of the District Mutual Health Insurance Scheme (DMHIS) in the relevant district.

However, enrollment is "de facto" voluntary because there is no penalty for failing to enroll, and individuals or households are not automatically enrolled. Ghanaians generally must go in person to a DMHIS office, complete registration paperwork (often after

waiting a substantial amount of time), and pay a small registration fee meant to cover the photo ID and administrative expenses of registration. Even workers who contribute to the NHIS through Social Security National Insurance Trust (SSNIT) contributions have to personally enroll and pay registration fees in order to obtain the insurance cards. In addition to SSNIT contributors, certain category of the population are exempt from paying premiums (but not registration fees), including: people over age 70 years; children under 18 years; the "core poor," which is defined as being unemployed with no visible source of income, no fixed residence, and not living with someone employed and with a fixed residence and since July 2008, all pregnant women.

Ghanaians who are not exempted pay an annual insurance premium in addition to the registration fees. The official NHIA guidelines call for a range of premiums to be charged according to a person's income or wealth. However, accurate income measures are not generally available, and so many DMHIS's have moved to charging a constant premium to all, typically in the GH7.2 to GH48ranges.

Official statistics on NHIS registration provided by the National Health Insurance Authority (NHIA) shows the increase in enrollment since operations began in late 2005. The report showed that the total number of active members reportedly increased from 2.4 million in 2006 to 11.1 million in 2009, suggesting that close to 50% of the population were covered by the insurance at the end of 2009. However, the NHIA changed its methodology for calculating active members and estimated in its 2010 annual report that about 34% of Ghanaians were active enrollees at the end of 2010.

A study was conducted by Blanchet, Fink and Osei-Akoto (2012) and it sought to investigate the effect of Ghana's National Health Insurance Scheme (NHIS) on healthcare utilization. The overall results suggested that the NHIS's goal of improving access to healthcare has been achieved at least amongst adult women living in the Accra Metropolitan Area. The report also revealed that people with higher educational levels as well as the old age people were the highest enrollees in NHIS. A USAID Report (2009) on the topic "an evaluation of the effects of the NHIS in Ghana'' revealed that wealth was strongly associated with enrollment in NHIS. In the household sample, about half of the individuals in the richest wealth quintile were insured under NHIS, compared to less than one-fifth of individuals in the poorest quintile. A similar pattern was observed in the patient exit survey data, where NHIS coverage also increased with wealth quintile: However 35 percent of the patients in the poorest wealth quintile were insured as compared to twice of that percentage of the patients in the richest wealth quintile insured.

1.1.4 Access to Healthcare and its Challenges

Access to healthcare may involve challenges. According to Ron Mandersheid (2013), there are impediments in seeking healthcare and some of these impediments are in relation with health insurance coverage and cost, the nature of the provider, and physical or psychosocial distance. According to Ron Mandersheid (2013), seeking healthcare through health insurance is very paramount, whether employer-provided, self-purchased, or made available through federal or state health plans. He reiterated further that having health insurance is not itself sufficient to be totally healthy. This is because the insurance

benefits may not cover, or adequately cover, certain health services. Thus the challenge of having access to healthcare can be limited by the amount and scope of coverage, as well as by the costs that one must pay.

In support of this assertion, Ghana's NHIS (including all DMHIS's) has a single benefit package that is set by Legislative Instrument 1809 and described by the NHIA as covering "95% of disease conditions" that afflict Ghanaians whilst the package excludes some very expensive procedures such as certain surgeries, cancer treatments (other than breast and cervical cancer), organ transplants, and dialysis; non-vital services such as cosmetic surgery; and some high profile items such as HIV antiretroviral drugs (which are heavily subsidized by the separate National AIDS Program)(CDCP, 2011).

The challenges in accessing healthcare may sometimes be provider-related. According to Ron Mandersheid (2013), health providers may encounter challenges with regards to low payment, too much record keeping and paperwork, delayed payment, and some even believe that patient-borne payments are part of the treatment process itself. Ron Mandersheid (2013) believed that health providers hold the key to access, and could close the door to care when they choose not to accept payment through any particular health insurance. In Ghana, mission health facilities or providers sometimes decline to participate in selected or all insurance programs as a result of delay in payment of claims.

Distance-related challenges may also be one of the problems in healthcare. Ron Mandersheid (2013) held the view that physical and psychological environments could be some of the challenges to healthcare and its access especially patients with a mental health condition. To him, if, for instance, a mental health patient is physically unable to get to a provider's office, access is denied. If distances are not bridged; costs of travel are not held down; and facilities are not physically accessible to individuals who deal with patients especially behavioral health issues and physical limitations, and so on, the challenges in accessing healthcare abound.

Stigma attached to certain diseases is perhaps one of the challenges in accessing healthcare. The stigma that remains attached to seeking care for certain chronic diseases (such as mental health conditions and substance use disorders) may disallow access to healthcare by patients. Ron Mandersheid (2013) argued that provider staff attitudes may be dismissive or unsupportive; their language may be insensitive; they may not be sufficiently attuned to manage effectively or even understand waiting room concerns regarding privacy and behaviour.

1.2 The Problem Statement

Migration all over the world is a problem. According to the World Migration Report (2010), 214 million people worldwide were on the move and 49% were women. Out of 190 million migrants in the world today, almost 50% are females, majority having migrated from and within developing countries (Omelaniuk, 2005). Stressful economic

conditions, poverty and unemployment, protracted ethnic conflicts, income disparities and living standards, landlessness, effect of environmental change, technological revolution, social network amongst other factors have been cited as motivation to inform the households decision to migrate (Adu-Gyamfi, 2001; Adepoju, 2005; 2008; Anarfi & Kwankye, 2005). Similarly, according to World Bank (2008), economic constraints push rural dwellers to migrate to the cities in search of non-exiting jobs. Migration has become a means of livelihood diversification to cope and escape poverty (Ellis, 2000). According to Manuh (2001), migration remains an important livelihood strategy for migrants to deal with declining socio-economic conditions.

In countries with huge poverty rate coupled with large informal economy, migration is inevitable and International Labour Organization (ILO) estimated that 75% of those countries did not have access to healthcare services mainly due to the fact that healthcare and medicine were inaccessible. A comparative analysis on Burkina Faso and Ghana revealed that 80% Burkinabe's did not have access to healthcare because of poverty, whilst in Ghana, the percentage of the population living below the national poverty line was 39.5% (World Bank, 2005) and the percentage of the population on less than $2 per day and $1 per day was 75% and 45.1% respectively (Central Intelligence Agency (CIA), 2006).

In Ghana, the northern regions were Ghana's poorest regions with high levels of food insecurity and malnutrition. Eighty percent of the population in the three northern regions were poor (Ghana Statistical Service, 2000; Awumbila, 2005; Norton, Botey-Doku,

Korboe & Dogbe, 1995) and access to healthcare was a problem. Some migration literature mentioned that poverty, lack of social infrastructure and employment opportunities, dehumanizing socio-cultural practices (genital cutting, early marriage, widowhood rites), and ethnic conflicts contributed to the North-South migratory stream (Nabila, 1975; Opare, 2003; Anarfi et al, 2003; Anarfi & Kwankye, 2005; Awumbila et al, 2008). The poverty levels in northern Ghana were high and poverty was feminizing (Ghana Statistical Service, 2007, Wrigley-Asante, 2008). More women suffered the incidence of income poverty than men.

The environment in which many of these informal workers work was unconventional and unprotected from a variety of different hazards. Job and income insecurity were prominent features of the labour market (Apt and Amankrah, 2004). Documented evidence indicated that majority of informal workers (*kayayei)* working in Accra hailed from the three northern regions and that women represented 47% as against 37% of men whilst 16% came from other regions in Ghana and neighbouring countries (Ghana Statistical Service, 2008). Majority of *"kayayei"* were unskilled and were relegated to a low status of the informal sector of economic activities. They occupied in the "three Ds" jobs, Dirty, Dangerous and Difficult as observed in Asia (ILO, 2001).

The situation in the study area was not different from these factual evidences about the many problems that these migrants may encounter. In the study area, there is a higher incidence of poverty amongst these informal workers than formal workers (Chen, 2004). Access to healthcare, enrollment in NHIS and their future health retirement plans as

being reported in certain parts of the globe was a problem. The environment in which many of these informal workers *"kayayei's*" work is unconventional and unprotected from a variety of different hazards. They suffer physical insecurity at market places and road sides, areas of traffic, the weather and criminal activities. Some even face large increases in market rents and taxes on a regular basis (Awuah, 1970). There is poor public and environmental health in both the residential and market areas and this according to Apt and Amankrah (2004) jeopardize the health of many of these informal workers.

The introduction of Trade Liberalization and Structural Adjustment Program (SAP) were to have minimized the poverty levels in Ghana as a whole but rather seriously affected the development in the north. The subsequent removal of subsidies on agriculture and health, and other important social services compounded the problems in the north. The poor and the destitute could not afford the cost of health services and the phenomenon of "cash and carry system" became popular in Ghana. The net result of this was that, the northern part of Ghana became the labour supply zone, hence, the current trend of North-South migration to some major cities in Ghana to engage in portering as occupation to earn a living.

The Ghanaian NHIS therefore became a much needed attempt to address the challenge of extending social health protection to Ghana's informal workers in all parts of Ghana so that every informal worker in Ghana can be included or enrolled into the scheme to make access to healthcare very easy and affordable by all. The conscious inclusion of informal

workers into a nationwide health insurance scheme became perhaps no surprise considering that over 90% of Ghana's workforce work in the informal economy (Heint, 2005). This was done by fusing elements of SHI with elements of CBHI. However, CBHI schemes often encountered problems of financial sustainability and high dropout rates (Coheur et al, 2007). Community Health Insurance Schemes (non profit schemes based on voluntary membership, low premiums and flexible payment schedules) also surface (Coheur et al, 2007). The NHIS (introduced in 2003) attempted to adopt the best aspects of the health financing models to fit the particular socio economic landscape of Ghana.

Inspite of these attempts, access to healthcare is still a challenge among these migrants. Until now, no research had been conducted on the actual stakeholders' view about migrant female headporters enrollment in NHIS and their access to healthcare at the Central Business District of Kumasi. Although several of the studies have focused on the impact of the NHIS on the poor, few studies appear to have specifically focused in depth on the impact of the NHIS on the "Kayayei". This study therefore sought to assess how female migrants access healthcare and the prevalence of their enrollment in NHIS in the Central Business District of Kumasi. It also sought to determine the challenges faced by female migrants in their effort to seek healthcare.

1.3 Justification of the Study

Access to healthcare especially among the vulnerable population remain acute. Factors which contribute to this are many and varied. They include geographical access, socio-

cultural, health system and financial. Ghana implemented the NHIS to minimize the financial access barrier. However, not much is known about the enrollment of vulnerable populations such as the headporters onto the NHIS and whether or not this translates into improved access to healthcare. The study sought to assess migrant female headporters' enrollment onto the NHIS and their access to healthcare to inform health policy. Specifically, policy makers such as the Ministry of Health (MOH) and Ghana Health Service (GHS), would be informed of the major challenges faced by migrant female headporters in their effort to seek healthcare, the reasons why some of them are not enrolled onto NHIS and how best to deal with such situations.

For researchers in health and education, the study can stimulate relevant hypotheses of which similar research in NHIS could be conducted.

1.4 Research Questions

This study sought to find answers to the following questions;

1. What is the level of knowledge of migrant female headporters on the National Health Insurance Scheme?
2. What is the prevalence of migrant female headporters enrollment in NHIS?
3. How do migrant female headporters access healthcare in the Central Business District of Kumasi?
4. What are the challenges faced by migrant female headporters in their effort to seek healthcare?

1.5 Research Objectives

1.5.1 Main Objective: To assess migrant female headporters enrollment in NHIS and their access to healthcare.

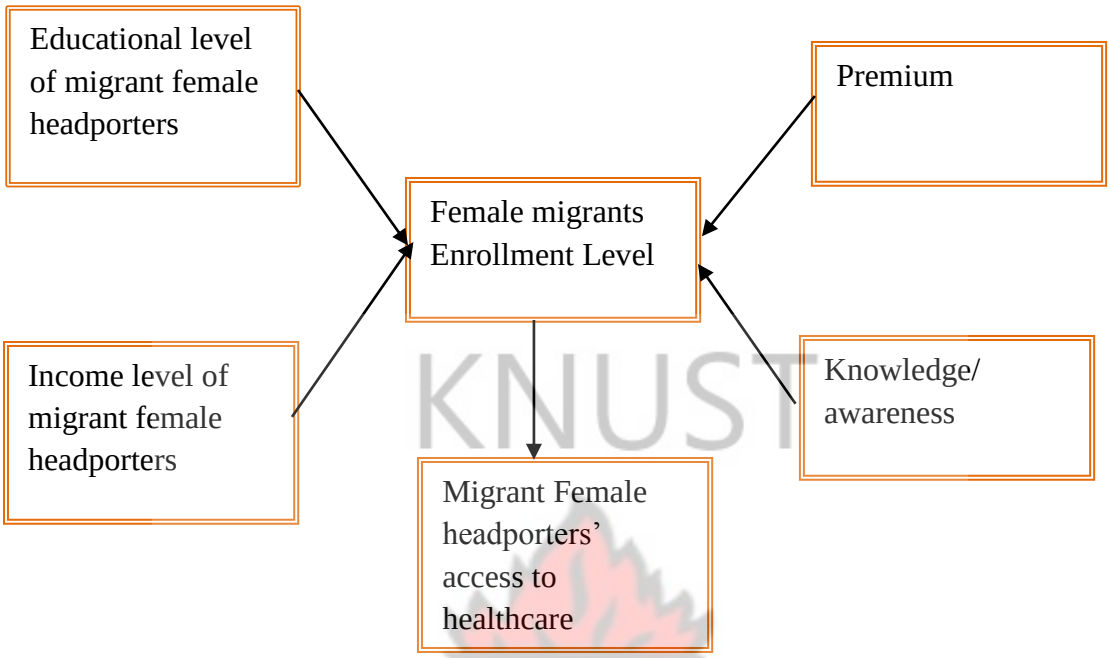
1.5.2 Specific Objectives

1. To assess the level of knowledge of migrant female headporters on the National Health Insurance Scheme.
2. To determine the prevalence of migrant female headporters enrolled in NHIS.
3. To assess how migrant female headporters access healthcare in the Central Business District of Kumasi.
4. To determine the challenges faced by migrant female headporters in their effort to seek healthcare.

1.6 Conceptual Framework

After reviewing available literature on the various concepts about the enrollment in NHIS and access to healthcare, this research work is conceptualised as presented in figure 2.1. It depicts the linkages on critical factors that may influence migrant female headporters' enrollment levels and access to healthcare in the Kumasi Metropolis.

Figure 1.1: Conceptual Framework



Source: Author's Own Construct, 2014

Migrant female headporters' enrollment onto NHIS is determined by knowledge and awareness of the scheme, income and premium levels as well as educational level of the headporters. High enrollment is expected if the migrant female headporters are aware of the existence of the schemes and if they have adequate knowledge about their principles and operations. The reverse holds if knowledge and awareness levels are low. An income level of the migrant female headporters which is a determining factor of ability to pay is quite critical to enrollment. Widespread poverty and low income among headportes can be a serious hindrance to enrollment in NHIS. Premium levels and their mode of collection largely determine the financing arrangements of the scheme. These two factors are critical in determining enrollment levels in NHIS. Migrant female headporters are not automatically enrolled onto the NHIS and they are not automatic members of the NHIS.

Flexibility in the premium collection where potential members are allowed to contribute in installments may encourage high enrollment levels.

The main idea behind the introduction of NHIS is to improve access to healthcare. Thus, it is expected that high enrollment levels among the headporters would lead to an increase in access to healthcare among migrant female headporters in the Kumasi Metropolis.

1.7 Organization of the study

This thesis is organized in six chapters. Chapter one provides background information of the study by highlighting the current knowledge on the topic and the problem statement in addition to the research questions and objectives. The conceptual basis of the study is also captured in chapter one.

Chapter two provides review of related literature based on the concepts of the subject under study and also per the study objectives. Chapter three deals with the methodology in terms of study design, study population, sample size estimation, sampling techniques and ethical issues among others. Chapter four shows the presentations of findings and its corresponding interpretations, while Chapter five illustrates the application of the findings in the form of discussions based on relevant literature. The final chapter, Chapter six, covers the conclusions and recommendations of the study.

1.8 Definition of Terms

1. **Headporters (otherwise known as** (*Kayayei / Paa-o-paa / Kayayoo*): These are female headporters who carry goods for shoppers or traders in and around commercial centres at a negotiated fee (Awumbila, 2005; Yeboah, 2008). *"Kayayoo*" is the Ga terminology used to describe a woman who carries head loads for a negotiated fee. Etymologically, "*kayayoo"* comes from two languages, Hausa and Ga. In Hausa, *''kaya"* means wares or goods whilst "*Yoo*" in Ga means woman.
2. **Healthcare**: Activities to maintain health or the provision of medical and related services aimed at maintaining good health, especially through the prevention and treatment of diseases.
3. **Migration:** Movement from one place to another or the act or process of moving from one region or country to another.
4. **Insurance**: Financial protection against loss or harm or disease: An arrangement by which a company gives customers (patients) financial protection against loss or harm such as illness or theft in return for payment premium.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Migration has become a means of livelihood diversification of the informal workers to cope and escape poverty (Ellis, 2000) and according to Manuh (2001), it remains an important livelihood strategy for migrants to deal with declining socio-economic conditions. The environment in which many of these informal workers work is unconventional and unprotected from a variety of different health hazards. The conscious inclusion of informal workers into a nationwide health insurance scheme was perhaps to have solved the inequity in access to healthcare. However, informal workers have often than not been faced with the challenges in access to healthcare. Arguably, this view could be disputed since times and conditions might have changed.

This chapter discusses some review of related literature on the headporters enrollment in the NHIS and their access to healthcare in the Central Business District of Kumasi that could positively affect health service delivery and policy direction in the Kumasi Metropolis.

2.2 Definition and Overview of NHIS

The National Health Insurance Scheme is a system of insurance benefits established by a federal government to cover all or almost all of the citizens of the country. These systems are entirely or partially funded with tax money. In Ghanaian context, NHIS is a form of

insurance established by the Government of Ghana, with a goal to provide equitable access and financial coverage for basic healthcare services to Ghanaians. Thus, Ghana established this NHIS to enhance the performance of its health systems, paying particular attention to the poor. The scheme therefore focuses heavily on meeting the needs of the poor and providing social health protection based on the principles of equity, subsidization, client and community ownership, value for money, solidarity, risk sharing, reinsurance, good governance and transparency in the healthcare delivery. Expanding on this point, Sikosana, Dlamini and Issakov (1995) stated that health insurance is a system where a prospective consumer of healthcare makes payments to a third party on the understanding that in the event of a future illness this third party will pay for some or all of the expenses incurred.

The National Health Insurance Scheme is a system that took off the "Cash and Carry" system of health delivery. Like many countries in the world, Ghana's health insurance was fashioned out to meet specific needs of Ghanaian citizens. According to NHIS Policy (2003), the health insurance was set up to allow Ghanaian citizens to make contributions into a fund so that in the event of illness Ghanaian contributors could be supported by the fund to receive affordable healthcare. Under this policy, three types of health insurance schemes were set up. They were: The District-Wide Mutual Health Insurance Scheme (DWMHIS), The Private Mutual Health Insurance Scheme (PMHIS), and The Private Commercial Health Insurance Scheme (PCHIS).

Health Insurance Scheme concept provides the opportunity for all Ghanaian citizens to have equal access to the functional structures of health insurance and the quality of healthcare provision not compromised under Health Insurance. Similarly, it replaced the unaffordable "cash and carry" regime to an "affordable" Health Insurance Scheme.

The NHIS has a minimum benefit package of about 95% of diseases in Ghana which every district-wide scheme covers for Ghanaian citizens. Diseases covered included among others, malaria, hypertension, diabetes, asthma, diarrhoea, upper respiratory tract infection, and skin diseases and excluding supply of AIDS drugs, treatment of chronic renal failure, optical aids, hearing aids, orthopaedic aids, dentures, beautification surgery, heart and brain surgery, etc. which contribute only 5% of the total number of diseases that Ghanaian citizens suffer from. The NHIS Policy (2003) however reiterated that all District-Wide schemes have the right under the law to organize their schemes to cover as many diseases and services for Ghanaian citizens as they desire, provided it was approved by the National Health Insurance Council. In brief, the nature of NHIS seemed to be taken into account people in the informal sector but fails to address the poverty and inequalities and challenges in access to healthcare. Although NHIS is a nationwide phenomenon, there seems to be a failure of adequate information and education on the need to sensitize its importance.

2.3 Migration and the Migrant Female Headporters "*kayayei's*" in Ghana

Ordinarily, migration is the movement of people or person(s) from one place to another or the act or process of moving from one region or country to another. According to Twumasi-Ankrah and others (1995), migration in general could be rural-rural, rural-urban, urban-rural and urban-urban. Rural-urban migration is the most dominant migratory stream particularly in the Northern Ghana (Twumasi-Ankrah et al, 1995).

Omelaniuk (2005) was of the view that migration in general is a problem everywhere in the world. According to him the number of migrants was about 190 million people worldwide, and almost 50% were females, majority having migrated from and within developing countries. Similarly, World Migration Report (2010) was not different and it suggested that 214 million people worldwide were involved in migration and 49% of migrants were women. Similar report from Ghana Statistical Service (2007) indicated that majority of north - south migrants "*kayayei"* working in Accra hailed from the three northern regions and that women represented 47% as against 37% of men while 16% came from other regions in Ghana and neighbouring countries.

Adu-Gyamfi and others (2001) cited stressful economic conditions, poverty and unemployment, protracted ethnic conflicts, income disparities and living standards, landlessness, effect of environmental change, technological revolution, social network amongst other factors as motivation to inform the household's decision to migrate. Awumbila and others (2008) shared similar view that poverty, lack of social

infrastructure and employment opportunities, dehumanizing socio-cultural practices (genital cutting, early marriage, widowhood rites), and ethnic conflicts contributed to the north-south migratory stream. Opportunities Industrialization Centre International (OICI) (2007) affirmed that Ghana was among countries with low income and food insecurity (OICI, 2007) and that the Northern, Upper East and Upper West regions were the Ghana's poorest regions with high levels of food insecurity and malnutrition. Eighty percent of the population in the three northern regions was poor (Ghana Statistical Service, 2000; 2003, Awumbila, 2005, Botey-Dokuet al, 1995).

Consequently, Participatory Poverty and Vulnerability Assessment (PPVA) (2011) was of the opinion that "*kayayei"* has been the most commonly sighted north-south migrants in the bigger cities in Ghana and that the "*Kayayei"* phenomenon has been the direct result of Ghana's internal migration, as a result of decades of economic deprivation in the north. Awumbila and others (2007) shared similar view and added further that the north-south migratory stream has been the unprecedented growing phenomenon of migrant female headporters in Ghana's commercial cities of Accra, Kumasi and Takoradi. These migrant female headporters have been tagged with different names within the social context that they operate their "*kaya"* business. In Kumasi, the migrants are called *"paa-o-paa"* and in Accra, they are referred to as *"kayayoo or kayayei". "Kayayoo*" is the Ga terminology used to describe a woman who carries head loads for a negotiated fee (Awumbila, 2007; Yeboah, 2008; Yeboah & Appiah –Yeboah, 2009). Thus, Adepoju's (2005) description of migration in Sub-Saharan Africa including Ghana as feminizing was in the right sense. On the contrary, the female migrants in these sub-Saharan Africa

including Ghana should have been given due attention with respect to equity in healthcare.

2.4 Migrant Female Headporters Enrollment in NHIS

The migrant female headporters in sub-Saharan Africa including Ghana has been described as feminizing (Adepoju, 2005), and many of these female migrants (in the informal sector) have been described as poor. Thus, the access to healthcare could be a challenge. Therefore accessing migrant female headporters enrollment in NHIS and their access to healthcare at the Central Business District of Kumasi could be in the right direction. The following are the reviewed literature on the level of knowledge of female migrants on the NHIS, the prevalence of their enrollment in NHIS and their access to healthcare and its challenges.

2.4.1The level of knowledge of migrant female headporters on the NHIS

Greater awareness among the migrant female headporters' population regarding the NHIS scheme, especially with regard to its benefits to the insured, has been crucial to win public enthusiasm for enrollment and active participation in the scheme. It is well known that knowledge is power and "*ceteris paribus*" (Katibi, Akande, and Akande, 2003)and therefore strong stimulus of knowledge of migrants on the NHIS could be in right sense. Thus, services requiring the active participation of individuals in the form of financial commitment or otherwise will require that people (female migrants), "ab initio", have full information on the outstanding benefits of such schemes. On the contrary, active

participation of individuals in the form of financial commitment or otherwise might not be possible that all people, "ab initio", have full information on the outstanding benefits of such schemes. The two scenarios may not be possible.

Similar to this assertion, Razum (1993) was of the view that the availability of a service does not ensure its utilization. Adequate information about the content, processes, roles of stakeholders/consumers, and the perceived benefits of program packages are therefore crucial for proper implementation and the buy-in of prospective consumers (Razum, 1993). On this score, Katibi, Akande and Akande (2003) also contended that the success of the implementation of the NHIS in Nigeria (and for that matter, Ghana) would largely depend on how much information the prospective beneficiaries/consumers have regarding the scheme. This, in addition to the opinions or attitudes of recipients/prospective consumers, has often times not given due importance during the design or implementation of health programs in Nigeria (and for that matter, Ghana).

Inspite of that, there seems to be a rising level of knowledge in NHIS and any health program in parts of Africa where health insurance is practiced among enrollees. A study conducted by Katibi, Akande and Akande (2003) on "awareness and attitude of medical practitioners in Ilorin towards the National Health Insurance Scheme*"*, with a cross-sectional descriptive study design and with a sample of 150 adults from the Local Government Areas (LGAs) were selected for the study and it revealed that more than half (52.0%) of the respondents had poor knowledge of the NHIS. Respondents' knowledge of NHIS did not differ significantly by age, sex, ethnicity, marital status, educational level,

or occupation. In the study, although the majority (74.7%) were of the opinion that the NHIS was a good initiative, a significant proportion was pessimistic about the scheme: 31.3% said that it was a good scheme but not practiceable and 28.0% felt that it was only for the rich.

A similar study was conducted by Adeniyi and Onajole (2010) in Nigeria on "the knowledge and perceptions of Nigerian Dentists to the NHIS". A cross-sectional descriptive survey of 250 Dentists with a total of 216 dentists (response rate of 82.4%) was used and it revealed that 132 (61.1%) of the respondents had a fair knowledge of the NHIS, whilst 22 (10.2%) and 62 (28.7%) had poor and good knowledge respectively. Majority of the dentists involved in this study had some knowledge of the NHIS and were generally positively disposed towards the scheme and viewed it as a good idea. From the two sides, one may only perceive that the level of knowledge of NHIS has risen considerably from time to time. However, results from the two researches indicated that participants involved in both studies had some knowledge of the NHIS and were generally positive towards the scheme and viewed it as a good idea.

Increasingly, Sanusi and Awe's (2009) study (carried out amongst the health service consumers in Ibadan, Oyo State), revealed that 87.4% of the respondents were aware of the scheme. On a different score, findings from a similar study by Sabitu and James (2005) on *"*the knowledge of healthcare workers at National Orthopedic Hospital in Igbobi, Lagos" *(*with a random sampling technique and two hundred questionnaires on the health workers) showed that all the respondents were aware of the scheme with 90%

satisfaction level of its publicity through seminars and conferences being their major sources of information about the scheme. Intensified enlightenment campaign through scientific conferences, seminars and workshops alongside that done through the print and electronic media was seen as a means of publicizing and providing adequate and correct information about the scheme to the healthcare workers.

From the above studies, it could be seen that the level of knowledge among people in general on NHIS is on the high side. What might be the difference is perhaps the level of knowledge of people in the informal sectors which might differ from the people in the formal sectors. Notwithstanding, the increasing awareness level and satisfaction level of NHIS in parts of Africa and Ghana has been the fact that NHIS coverage was tailored in the most disadvantaged districts, where there is higher incidence of poverty, lower levels of female literacy and lesser healthcare facilities, and where the needs of pregnant women and the elderly may not be met. NHIS has been a growing known phenomenon in Ghana and Africa and the high level of knowledge among "*kayayei's"* in NHIS or any health program is impeccable.

2.4.2The Prevalence of Migrant Female Headporters' Enrollment in NHIS

Ghana's NHIS established and implemented as a "pro-poor" method of health financing has made a great progress in enrollment of members of the general population. Bruno, Bart, and Guy (2002) added that many African countries, including Ghana implemented the NHIS to complement funding for the health sector, with a view to improve equity in

health. Jehu-Appiah and others (2010) added that low-income countries are increasingly moving to social health insurance so as to improving equity in the provision of healthcare and providing risk protection to poor households. To Jehu-Appiah and others (2010), assessing the prevalence and equity in enrollment requires that one must compare enrollment of migrants between consumption quintiles.

According to Jones and others (2008), figures from 2008 indicated that there has been over 9 million enrollment of health insurance and this represents 45% of the total population (Jones et al, 2008). Women in Informal Employment, Generalization and Organization (WIEGO) Policy Brief (2012) figures on the scheme's coverage in 2010 by the NHIA however, showed that 6% of the informal workers population was registered with the NHIS – suggesting that the strategy has been successful. WIEGO policy brief (2012) stated that informal workers had generally welcomed the idea of the NHIS as an alternative to the previous system, which was based on "out-of-pocket" cash payments at the point of service. Particularly noteworthy was the mention by several women that they had used the NHIS to have regular blood pressure checks. Thus, in 2008 the Government extended free care to all pregnant women, regardless of their NHIS status.

Similar to this, official statistics on NHIS registration provided by the NHIA showed that there could be increase in enrollment in general since operations began in late 2005. Thus the report showed that the total number of members reportedly increased from 2.4 million in 2006 to 11.1 million in 2009, suggesting that close to 50% of the population was covered by the insurance by 2009. NHIA Annual Report (2010), however, was

suggestive that there could be active enrollees in NHIS and reported that about 34% of Ghanaians were active enrollees at the end of 2010.

On this score, a study conducted by Blanchet, Fink and Osei-Akoto (2012) contended that people with higher educational levels as well as the old age people were the highest enrollees in NHIS. USAID Report (2009) on the topic "an evaluation of the effects of the NHIS in Ghana'' was in support of this assertion and revealed further that wealth was strongly associated with enrollment in NHIS. In the endline household sample, about half of the individuals in the richest wealth quintile were insured under NHIS, compared to less than one-fifth of individuals in the poorest quintile. A similar pattern was observed in the patient exit survey data, where NHIS coverage also increased with wealth quintile; with 35 percent of the patients in the poorest wealth quintile insured, twice as many in the richest quintile also insured.

While there seems to be high enrollment in NHIS between consumption quintiles, Musango et al., (2004); De Allegri and others (2006) and Basaza and others (2008) contended that there was a low enrollment coverage among those who fulfill the criteria of exemption from premiums and this was a problem that health insurances in Africa face frequently. A study by WIEGO (2012) on "The Ghana National Health Insurance Scheme-Assessing Access by Informal Workers" revealed that there were a number of barriers which meant that majority of the informal workers were not NHIS members(32 out of 40) as a result of high cost of premium. This was far out of reach for many of the poorest workers, particularly rural migrants such as the "*Kayayei*" who on average earned

just over $1 a day (WIEGO, 2012).Katibi, Akande and Akande (2003) were of the opinion that most respondents (43.9%) had reservations on the scheme as presently packaged and this could support the contention of Musango and others (2004); De Allegri and others (2006) and Basaza and others (2008) about the low enrollment coverage among those who fulfill the criteria of exemption from premiums and its subsequent problem(s) that health insurances in Africa were faced with frequently.

Nevertheless, Apoya and Marriott (2011) succinctly argued that, NHIS could offer good intentions in increasing equity in healthcare provision inspite of the fact that it could be a deeply unfair system. Apoya and Marriott were of the view that coverage figures could be grossly inflated by the NHIA, and pointed out that the scheme results in poorer people subsidizing healthcare for those who are richer. Thus, while everyone must pay the NHIS VAT levy, only those who can afford to pay premiums are able to access the service. The question is that despite the challenges, how many of "kayayei's" could enroll in NHIS? The need therefore to assess the number of "kayayei's" enrollment in NHIS is impeccable.

2.5 Access to Healthcare and its Challenges (Kayayei's)

Migration has always been a characteristic of human society, and one that has probably always been pregnant with health challenges (Carballo and Mboup, 2005). The growing scope of migratory movements all over the world raises specific health questions in countries. Migrants are particularly vulnerable to health problems (Ponsonby, 2010).

Carballo and Mboup (2005) was of the view that the biomedical and bio-psychosocial dimensions of migration possibly pose new and more difficult challenges to immigrants, those they leave behind and even to those who host them in receiving societies. Kenan, Topal and others (2002) added that migrants often experience other life transitions, such as occupational and socio-economic changes and social network alterations after physical relocation. Like other vulnerable groups, they face various obstacles in access to healthcare services.

Majority of these immigrants who face various obstacles in access to healthcare services are women. Women in Ghana as in many developing countries tend to face greater financial and cultural barriers to healthcare access than men (Bour, 2004). Member states of the World Health Organization (WHO, 2008) were of the view that a universal health system was paramount to ensure that all residents have adequate access to needed healthcare without being required to make "out-of-pocket" payments for healthcare at the time of illness. International development organizations also shared the opinion that access to healthcare should involve prepayments and risk pooling through social health insurance. Hence the implementation of NHIS by Ghana and some African countries to complement funding for the health sector, with a view to improve equity in health (Bruno, Bart and Guy, 2002) and to help promote access to healthcare services for Ghanaians. Jehu-Appiah and others (2010) were however, of the opinion that in promoting access to healthcare services, what determines enrollment between the rich and the poor should not differ. To them, both current and previous enrollment in NHIS should not be influenced by predisposing, enabling and social factors. Evidence of

inequity in enrollment in the NHIS and significant differences in determinants of current and previous enrollment across socio-economic quintiles abound. Ron Mandersheid (2013) shared similar view and argued that there are impediments in seeking healthcare and some of these impediments are in relation with health insurance coverage and cost; the nature of the provider; and physical or psychosocial distance. According to Ron Mandersheid (2013) seeking healthcare is having the key to health insurance, whether employer-provided, self-purchased, or made available through federal or state health plans. He reiterated further that having insurance is not itself sufficient "to open the door" because the insurance benefits may not cover, or adequately cover, certain health services, thus the challenge of having access to care can be limited by the amount and scope of coverage, as well as by the costs that one must pay. This could be one of the various obstacles in access to healthcare services that Kenan, Topal, and others (2002) reiterated.

In agreement to this assertion, Price Water House Coopers (2010) argued that access to healthcare could be limited by dysfunctional physical infrastructure, lack of adequate human capital and poor healthcare financing. They were of the opinion that healthcare system goals are all about cost efficient, quality, access and patient centric. Therefore, if there is inefficient public healthcare system, buildings in a dilapidated condition, lack of proper roads, lack of electricity, lack of drugs and essential supplies, non-functional equipments, shortage of medical manpower, poor healthcare financing, etc challenges in healthcare delivery system would abound.

A study carried out by Price Water House Coopers (2010) revealed an increase in the absolute number of persons unable to seek healthcare due to financial reasons. In the study, about 40% of the hospitalized had to borrow money or sell assets during the decade 1986–96. Around 24% of all people hospitalized in India in a single year fell below the poverty line due to hospitalization. An analysis of financing of hospitalization showed that a large proportion of people, especially those in the bottom four-income quintiles borrow money or sell assets to pay for hospitalization (World Bank, 2002). Koh et al (2002) added that 66% of medical professionals are in urban areas and thereby creating the challenge of income inequity, gender inequity and social inequity.

In Ghana, inequity in access to healthcare could be distance-related, stigma attached to certain diseases, language barriers, and others. Ron Mandersheid (2013) held the view that physical and psychological environments are some of the healthcare challenges that patients with mental health conditions could go through. To him, if, for instance, a mental health patient is physically unable to get to a provider's office, access is denied. To him, if distances are not bridged; costs of travel are not held down; and facilities are not physically accessible to individuals, access to healthcare is equally denied. Stigma attached to certain diseases (such as mental health conditions and substance use disorders) may disallow access to healthcare by patients. Ron Mandersheid (2013) therefore argued that provider staff attitudes may be dismissive or unsupportive; their language may be insensitive; they may not be sufficiently attuned to manage effectively or even understand waiting room concerns regarding privacy and behaviour.

Access to healthcare by "*kayayei's"* (with respect to NHIS) and its challenges could be due to the fact that there could be other related factors that might hinder the migrant female headporters (kayayei's) to enroll in NHIS. One of the points of views could be lack of design of National Health Retirement Insurance Schemes in Africa (of which Ghana has been no exception to this rule (Atim et al, 2009).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the general research design. It covers the study population, study variables, data collection techniques and tools, study type, sampling techniques and sample size, pre-testing, plan for the data handling, ethical consideration, field work preparation, data entry, limitations of the study and assumptions.

3.2 Study Type and Design

The research work employed the descriptive cross-sectional study design. Descriptive cross-sectional study design is a survey in which data collection (measurement) are done as a single observation like a snapshot with the aim of describing a situation where both e.g. exposure and disease are measured at the same time. The study employed quantitative method. This approach was adopted because it offered the best means of obtaining valid data for the study.

3.3 Study Population

The study population was made up of migrant female headporters within the Central Business District in the Kumasi metropolis which has over 20,000 female headporters aged between 12-40 years in the Kumasi metropolis (Baffour Owusu Afriyie, 2009). The headporters studied were all selected within the Adum shopping centre, Asafo market,

Kumasi central market, Bantama market and Kejetia, all within the Kumasi metropolis. All such persons that fell outside the groups described above were excluded from the work.

3.4 Profile of the Study Area

The study was organized in the Central Business District in Kumasi Metropolis. The Kumasi Metropolis is organized around five sub Metro Health Teams; namely, Bantama, Asokwa, Manhyia North, Manhyia South and Subin. The Kumasi Metropolis population has a total of 1,170,270 people, reflecting an inter-censal growth of 5.4% between 1984 and 2010. It has been projected to a population of 1,915,179 in 2011 based on the same growth rate of 5.4%. This unprecedented growth of the population between 1984 and 2010 has made Kumasi the most populous district in the Ashanti Region in that it accounts for almost a third (32.4%) of the region's population. Compared to the national and regional growth rate of 3.4% and 2.7% respectively. The Kumasi Metropolis is growing at a faster rate indicating the attractiveness of Kumasi in the region. The metropolis has a youthful population having about 39.9% of the total population below 15 years (Population and Housing Census Report, 2010). The Kumasi metropolitan area has a total surface area of 254 sq km with a population density of 7,540 persons per sq. km. The Kumasi metropolis is second to Accra metropolis in terms of population density.

The Kumasi metropolis has a number of health facilities in both the public and private sectors such as the Komfo Anokye Teaching Hospital (KATH), which is one of the two

national autonomous hospitals. It also has five government (public) hospitals and four quasi health institutions. In addition, there are over 180 known private health institutions and 13 Industrial clinics in the metropolis. The health facilities are evenly distributed

In the metropolis, people patronize the public health facilities more than the private ones. This is attributable to the fact that relatively higher fees are charged by the private health facilities coupled with the fact that some of the sophisticated and essential equipments are obtained at the public health facilities. In the metropolis, OPD and delivery services are accessed in all the five public hospitals and KATH.

The key problems in the metropolis include high communicable and non-communicable disease burden (malaria, HIV/AIDS, cholera, hypertension), poor National Health Insurance registration and high population growth.

Despite the challenges, Kumasi metropolis has some potentials and opportunities of the health delivery system and these include the availability of skilled labour force, National Health Insurance Scheme (NHIS), committed staff, basic logistics, technical support from Ghana Health Service (GHS) and the Regional Health Administration. To sum up, it has been established that the number of health distribution outlets is adequate for the population of Kumasi and its surroundings. However, lack of adequate logistic support and high ratio of patients/doctor militate against equitable health delivery.

3.5 Sampling Techniques

This study was conducted among 665 selected migrant female headporters in the Central Business District in the Kumasi metropolis. The 665 female headporters were selected to have a representation of female headporters in the Kumasi metropolis. A snowballing sampling technique was employed. The snowballing sampling technique is a technique used to recruit new participants into the study. Thus, the current participant(s) were asked to recommend new people for the study. It was used to get more people involved in the study. Data were taken over a five working days period in Kejetia, Adum shopping centre, Kumasi Central Market, Bantama market and Asafo market, all in the Kumasi metropolis.

3.6 Sample size calculation

A total of 665 headporters were selected from the Central Business District in the Kumasi metropolis for the study. This number was obtained from the total number of headporters who qualified for the study and was available during the period of the research. It was estimated as follows:

$$n = \frac{Z^2 pq}{d^2}$$ (Kirkwood and Sterne, 2003)

Where n = the desired sample size

z = the standard normal deviation 1.96

p = the proportion of headporters in the Central Business District of Kumasi was estimated to be 50%

q = 1.0-p

d = degree of accuracy desired at 0 .04.

$n = [(1.96)^2 (0.50) (0.50)] / (0.04)^2$

n = 600

10% of non-respondent effect was used, thus 10/100* 600 =60. The sample size was thus 60+ 600 = 660. The sample size was then rounded up to **665**.

3.7 Data collection tools and techniques

The study relied on primary data. Primary data were collected using quantitative method. Structured questionnaire was used to elicit responses for the quantitative data through interviewing. This structured questionnaire was sectioned into section A, B, C and D. Section A captured the socio-demographic data of the respondents such as gender, age, educational background, etc. Section B captured the knowledge level of NHIS. Section C and D captured data on Female migrants' enrollment in NHIS and the challenges they go through in accessing healthcare (NHIS) respectively.

On issues of the level of knowledge of female migrants on the NHIS, open ended and closed questionnaires were used to elicit responses from the headporters on their awareness of NHIS as well as the importance. Responses on female migrants' enrollment in NHIS and how that could determine their number of enrollment were also elicited with open ended and closed questionnaires. The challenges faced by female migrants in their effort to seek healthcare were determined through questionnaire administration.

3.8 Data Quality Assurance Measures

3.8.1 Recruitment and Training of Research Assistants

Eight research assistants were recruited to assist the principal investigator in the questionnaire administration. The researcher recruited the research assistants because the respondents were difficult to locate and to ensure completion of the research work on time; as a result more hands were needed. The research assistants were trained on how to properly administer the questionnaire to ensure consistency. They were also trained on how to handle data confidentially.

3.8.2 Pre-testing of Research Tools

The questionnaire for the study was pre-tested in Accra Central Business area (Tema station and Tudu) which was not part of the study area but has similar characteristics with Kumasi metropolis. This was done to check for clarity, consistency and acceptability of the questions to respondents. Following this, the necessary corrections were made and questionnaires finalized for the actual field work.

3.9 Study Variables

Quantitative method was used in measuring both the dependent and independent variables. The dependent variable was migrant female headporters enrollment in NHIS and their access to healthcare. The independent variables were basically the circumstances or conditions that do not allow migrant female headporters to have access

to healthcare and their lack of knowledge of NHIS. A table of conceptual definitions and scales of measurement of the variables are presented in Table 3.1.

Table 3.1: Study Variable Table

Objective	Dependent Variable	Independent variable	Conceptual Definition	Scale of measurement	Indicators	Data Collection Method	Statistical analysis
To ascertain female migrants level of knowledge of NHIS and its importance	Level of knowledge of NHIS and its importance	Age, educational level and religion	Responses from respondents .	Nominal	Frequencies	Questionnaire,	Descriptive, Chi- square
To determine the prevalence of female migrants enrollment in NHIS	"Kayayei's" enrollment in NHIS	Educational level, income level, awareness and premium	Responses from respondents	Nominal/ Ordinal		Questionnaire,	Descriptive, Chi- square
Relationship between enrollment in NHIS and access to healthcare	Access to Healthcare	Enrollment in NHIS	Enrolment in NHIS, Access to healthcare	Nominal/ Ordinal	Responses from respondents	Questionnaire	Chi-square
Challenges to access to healthcare	Access to healthcare	Traffic congestion, lightout, shortage of drugs, financial problem etc.					

Source: Author's Own Construct, 2014

3.10 Data Handling and Analysis

Data was coded before entering using Statistical Package for Social Sciences (SPSS – Version 16.00). The data were analyzed and presented in the form of tables, using the SPSS – Version 16.00 software. Thus, the close – ended questions were analyzed by scoring the responses whilst the open – ended questions were analyzed thematically. Associations were then tested using chi-square analysis.

3.11 Ethical Considerations

The researcher was given a letter of introduction from the Department of Community Health, Kwame Nkrumah University of Science and Technology (KNUST) for the study, which was then shown to the Ashanti Regional Director of Health Services, Kumasi metropolitan Director of Health Services and the head of all the headporters in the Kumasi Metropolis.

The study moreover, sought the consent of the "Kayayei". The "Kayayei's" were informed of the purpose of the study, the nature of their participation, the kind of information needed from them and the required time for their participation. The participants were assured of privacy and confidentiality. Questionnaires were neatly and confidentially handled by the researchers before, during and after filling-in of the questionnaire by the respondents.

3.12 Study Limitations

The likelihood anticipated limitations of the study included:

i. The descriptive cross-sectional study design did not permit an investigation of the cause-effect relationships.

ii. Assessment of migrant female headporters in NHIS as a study has never been undertaken in Ghana therefore it was very difficult to lay hands on previous data on the same subject.

3.13 Assumptions of the Study

The study was based on the following assumptions that;

i. The sample size adequately represented the study population.

   The respondents were honest and frank with their responses.

ii. The migrant female headporters carried out their working operations ("kaya" business) at the area within the Central Business District in Kumasi.

iii. The research assistants followed all the laid down rules governing the research.

CHAPTER FOUR

4.0 STUDY RESULTS

4.1 Introduction

This chapter presents results of the study. Data were collected from migrant female headporters in the Kumasi Metropolis. A total number of 665 headporters were sampled from Adum shopping centre, Kejetia, Bantama market, Asafo market and Kumasi Central Market areas.

4.2 Background characteristics of Respondents

Table 4.1 presents results of the background characteristics of the respondents involved in the study. The mean age of the respondents was 24 years and majority (60.0%) of the respondents was between 18 years and 25 years. The remaining 266 forming 40.0% of the respondents were between 26 years and 35 years. The study did not consider headporters below 18 years and none of the respondents was above 35 years.

From Table 4.1, majority (599, forming 90.1%) of the respondents were Moslems with the remaining 66, representing 9.9% as Christians. Majority (59.8%) of the respondents lived with friends or relatives whilst 40.2% of them lived in rented houses. Basic education was the highest academic qualification for the migrant female headporters and 266 respondents, forming 40.0% had basic education ,whilst 60.0% had no formal education.

Income level was another important variable considered in the characteristics of the respondents. 55.9% of the respondents earned monthly income between GH¢150 and GH¢200. The remaining

11.1% and 33.0% earned monthly income below GH¢150 and between GH¢200 and GH¢300 respectively.

Table 4.1: Background Characteristics of Respondents

Variables	Frequency (n=665)	Percentage
Age		
Between 18years and 25 years	399	60.0
Between 26years and 35 years	266	40.0
Religion		
Christian	66	9.9
Moslems	599	90.1
Highest academic qualification		
No formal education	399	60.0
Basic education	266	40.0
Residence		
Living with friends/ relative	398	59.8
Tenant	267	40.2
Average monthly income		
Below GH¢150	74	11.1
Between GH¢150 and GH¢200	372	55.9
Between GH¢200 and GH¢300	219	33.0

Source: Field Data, 2014

4.3 Level of Knowledge of Migrant Female Headporters on the NHIS

All the respondents attested that they had heard about NHIS but the respondents heard about NHIS through different media and this is shown in Table 4.2. From Table 4.2, 332 of the

respondents, forming 49.9% first heard about NHIS from radio advertisement at various FM stations. The remaining 10.1% and 40.0% first heard about NHIS through NHIS representative(s) and friends/ relatives respectively. The respondents had different perceptions on the benefits of NHIS to people and this was influenced by what they first heard about NHIS. From Table 4.2, majority (50.1%) of the respondents attested that they first heard that NHIS offered free healthcare and they were not supposed to pay any fee when they visited any accredited health facility. Also, 40.0% of the respondents said they were first told that with NHIS they did not have to pay for drugs whilst 9.9% of the respondents indicated that they first heard that NHIS provided free pregnancy care.

From Table 4.2, majority (80.2%) of the respondents attested that they understood the information about NHIS whilst 19.8% of them did not understand the information. Moreover, 466 of the respondents, forming 70.1% revealed that information received about NHIS brought some excitement and happiness to them whilst the remaining 29.9% indicated otherwise. 49.8% of the respondents described their level of knowledge on NHIS as low. The remaining 16.1%, 21.5% and 12.6% of respondents described their level of knowledge as very high, high and very low respectively.

Table 4.2: Level of Knowledge of Migrant Female Headporters on the NHIS

Variables	Frequency (n=665)	Percentage
Have you heard about NHIS?		
Yes	665	100.0
No	0	0.0
Through which medium did you first hear about NHIS		
Radio	332	49.9
NHIS representatives	67	10.1
Friends/ relatives	266	40.0
What did you hear about NHIS		
Free healthcare	333	50.1
No payment for drugs	266	40.0
Free pregnant care	66	9.9
Did you understand the information		
Yes	533	80.2
No	132	19.8
Were you happy when you received the information		
Yes	466	70.1
No	133	20.0
Somehow	66	9.9
How would you describe your level of knowledge on NHIS		
Very high	107	16.1
High	143	21.5
Low	331	49.8
Very low	84	12.6

Source: Field Data, 2014

Furthermore, NHIS can increase the level of knowledge of migrant female headporters through other means. The study selected NHIS durbar for headporters, free registration of headporters,

distribution of NHIS leaflets, distribution of items with pictures of NHIS activities. The respondents were asked to indicate the extent of agreement and disagreement to the selected means of increasing the level of knowledge of the migrant female headporters (see Table 4.3). The study employed Likert scale of 1 – 5 (1= strongly disagree, 2= disagree, 3= undecided, 4= agree and 5= strongly agree) in this section. A high mean score (3.50 – 5.00) indicated effective tool for NHIS awareness creation among migrant female headporters whilst a low mean score (1.00 – 3.49) indicated ineffective tool for NHIS awareness creation among migrant female headporters.

Among the other means of creating NHIS awareness, free NHIS registration for migrant female headporters had the highest mean score of 4.79. This suggested that, majority of the respondents strongly agreed that free NHIS registration for migrant female headporters could best help NHIS to create awareness of its activities among migrant female headporters in the Kumasi Metropolis. This was followed by NHIS durbar for migrant female headporters with a mean score of 4.60. This meant that majority of the respondents strongly agreed that NHIS durbar for migrant female headporters could help NHIS to effectively create awareness of its activities among migrant female headporters in the Kumasi Metropolis. However, distribution of NHIS leaflets and distribution of items with pictures of NHIS activities were not found to be effective in creating NHIS awareness among migrant female headporters in the Kumasi Metropolis.

Table 4.3: Other Ways of Increasing the Level of Knowledge/ Awareness of NHIS Activities among Migrant Female Headporters

Effective ways of increasing NHIS awareness	Strongly Disagreed	Disagreed	Undecided	Agreed	Strongly Agreed	Mean
NHIS durbar for headporters	0 (0.0%)	0 (0.0%)	188 (28.7%)	237 (35.6%)	310 (46.6%)	4.60
Free registration of headporters	0 (0.0%)	0 (0.0%)	0 (0.0%)	138 (20.8%	527 (79.2%)	4.79
Distribution of NHIS leaflets	239 (35.9%)	217 (32.6%)	209 (31.5%)	0 (0.0%)	0 (0.0%)	1.95
Distribution of items with pictures Of NHIS activities	0 (0.0%)	222 (33.4%)	358 (53.8%)	85 (12.8%)	0 (0.0%)	2.79

Source: Field Data, 2014

The Chi-square was used to test for independence of headporters' level of knowledge on NHIS. The test was to show whether headporters level of knowledge on NHIS is independent of factors as age, educational level and religion of the migrant female headporters. From Table 4.4, educational level of migrant female headporters significantly influenced the level of knowledge on NHIS (Chi-square= 601.556: P-value= 0.000) and the headporters with basic education had higher level of knowledge on NHIS than headporters with no formal education. However, age and religion did not significantly influence headporters level of knowledge on NHIS (see Table 4.4).

Table 4.4: Cross Tabulation of Level of Knowledge of NHIS and Demographic Characteristics of Migrant Female Headporters

Characteristics	VL	L	H	VH	Chi-sq.	P-value
Academic qualification (n=665)					**601.556**	**0.000**
No formal education (n=399)	84 (21.1%)	315 (78.9%)	0 (0.0%)	0 (0.0%)		
Basic education (n=266)	0 (0.0%)	16 (6.0%)	143 (53.8%)	107 (40.2%)		
Age (n=665)					**7.717**	**0.052**
Between 18 and25 years	40 (11.8%)	156 (46.0%)	77 (22.7%)	66 (19.5%)		
Between 26 and 35years	44 (13.5%)	175 (53.7%)	66 (20.2%)	41 (12.6%)		
Religion (n=665)					**3.824**	**0.281**
Moslem	71 (11.9%)	300 (50.1%)	132 (22.0%)	96 (16.0%)		
Christian	13 (19.6%)	31 (47.0%)	11 (16.7%)	11 (16.7%)		

Source: Field Data, 2014 (where VR=very low; L=low; H=high; VH= very high)

4.4 Prevalence of Migrant Female Headporters Enrollment in NHIS

The prevalence of migrant female headporters enrollment on NHIS is presented in Table 4.5. From Table 4.5, out of 665 respondents, 498 of them forming 74.9% were enrolled in NHIS whilst 167 of the respondents, accounting for 25.1% had never enrolled in NHIS. Out of 498 respondent's enrolled in NHIS, 287 of them, forming 57.1% had valid NHIS cards at the time of conducting the study whilst 42.4% had expired NHIS cards. The study sought for annual renewal of NHIS cards among the migrant female headporters enrolled in NHIS and the study found that

52.4% of headporters enrolled in NHIS renewed their NHIS cards annually. The remaining 47.6% of the headporters enrolled in NHIS did not renew their NHIS cards annually.

Table 4.5 shows that the headporters had their choice of NHIS centers and this was different from one headporter to another. 37.3% of the respondents enrolled in NHIS preferred Mahyia sub-Metro, followed by Bantama sub-Metro (25.3%), Subin sub-Metro (24.9%) and Asokwa sub-Metro (12.5%) as their NHIS centers.

Table 4.5: Enrollment of Migrant Female Headporters on the NHIS

Variables	Frequency	Percentage
Are you enrolled in NHIS? (n=665)		
Yes	498	74.9
No	167	25.1
Do you have valid NHIS card? (n=498)		
Yes	287	57.6
No	211	42.4
Have you been renewing your card every year? (n=498)		
Yes	261	52.4
No	237	47.6
Where did you register for the NHIS? (n=498)		
Manhyia sub Metro center	186	37.3
Subin sub Metro center	124	24.9
Bantama sub Metro center	126	25.3
Asokwa sub Metro center	62	12.5

Source: Field Data, 2014

The study selected key benefits of NHIS to the NHIS subscribers among the respondents and requested that they indicate the extent of agreement and disagreement as to how these benefits benefitted them. The responses of the respondents are shown in Table 4.6. A Likert scale from 1(strongly disagree) to 5 (strongly agree) was used to examine the benefits of NHIS to migrant female headporters. A high mean score (3.50 – 5.00) indicated positive perception on the benefits of NHIS to its subscribers whilst a low mean score (1.00 – 3.49) indicated negative perception of the benefits of NHIS to its subscribers.

From Table 4.6, majority (55.8%) of the respondents who were NHIS subscribers had the view that NHIS offered free healthcare to them whilst 24.9% of them indicated otherwise and 19.3% were undecided. Free healthcare however had a mean score of 3.49 with a standard deviation of 1.54 and this indicated that respondents disagreed that NHIS offered free healthcare to migrant female headporters in the Kumasi Metropolis. With regards to payment for drugs under NHIS, majority (76.1%) of the respondents attested that NHIS provided free drugs for them any time they visited health facility whilst 23.9% remained undecided. This had a mean score of 3.93 (stdv= 0.40) indicating that the migrant female headporters perceived provision of free drugs as benefit of NHIS to its subscribers.

All the respondents perceived provision of free pregnancy care as benefit of NHIS to its subscribers.(mean score=4.32; stdv= 0.22). The respondents perceived healthcare to be cheaper with NHIS when compared to "cash and carry" system (mean score=4.62; stdv= 0.48). However, majority (63.9%) of the migrant female headporters who were NHIS subscribers disagreed that

NHIS provided quality healthcare to them, whilst 24.7% of them agreed that NHIS provided quality healthcare to them. The remaining 11.4% of the migrant female headporters remained undecided whether NHIS had provided quality healthcare to them or not. Therefore, migrant female headporters did not perceive NHIS to be providing quality healthcare to its subscribers (mean score = 2.43; stdv= 1.22).

Table 4.6: Migrant Female Headporters Perception of Importance of NHIS (n=498)

Statements	Strongly Disagreed	Disagreed	Undecided	Agreed	Strongly Agreed	Mean	STDV
It offers free healthcare	35 (7.0%)	89 (17.9%)	96 (19.3%)	152 (30.5%)	126 (25.3%)	3.49	1.54
No payment for drugs	0 (0.0%)	0 (0.0%)	119 (23.9%)	294 (59.0%)	85 (17.1%)	3.93	0.40
Free pregnant care	0 (0.0%)	0 (0.0%)	0 (0.0%)	337 (67.7%)	161 (32.3%)	4.32	0.22
Provides quality healthcare	121 (24.3%)	197 (39.6%)	57 (11.4%)	123 (24.7%)	0 (0.0%)	2.43	1.22
It is cheaper than "cash and Carry" health care	0 (0.0%)	0 (0.0%)	0 (0.0%)	187 (37.6%)	311 (62.4%)	4.62	0.48

Source: Field Data, 2014

The study further found out from the respondents who were not enrolled in NHIS whether they were willing to enroll in NHIS and the major reasons for not enrolling in NHIS, and the responses are summarized in Table 4.7. From Table 4.7, out of 167 respondents who were not

enrolled in NHIS at the time conducting the study, 82.6% were willing to enroll in NHIS whilst the remaining 17.4% were not willing to enroll in NHIS.

The Non-NHIS migrant female headporters subscribers cited many reasons for not enrolling in NHIS and the major one was high premium, followed by the introduction of NHIS Capitation in the Kumasi Metropolis, poor healthcare under NHIS, delay in issuance of NHIS cards and inaccessibility of NHIS offices (see Table 4.7).

Table 4.7: Enrollment of Migrant Female Headporters on the NHIS

Variables	Frequency	Percentage
Are you willing to enroll in NHIS? (n=167)		
Yes	138	82.6
No	29	17.4
Major reasons for not enrolling in NHIS (n=167)		
High premium	65	38.9
Capitation	43	25.7
Inaccessibility of NHIS office	11	6.6
Poor healthcare under NHIS	27	16.2
Delay in issuance of NHIS cards	21	12.6

Source: Field Data, 2014

The variables that influence migrant female headporters' enrollment in NHIS are presented in Table 4.8. The Chi-square was used to test for independence of the NHIS enrollment. The test was to show whether the enrollment in NHIS is independent of factors as educational level and income level of headporters and their level of knowledge on NHIS.

From Table 4.8, 40.9% of the migrant female headporters without formal education were not enrolled in NHIS whilst the remaining 59.1% were enrolled in NHIS. Also, 1.5% of the migrant female headporters with some level of formal education (basic education) were not enrolled in NHIS where as the remaining 98.5% were enrolled in NHIS.

Another characteristic considered was income level of the headporters. From Table 4.8, out of 74 headporters with monthly income below GH¢150, 17.6% of them were enrolled in NHIS whilst 82.4% were not enrolled in NHIS. Also, out of 372 headporters with monthly income between GH¢150 and GH¢200, 71.5% of them were enrolled in NHIS whilst 28.5% were not enrolled in NHIS. All the 219 headporters with monthly income between GH¢200 and GH¢300 were enrolled in NHIS.

With regards to level of knowledge, all the headporters who had high and very high level of knowledge on the scheme were enrolled whilst out of 84 headporters who had very low level of knowledge on the scheme, 86.9% were not enrolled whilst 13.1% were enrolled. From Table 4.8, both educational level, income level and level of knowledge on NHIS significantly influenced enrollment in NHIS. This suggests that headporters with high level of education, income and knowledge on NHIS were enrolled more than headporters with low level of education, income and level of knowledge on the scheme.

Table 4.8: Cross Tabulation of NHIS Enrollment and Characteristics of Migrant Female Headporters

Characteristics	Yes (n=498)	No (n=167)	Chi-sq.	P-value
Academic qualification (n=665)			**6.649**	**0.011**
No formal education (n=399)	236 (59.1%)	163 (40.9%)		
Basic education (n=266)	262 (98.5%)	4 (1.5%)		
Average monthly income (n=665)			**18.146**	**0.010**
Below 150 (n=74)	13 (17.6%)	61 (82.4%)		
Between 150 and 200 (n=372)	266(71.5%)	106 (28.5%)		
Between 200 and 300 (n=219)	219 (100.0%)	(0.0%)		
Awareness/ level of knowledge (n=665)			**256.281**	**0.000**
Very Low	11 (13.1%)	73 (86.9%)		
Low	237(71.6%)	96 (28.4%)		
High	143 (100.0%)	0 (0.0%)		
Very High	107 (100.0%)	0 (0.0%)		

Source: Field Data, 2014

4.5 Migrant Female Headporters Access to Healthcare

Access to healthcare among the migrant female headporters in the Kumasi Metropolis is shown in Table 4.9. All the respondents were aware of the various health centers in the Kumasi Metropolis but from Table 4.9, only 31.8% of them visited health facility at their first sign of sickness. Also, 35.6% of them visited chemical shop at their first sign of sickness, whilst the remaining 17.1% and 15.5% of them resorted to self medication and herbal medicine at their first sign of sickness. Moreover, out of the 665 respondents, majority (74.1%) indicated that they often visited health facility anytime they were sick whilst the remaining 25.9% did not often visit health facility anytime they were sick.

The respondents who were NHIS members were asked whether they had been seeking healthcare with their NHIS cards and 72.7% attested that they sought healthcare with their NHIS cards whilst the remaining 27.3% indicated otherwise. Out of 136 respondents who were NHIS members but had been visiting health facilities without their NHIS cards, majority (72.1%) of them indicated that they paid the medical bills themselves. The remaining 10.3% and 17.6% indicated that all medical bills were paid by husbands and family members respectively.

From Table 4.9, 58.3% of the respondents indicated that they lived close to a health facility whilst the remaining 41.7% indicated that they lived far away from health facility.

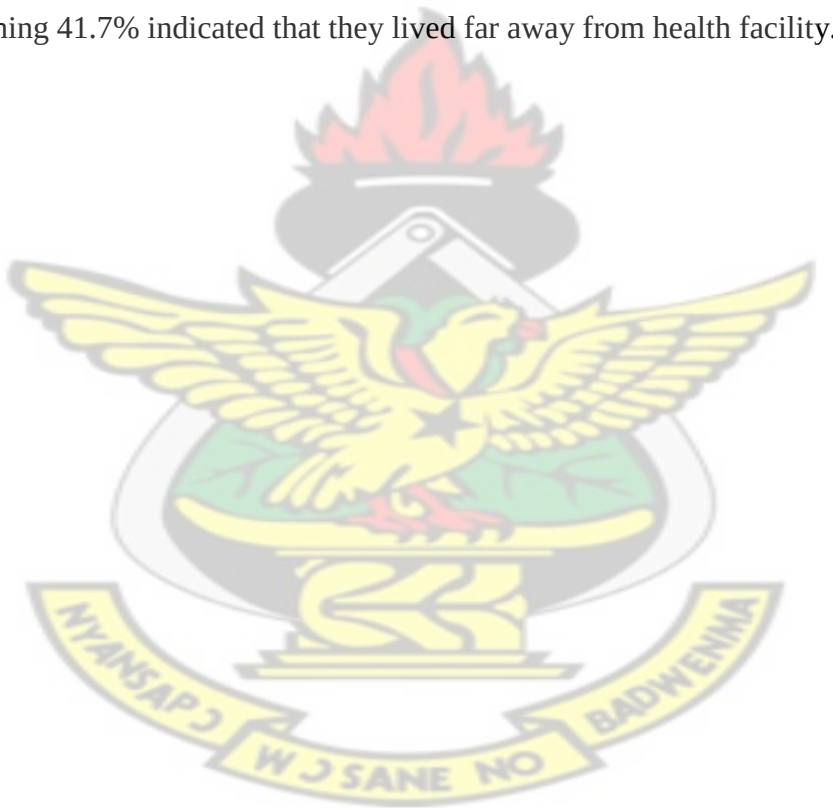


Table 4.9: Migrant Female Headporters Access to Healthcare

Variables	Frequency	Percentage
Where do you go first when sick? (n=665)		
Visit health facility	211	31.8
Visit chemical shop	237	35.6
Self-medication	114	17.1
Use traditional medicine	103	15.5
I often visit health facility any time I am sick (n=665)		
Strongly agreed	374	56.2
Agreed	119	17.9
Undecided	129	19.4
Disagreed	43	6.5
Do you attend health facility with NHIS card? (n=498)		
Yes	362	72.7
No	136	27.3
Who mostly pay for your healthcare cost? (n=136)		
Myself	98	72.1
My husband	14	10.3
My family	24	17.6
Do you live closer to a health facility? (n=665)		
Yes	388	58.3
No	277	41.7

Source: Field Data, 2014

The study further found out whether enrollment in NHIS increases access to healthcare among migrant female headporters in the Kumasi Metropolis and the responses are summarized in Table

4.10. The Chi-square was used to test for independence of the access to healthcare. The test was to show whether access to healthcare is independent of enrollment in NHIS. Out of 498 respondents who were enrolled in NHIS, 71.1%, 22.5% strongly agreed and agreed respectively that they often visited health facility anytime they were sick. The remaining 5.4% were undecided. Moreover, out of 167 respondents who were not enrolled in NHIS, majority (86.8%) disagreed that they often visited health facility anytime they were sick. The remaining 13.2% agreed that they often visited health facility anytime they were sick.

Access to healthcare is significantly influenced by enrollment in NHIS, and migrant female headporters who were enrolled in NHIS often visited health facility more often than those who were not NHIS subscribers (see Table 4.10).

Table 4.10: NHIS increases access to Healthcare among Migrant Female Headporters in the Kumasi Metropolis

Responses	**Are you enrolled in NHIS?**	
I often visit health facility Anytime I am sick	**Yes (498)**	**No (167)**
Strongly agreed	359 (72.1%)	15 (9.0%)
Agreed	112 (22.5%)	7 (4.2%)
Undecided	27 (5.4%)	102 (61.1%)
Disagreed	0 (0.0%)	43 (25.7%)
Chi-square = 437.845		P-value= 0.00

Source: Field Data, 2014

4.6 Challenges facing Female Migrants in Accessing Healthcare in the Kumasi Metropolis

Respondents were asked to indicate the extent of agreement and disagreement to some selected statements related to challenges facing healthcare delivery in the Kumasi Metropolis. (see Table 4.11). The study employed Likert Scale with high mean score (3.50-5.0) indicating challenge to access to healthcare whilst a low mean score (1-3.49) indicated otherwise.

The major challenge facing access to healthcare among migrant female headporters in the Kumasi Metropolis was finance (mean score =5.00; standard deviation= 0.000). This was followed by frequent strikes of medical staff (mean score= 4.80; standard deviation = 0.354). Shortage of drugs in health facilities was the third challenge to access to healthcare and traffic congestion was the fourth major challenge to healthcare delivery in the Kumasi Metropolis. Frequent light out was the fifth challenge to access to healthcare among the migrant female headporters in the Kumasi Metropolis. Non-functional equipments were not found to be a challenge to healthcare delivery in the Kumasi Metropolis (see Table 4.11).

Table 4.11: Challenges facing Access to Healthcare among Migrant Female Headporters in the Kumasi Metropolis

Statements	Undecided	Agreed	Strongly Agreed	Mean	STDV
Traffic congestion is a challenge to access to healthcare.	39 (5.9%)	412 (62.0%)	214 (32.1%)	4.26	0.311
Frequent light out is a challenge to access to healthcare.	72 (10.8%)	451(67.8%)	142 (21.4%)	4.11	0.312
Shortage of drugs is a challenge to access to healthcare.	143 (21.5%)	123 (18.5%)	399 (60.0%)	4.38	0.667
Non functional equipment is a challenge to access to healthcare.	373 (56.1%)	291 (43.9%)	0 (0.0%)	3.43	0.246
Frequent strikes is a challenge to access to healthcare.	0 (0.0%)	134 (21.5%)	531(78.5%)	4.80	0.354
Finance is a challenge to access to healthcare.	0 (0.0%)	0 (0.0%)	665 (100.0%)	5.00	0.000

Source: Field Data, 2014

The challenges to access to healthcare in the Kumasi Metropolis had made the migrant female headporters resort to different means of healthcare and this is shown in Table 4.12. All the respondents attested that, challenges to access to healthcare had made the migrant female headporters vulnerable to diseases in the Kumasi Metropolis and this was the major outcome of lack of access to healthcare delivery (mean score=4.81; standard deviation=0.153). Another major outcome of challenges to access to healthcare was self medication among migrant female headporters in the Kumasi Metropolis. Visitation to prayer camp for healthcare was not found to

be an outcome of the challenges confronting access to healthcare among migrant female headporters in the Metropolis (see Table 4.12).

Table 4.12: Inadequate Access to Healthcare makes Migrant Female headporters Vulnerable to Diseases in the Kumasi Metropolis.

Statements	Disagreed	Undecided	Agreed	Strongly Agreed	Mean	STDV
Poor access to healthcare increases self-medication among headporters.	31(4.7%)	68 (10.2%)	367(55.2%)	199 (29.9%)	4.00	0.590
Poor access to healthcare makes head porters more vulnerable to diseases.	0 (0.0%)	0(0.0%)	129 (19.4%)	536 (80.6%)	4.81	0.153
Poor access to healthcare makes headporters visit prayer camps for care.	141(21.2%)	258 (38.8%)	266 (40.0%)	0 (0.0%)	3.19	0.577

Source: Field Data, 2014

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

The National Health Insurance Scheme is a form of National health insurance established by the Government of Ghana, with a goal to provide equitable access and financial coverage for basic healthcare services to Ghanaians. Ghana established NHIS to enhance the performance of its health system, paying particular attention to the poor. The migrant female headporters are noted to be among the poor or less privileged group in Ghana and noted to be migrated from poverty prone region in Ghana (Northern Region). The study therefore looks at how the NHIS has benefited the migrant female headporters by specifically considering their level of knowledge on the scheme, their level of enrollment in the scheme and their access to healthcare in the Kumasi Metropolis.

5.2 Level of Knowledge of Migrant Female Headporters on the NHIS

Knowledge is power (Katibi, Akande and Akande, 2003) and the study sought for the level of knowledge of migrant female headporters on the NHIS in the Kumasi Metropolis. Katibi and others (2003) contended that the success of the implementation of the NHIS in Ghana, in particular would largely depend on how much information the prospective beneficiaries/consumers have regarding the scheme. Therefore for the NHIS to achieve its intended goal, Ghanaians, especially the poor must be well informed about the scheme. From the study, all the respondents attested that they had heard about NHIS, either through radio advertisements, NHIS representatives and friends or relatives. This clearly suggests that the level

of knowledge of NHIS among migrant female headporters was high in the Kumasi Metropolis. Greater awareness among the migrant female headporters' population concerning the NHIS scheme, especially with regards to its benefits to the insured, was crucial for migrant female headporters' enthusiasm for enrollment and active participation in NHIS in the Kumasi Metropolis.

This finding is consistent with the study by Adeniyi and Onajole (2010) conducted in Nigeria on "the knowledge and perception of Nigerian Dentists on the NHIS". A cross-sectional descriptive survey of 250 Dentists with a total of 216 dentists (response rate of 82.4%) was used and it revealed that 132 (61.1%) of the respondents had a fair knowledge of the NHIS, whilst22 (10.2%) and 62 (28.7%) had poor and good knowledge respectively. Majority of the dentists involved in this study had some knowledge of the NHIS and were generally positively disposed towards the scheme and viewed it as a good idea. Also a study by Sanusi and Awe (2009) in Ibadan, Oyo State, revealed that 87.4% of the respondents were aware of the scheme. On a different score, findings from a similar study by Sabitu and James, (2005) on "the knowledge of healthcare workers at National Orthopedic Hospital in Igbobi, Lagos" showed that all the respondents were aware of the scheme with 90% satisfaction level of its publicity.

The study sought for other ways of increasing awareness of the scheme among the migrant female headporters. This is of particular importance since the goal of the scheme is for all Ghanaians to enroll in the scheme. From the study, free registration of migrant female headporters on the scheme` had the highest mean score of 4.79 out of scale of 5, suggesting that the most effective way to increase migrant female headporters' awareness of the scheme was

through free registration. The study indicated that migrant female headporters had low income and therefore would appreciate and accept anything that was free, and the NHIS could use this as a means of wining the attention of the migrant female headporters. They further indicated that after they had enrolled and experienced the benefits of the scheme for the first time, they could appreciate the true benefits of the scheme and this could increase their level of knowledge and acceptance of the scheme.

It was also revealed that educational level of migrant female headporters significantly influenced the level of knowledge on NHIS but age and religion of the headporters did not significantly influence headporters' level of knowledge on NHIS. The findings to some extent is consistent with the study carried out by Katibi, Akande and Akande (2003). A study conducted by Katibi, Akande and Akande, (2003) on "Awareness and attitude of medical practitioners in Ilorin towards the National Health Insurance Scheme", with a cross-sectional descriptive study design and with a sample of 150 adults from the Local Government Areas (LGAs) were selected for the study and it revealed that respondents' knowledge of NHIS did not differ significantly by age, sex, ethnicity, marital status, educational level, or occupation. The Katibi, Akande and Akande (2003) study focused on medical practitioners where all the respondents had higher level of education, but in this present study, some of the headporters had no formal education, and this explains the differences in the outcome of the two studies; on the influence of education on the level of knowledge of respondents on NHIS.

5.3 Prevalence of Migrant Female Headporters Enrollment in NHIS

Ghana's NHIS established and implemented as a "pro-poor" method of health financing, has made a great progress in enrollment of members of the general population. Jones and others (2008) indicated that the scheme has over 9 million enrollees representing 45% of the total population of Ghana. Act 650 that establishes NHIS requires all Ghanaians to enroll in the NHIS or in another health insurance plan. Specifically, Section 31 of Act 650 requires a person resident in Ghana other than a member of the Armed Forces of Ghana and the Police Service shall belong to a health insurance scheme licensed under this Act. Again the Act requires a person resident in a district, who is not a member of a private health insurance scheme or any other district scheme registered under this Act, to apply to be enrolled as a member of the District Mutual Health Insurance Scheme (DMHIS) in the relevant district.

Though all the respondents had heard about NHIS, only (74.9%) of the migrant female headporters in the Kumasi Metropolis were enrolled in NHIS, whilst 25.1% had never enrolled in NHIS. It was revealed from the study that migrant female headporters enrolled in the NHIS understood the benefits related to the NHIS and were ready to take advantage of them. To them NHIS provided free healthcare and an opportunity to visit health facility at any time, whether one had money or not. They perceived NHIS as a good scheme for them. Some (25.1%) of the migrant female headporters had never enrolled in the scheme because there is no penalty for failing to enroll, and individuals or households are not automatically enrolled. The migrant female headporters generally must go in-person to a DMHIS office, complete registration paperwork (often after waiting a substantial amount of time), and pay a small registration fee

meant to cover the photo ID and administrative expenses of registration. They therefore saw the enrollment in the scheme as voluntary.

However, it was revealed from the study that a sizeable number (42.4% of the migrant female headporters enrolled in NHIS) had their NHIS cards expired at the time of conducting the study and 47.6% of the headporters enrolled in NHIS could not renew their NHIS cards annually. The headporters in this category indicated high premium and the introduction of capitation as reasons for non renewal of NHIS cards. They indicated that the present premium ranging between "GH¢7.2-GH¢48" is high for them to afford. This presents a serious challenge to the NHIS, since high dropout rate undermines the sustainability of the scheme.

5.3.1 Enrollment in NHIS and Characteristics of Migrant Female Headporters

The level of educational attainment and income level influence enrollment in NHIS. From the study it was revealed that migrant female headporters with some level of formal education were more enrolled in NHIS than those without any formal education. Education enlightens people and helps people to read and write thereby increasing the understanding of people. Understanding and appreciation of any policy increases the acceptance of that policy. The headporters with some level of education were more able to understand the content of advertisement on NHIS than those without any formal education and the educated migrant female headporters were more enrolled in NHIS.

From the study, income level influenced migrant female headporters enrollment in NHIS, as those with higher income were more enrolled than those with little income. The enrollment in NHIS comes with a cost, which is the payment of premium and an annual renewal of the policy. Migrant female headporters with higher income (monthly income between GH¢200 and GH¢300) were able to afford the premium than those with lower income (monthly income below GH¢150).

The findings of the study is consistent with a study by Fink and Osei-Akoto (2012) which indicates that people with higher educational levels were the highest enrollees in NHIS. USAID Report (2009) on the topic "An evaluation of the effects of the NHIS in Ghana'' was in support of this assertion and revealed that wealth was strongly associated with enrollment in NHIS. In a household sample, about half of the individuals in the richest wealth quintile were insured under NHIS, compared to less than one-fifth of individuals in the poorest quintile. A similar pattern was observed in the patient exit survey data, where NHIS coverage also increased with wealth quintile: While 35% of the patients in the poorest wealth quintile were insured, twice as many in the richest quintile were insured. A study by WIEGO (2012) on "The Ghana National Health Insurance Scheme-Assessing Access by Informal Workers" revealed that there were a number of barriers which meant that majority of the informal workers were not NHIS members(32 out of 40) as a result of high cost of premium. This was far out of reach for many of the poorest workers, particularly rural migrants such as the "Kayayei" who on average earned just over $1 a day (WIEGO, 2012).

5.4 Migrant Female Headporters Access to Healthcare

All the respondents attested that they were aware of the various health centers in the Kumasi Metropolis but 31.8% of them visited health facility at their first sign of sickness. A sizable number (35.6%) of them visited chemical shops at their first sign of sickness, whilst the remaining 17.1% and 15.5% of them resorted to self medication and herbal medicine at their first sign of sickness. This creates great concern as to why a good number (68.2%) of migrant female headporters were not attending health facility for healthcare at their first sign of sickness. This may suggest that the introduction of NHIS had not entirely removed barriers to access to healthcare in the Metropolis.

Moreover, 27.3% of NHIS members visited health facility without NHIS cards and preferred to be treated as non-NHIS members. This group of migrant female headporters had the perception that those who were willing to pay for healthcare received better and quicker services than those under NHIS.

The hypothesis that enrollment in NHIS increases access to healthcare among migrant female headporters in the Kumasi Metropolis was accepted and this indicated that migrant female headporters who were enrolled with the scheme had more access to healthcare than the non-enrollees.

5.5 Challenges to Healthcare Delivery in the Kumasi Metropolis

It is a fact of life that seeking healthcare involves challenges (Mandersheid, 2013). Majority of immigrants who face various obstacles in access to healthcare services are women. From the study, the migrant female headporters faced a number of challenges in accessing healthcare. The major challenge facing the migrant female headporters was financial consideration. The respondents indicated that, though some of them had valid NHIS cards, they paid some fees at the point of receiving healthcare and this in their opinion suggested that healthcare was not free under NHIS. They further indicated that some had difficulty of paying for the NHIS premium and thereby were not able to renew their NHIS cards to enable them access healthcare.

This is consistent with the notion of Mandersheid (2013). According to Mandershield (2013) having insurance is not itself sufficient "to open the door" to healthcare because the insurance benefits may not cover, or adequately cover, certain health services. Thus the challenge of having access to healthcare can be limited by the amount and scope of coverage, as well as by the costs that one must pay. Ghana's NHIS (including all DMHIS's) has a single benefit package that is set by Legislative Instrument 1809 and described by the NHIA as covering "95% of disease conditions" that afflict Ghanaians whilst the package excludes some very expensive procedures such as certain surgeries, cancer treatments (other than breast and cervical cancer), organ transplants, and dialysis; non-vital services such as cosmetic surgery; and some high profile items such as HIV antiretroviral drugs (which are heavily subsidized by the separate National AIDS Program)(CDCP, 2011). A study carried out by GOI (2010) revealed that an increase in the absolute number of persons unable to seek healthcare was due to financial reasons. In the study, about 40% of the hospitalized had to borrow money or sell assets during

the decade 1986–96. Around 24% of all people hospitalized in India in a single year fell below the poverty line due to hospitalization. An analysis of financing of hospitalization showed that a large proportion of people, especially those in the bottom four-income quintiles borrow money or sell assets to pay for hospitalization (World Bank, 2002).

Another important challenge to access to healthcare in the view of the respondents was frequent strikes of medical staff and shortage of drugs. They indicated that strikes of medical staff were rampant in Kumasi and they sometimes went to hospital without being attended to by a medical doctor or a nurse or pharmacist due to strikes. They further indicated that medical staff were not many and strikes worsened the situation, and the poor and the sick migrant female headporters suffered the consequences. These challenges are service or provider-related problems. In agreement to this assertion, GOI (2010) argued that access to healthcare could be limited by dysfunctional physical infrastructure, lack of adequate human capital. They were of the opinion that healthcare system goals are all about cost efficient, quality, access and patient centric. Therefore, if there is inefficient public healthcare system, buildings in a dilapidated condition, lack of electricity, lack of drugs and essential supplies, non-functional equipments, shortage of medical manpower etc challenges to access to healthcare would abound.

Distance-related challenges may also be one of the problems in healthcare (Mandersheid, 2013) and the study found that huge traffic congestion in the metropolis was the third significant challenge to healthcare delivery. In the view of Mandershield (2013), if distances are not bridged; costs of travel are not held down; and facilities are not physically accessible to individuals, then healthcare will be denied.

The outcome of the challenges confronting healthcare delivery in the Metropolis had made migrant female headporters more vulnerable to diseases since they could not afford services of private healthcare providers. The migrant female headporters had therefore resorted to self medication as a replacement of services provided by healthcare providers in the Metropolis.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

The migrant female headporters in Ghana has been described as feminizing (Adepoju, 2004), and many of these female migrants (in the informal sector) has been described as poor. Thus, they face many barriers to access to healthcare in the Metropolis. The NHIS was introduced to remove the major barrier (financial barrier) among the poor and increase access to healthcare. The study therefore assesses migrant female headporters enrollment in NHIS and their access to healthcare in the Kumasi Metropolis.

6.1 Conclusions

6.1.1 Level of Knowledge of Migrant Female Headporters on the NHIS

It can be concluded from the study that migrant female headporters had some level of knowledge about the NHIS in the Kumasi Metropolis. The majority of the migrant female headporters heard about NHIS through radio advertisement from various FM stations.

The study further found that NHIS could catch the attention and increase the level of knowledge of migrant female headporters about NHIS through free NHIS registration of migrant female headporters.

6.1.2 Prevalence of Migrant Female Headporters Enrollment in NHIS

It can be concluded from the study that not all migrant female headporters in the Kumasi Metropolis were enrolled in NHIS and 17.4% of the non- subscribers had made up their minds not to enroll in the scheme. Moreover, it was revealed from the study that a sizeable number

(42.4% of migrant female headporters enrolled in NHIS) had their NHIS cards expired at the time of conducting the study and 47.6% of the headporters enrolled in NHIS did not renew their NHIS cards annually.

It can be concluded from the study that migrant female headporters with formal education (basic education) were more enrolled in NHIS than those without any formal education. The study also found that migrant female headporters with higher income were more enrolled in NHIS than those with lower income.

6.1.3 Migrant Female Headporters Access to Healthcare

It can be concluded from the study that all the migrant female headporters were aware of the various health centers in the Kumasi Metropolis but a sizable number (68.2%) did not visit health facility at their first sign of sickness.

Moreover, it can be concluded that 27.3% of NHIS members visited health facility without NHIS cards and preferred to be treated as non-NHIS members. The study found that NHIS had increased access to healthcare among the migrant female headporters in the Kumasi Metropolis.

6.1.4 Challenges to Healthcare Delivery in the Kumasi Metropolis

The study found that the major challenge facing the migrant female headporters in accessing healthcare was financial consideration. This was followed by frequent strikes of medical staff and shortage of drugs and huge traffic congestion in the Kumasi Metropolis.

6.2 Recommendations

Based on the outcome of the study, the following recommendations are made to key stakeholders to improve migrant female headporters' enrollment in the NHIS and improve access to healthcare in the Kumasi Metropolis.

National Health Insurance Authority

1. The Authority should intensify their education on NHIS so that migrant female headporters can understand the benefits associated with the scheme.
2. The right channel of communication and advertisement should be used by the scheme especially the use of radio and information centers at the communities as migrant female headporters listen to them most often.
3. The NHIA should use the right medium of communication especially the various Ghanaian dialects as they can be easily understood by Ghanaians of which migrant female headporters are a part.
4. NHIA should expand their outlets so that it can be easily accessible by all, especially the migrant female headporters.

5. The authority should conduct free NHIS registration for all migrant female headporters to enable them first appreciate and accept the actual benefits of the scheme.
6. The authority should work towards improving the healthcare delivery system under the scheme since migrant female headporters expect healthcare which is both affordable and quality care. The affordable and quality care under the scheme would enable more migrant female headporters to enroll in the scheme.
7. The authority should consider the poor, migrant female headporters when designing the premium as the current premium serves as a barrier for their enrollment in the scheme. The authority if possible should review the current premium or design a new one taking the poor migrant female headporters into consideration.

Migrant Female Headporters

1. It is recommended that migrant female headporters should be educated on the importance of seeking healthcare with their valid NHIS cards since healthcare under NHIS is more affordable than "cash and carry".
2. It is recommended that migrant female headporters should be educated to visit health facilities for healthcare at their first sign and at each stage of sickness.

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APPENDIX 1

QUESTIONNAIRE FOR MIGRANT FEMALE HEADPORTERS

Good morning/afternoon. I am a student at the School of Medical Sciences, KNUST. I will be conducting several meetings with people like you in the Central Business District of Kumasi metropolis to find out your views and ideas about "The migrant female headporters enrollment in NHIS and their access to healthcare at the Central Business District of Kumasi**".** Your opinions are highly essential at the same time vital as they will help us to improve the kind of service the health sector provides. Whatever you say will be treated confidential, so feel at ease to express your candid opinion**.** Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by indicating a tick or writing the appropriate answer when needed. **THANK YOU.**

Questionnaire number:

Date of Interview:

Place of Interview/ Name of community:

1. Adum Shopping area[ ] 2. Asafo Market [ ] 3.Kejetia [ ]4.Bantama Market[ ]5. Kumasi Central Market [ ]

SECTION A: BACKGROUND CHARACTERISTICS

1. Age……

2. Religion: 1= Christian [ ] 2= Moslem [ ] 3= Traditionalist [ ] 4= Other [ ]

3. Please indicate your highest academic qualification: 1= None [ ] 2= Pre-school level [ ] 3= primary level [ ] 4 = JHS [ ] 5= SHS/ Middle Level [ ] 6= any other [ ]

4. Residence: 1= living with friends/ relatives [ ] 2= tenant [ ]

5. Monthly income level: 1= below GH¢50 [ ] 2= between Gh¢150 and Gh¢200 [ ] 3= between Gh¢200 and Gh¢250 [ ] 4= between Gh¢250 and Gh¢300 [ ]

SECTION B: KNOWLEDGE LEVEL OF MIGRANT FEMALEHEADPORTERS ON THE NHIS

8. Have you ever heard about the NHIS? Or Are you aware about the existance of NHIS?

1= Yes [ ] 2= No [ ]

9. If yes, how often do you hear about it?***(Please tick the one that applies***): 1= every day [ ] 2= every week [ ] 3= once a month [ ] 4= every 2-3 months [ ] 5= once a year [ ] 6= other, please specify …….....

10. Where did you get the information on NHIS from?: 1= Television [ ] 2= Radio/ FM station [ ] 3= NHIS Representative [ ] 4= Friends/ Family [ ]

11. Did you understand the content of the information on NHIS that you heard? 1= Yes [ ] 2= No [ ]

12. What other ways can NHIS increase the level of knowledge among the migrant female headporters?

……

……

……

(STRONGLY AGREE=1 AGREE=2 DON'T KNOW=3 DISAGREE=4 STRONGLY DISAGREE=5)(Please tick the one that applies)

Statement	**1**	**2**	**3**	**4**	**5**
Organization of durbar					
Free NHIS registration					
Distribution of leaflet					
Distribution of bags with picture of activities of NHIS					

SECTION C: PREVALENCE OF MIGRANT FEMALE HEADPORTERS ENROLLEMENT IN NHIS

13. Are you enrolled in NHIS?

1= Yes [ ] 2=No [ ]

14. If **Yes**, how much did you pay?I paid Gh¢ .....

15. If **Yes**, do you think what was paid was expensive?

1=Yes [ ] 2= No [ ]

14. If **No**, what are the top three (3) reasons that made you unable to enroll in NHIS? ***(Please tick the one that applies***): 1= Lack of money [ ] 2= Because of the capitation system [ ] 3= Ineffective systems and processes in some health facilities [ ] 4= Lack of proper healthcare at the health facilities[] 5= Any other (please specify), in case there are other reasons apart from those mentioned above. ....
.....

15. If No, do you wish to enroll? 1= Yes[ ] 2= No [ ]

16. Do you think NHIS is important at all?

2=Yes [ ] 2=No [ ]

17. Rate the steps in terms of importance of NHIS that you were informed.

(STRONGLY AGREE=1 AGREE=2 DON'T KNOW=3 DISAGREE=4 STRONGLY DISAGREE=5)(Please tick the one that applies)

Statement	**1**	**2**	**3**	**4**	**5**
NHIS offers free healthcare					
There is no payment for drugs with NHIS					
NHIS offers free pregnant care					
NHIS provides quality healthcare					
NHIS is cheaper than "cash and carry" healthcare					

SECTION D: MIGRANT FEMALE HEADPORTERS ACCESS TO HEALTHCARE AND THEIR CHALLENGES IN THE CENTRAL BUSINESS DISTRICT OF KUMASI

18. Where do you usually go when you are sick? ***(Please tick the one that applies***)

1=Health facility [ ] 2= chemical shop [ ] 3=pharmacy shop [ ] 4=prayer centre [ ] 5= herbal center [ ]

19. If you are an NHIS enrollee(when sick) and you usually visit health facility, do you go with your NHIS card?

1=Yes [ ] 2= No [ ]

20. If you are an NHIS enrollee(when sick) and you usually visit health facility, do you pay for some medications?

1= Yes [ ] 2=No [ ]

21. If **YES**, how do you pay for the medications?

1=myself [ ] 2=friends [ ] 3= husband [ ] 4= relatives [ ]

22. Do you live closer to a health facility? 1= Yes [ ] 2= No [ ]

23. What are the challenges in NHIS enrollment? ***(Please tick the one(s) that apply***)

1= Difficulty when getting referrals to a hospital [ ] 2= Difficulty after being referred to a hospital [ ] 3=High cost of premium 4= Lack of proper healthcare at the health facilities [ ] 5= lack of interpreter for healthcare services (language barriers) [ ] 6= stigma attached to certain diseases [ ]

24. What are the challenges in access to healthcare? ***(Please tick the one(s) that apply***): 1= lack of proper road [ ] 2= unreliable electricity [ ]

3= lack of drugs [ ] 4=non-functional equipments [ ] 5= shortage of medical manpower [ ] 6= poor healthcare financing [ ]

25 How do these mentioned challenges affect provision of healthcare? 1= poor service delivery [ ] 2= improper patient care [ ] 3= neglect of patient [ ] 4= disrupts of work routine [ ] 5= others, specify ……...

THANK YOU FOR YOUR TIME