Understanding the Influence of Ghanaian Women's Migration Patterns on Access to Health Care

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Research Article

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Abstract

Background: In recent years, there has been a noted increase in migration rates with trends marking a rise in women seeking relocation as means to access employment or academic opportunities; this growth is referred to as the feminization of migration. Migration stimulates female empowerment, increases access to financial opportunities, and promotes cultural diversity; all while simultaneously exposing women to detrimental conditions that impose risks to their physical and psychological well-being. Health is a fundamental human right that female migrants often get deprived of due to various social, cultural, political and economic factors in the destination region. These factors catalyze inhabitable environments in which migrant women are further exposed to harm, stimulating their status as vulnerable populations.

Methods: We performed a secondary analysis to explore how the social determinants of health, specifically socioeconomic status, culture, and education impact health outcomes and health care access of Ghanaian women who migrated internally within Ghana or externally to Canada. Fourteen interview transcripts, seven from each primary study dataset, were analyzed using thematic analysis and an intersectionality approach. Ethical approval was received for the primary studies and our secondary analysis via the Ethics Review Board at the University of Alberta, Canada.

Results: Ghanaian female migrants experienced varying obstacles in terms of accessing health care services. The barriers were identified as cultural, financial, social, and lack of health insurance. Ghanaian women's health outcomes were influenced by the conditions surrounding their migration including working conditions, separation from family, altered social support systems, and financial constraints.

Conclusion: Areas requiring further research and development were identified by assessing migrants' social determinants of health in the destination country and the associated-barriers in accessing health services. We hope our findings will serve as a foundation for improving health outcomes for female migrant populations and support health care professionals' practice of cultural competence.

Background

The World Health Organization[1] reported approximately 763 million internal migrants and 258 million international migrants in 2019. According to the 2016 Canadian Census, 7.5 million foreign-born people entered Canada through the immigration process from 2011 to 2016[2]. During this time, there were 2 690 immigrants from Ghana to Canada, with 24.7% residing in Alberta[3]. Alberta holds the highest number of Ghanaian economic immigrants in comparison to the rest of Canada[3]. Female migrants accounted for 47.8% of international migrants from sub-Saharan Africa[4]. There is a significant development of the feminization of migration; the International Labor states that 50% of the global migrant population consists of women[5].

Migration, whether internal or external, presents women with means to enhance quality of life and economic well-being of their family unit, alter conventional gender norms, and improve autonomy. Education is positively correlated with female empowerment as it promotes development of confidence and competencies that assist women in independent decision-making regarding their health[6]. Women's access to education has a significant impact on their employability and the health outcomes of their family unit[7]. The Participatory Poverty Assessment (PPA) carried out in Ninh Thuan, Vietnam concluded job availability and improved wages as underlying factors in participants' decision to migrate[8]. Previous studies in Ghana, Rwanda, Uganda, Turkey, Bangladesh, and Thailand concluded that household wealth as a key determinant of health[6]. The theory of social gradients in health postulates that health inequities are a direct result of individuals' socioeconomic conditions differences[9]. There is a linear relationship between individuals' low socioeconomic status and higher rates of ill-health. This emphasizes the importance of bridging socio-economic gaps to improve health conditions globally[10].

Adongo and Asaarik[11] emphasize how community ideals and attitudes regarding health and illness impact the utilization of health services of its inhabitants. Previous research demonstrates a notable account of health care underutilization amongst minority ethnic groups in comparison to those within the dominant culture of the destination country[12]. Social, financial, and cultural adversities presented by the destination country will increase health disparities encountered by vulnerable female migrants. Impaired access to health care services, cultural and linguistic barriers, and differences in conceptualization of health and illness have resulted in inadequate health care delivery, delay in health care seeking behaviors, and negative health outcomes for individuals[13]. With increasing global migration rates, evaluating the impact of external factors on migrants' health behaviors and their access to health care services is of critical importance; these factors include social and cultural integration barriers, low socioeconomic status, discrimination, acculturation stress, lifestyle changes, and lack of social support networks[14].

Aim of the Research

In sub-Saharan Africa, there is insufficient research regarding the intersection between socioeconomic status and access to health care. The purpose is to explore how the social determinants of health impact health outcomes and health care access of Ghanaian women who have migrated internally in Ghana or externally to Canada.

Methodology

We employed a secondary analysis which consisted of examining data, collected by someone else, to answer questions different from those posed by the primary study[15]. We analysed unexplored concepts gathered from the existing data of two primary focused ethnographic studies; Study A conducted by Richter, Vallianatos, and Toosi (2017-2020) and Study B conducted by Vallianatos, Richter, Ansu Kyeremeh, and Aniteye (2014-2015). For more details on the primary studies, see Table 1. The purpose of this study is not to compare the two participant groups, as we acknowledge the distinction in their socio-cultural, economical, and environmental circumstances.

Table 1: ***Primary Study Details***

	Study A Richter, S., Vallianatos, H., & Toosi, A. (2017-2020). *Intersection of place, social relations, gender, culture on health of female immigrants to Canada.*	Study B Vallianatos, H., Richter, S., Ansu Kyeremeh, K., & Aniteye, P. (2014-2015). *Gender, Health and Place. A Multi-site Ethnographic of women's Experiences and Perceptions of Health, Culture and Place in Ghana.*
Purpose	The purpose was to explore the intersection of place, social connectedness, income, culture and physical, mental and social health of economic female migrants to Canada and how this determines health and access to health care.	The purpose was to examine how women who have migrated to Accra, the capital city of Ghana, understood health and how this shaped their health behaviors for their own self-care, and secondarily that of their children's wellness. Furthermore, the research investigates how place and culture intersect and shape health beliefs and practices, while considering social, political, economic, and physical aspects of the local milieu.
Setting	This research was conducted in Edmonton, Alberta, Canada. The sampling approach utilized by Richter, et al. (2017-2020) to recruit participants was purposive and snowball sampling.	The setting for the study was Accra, the capital city of Ghana. Vallianatos, et al. (2014-2015) relied on snowball sampling to achieve the desired sample size.
Inclusion Criteria	Inclusion criteria consisted of low socio-economic status female migrants from Ghana (low-middle income), Nigeria (low-middle income), and South Africa (middle-high income) that had migrated during 2007-2017 to Canada, classified as economic class, were willing to participate, and between the age of 20-60 years of age.	The sole inclusion criteria for this study were women that moved independently, without their family, from the Northern region in Ghana to work in the market in Accra.

We applied the intersectionality approach to our theoretical framework for the study; intersectionality refers to the interactions between categories, such as race, gender, institutional arrangements, cultural ideologies and outcomes, and other aspects that formulate an individual's life[16]. This approach centralizes its focus on individuals with different historical backgrounds and experiences of marginalization; in our study we addressed females migrating within Ghana and to Canada and explored their unique experiences with adversity.

Setting and Sampling

The secondary analysis methodology allowed for the utilization of datasets from the primary studies; we selected a subsample of 14 interviews, seven from each primary study. Our inclusion criteria consisted of interviews with a duration of at least one hour, individuals who were able to articulate well, and interviews conducted by various members of the primary research teams.

Data Collection and Framework of Analysis

Both in Study A and B, a focused ethnography design was employed that allowed for comprehensive data collection methods. The semi-structured narrative interviews introduced detailed concepts related to our research questions. The majority of the interviews were conducted in English and the remaining were translated from Twi, one of the 9 official government-recognized languages in Ghana. The participants were allowed to have the interview directed in the language of choice which was transcribed verbatim by local researchers to maintain accuracy.

Data cleansing and back translation were performed in the primary studies to confirm accuracy of the data. The translations were reviewed by Ghanaian researchers, to assess for quality and credibility.

The data obtained in the original two studies were utilized for the secondary analysis; we conducted thematic content analysis[17]. Our team had access to the verbatim transcriptions and English translations of the 14 digitally recorded interviews. We performed in-depth readings of all the selected interviews and reviewed the non-translated audio recordings to assess participants' emotions. Through thematic analysis, we created a coding framework for the participant interviews. Initial codes were formulated via a line-by-line analysis of the transcripts and the transcribed data was further examined for patterns. Categories were developed from a comparative analysis of the codes which facilitated the identification of themes emerging from the selected participant transcripts. We incorporated investigator triangulation by utilizing two individuals from the research team to code the data and make analysis decisions; by collaborating in our efforts, we "reduce[d] the possibility of biased decisions and idiosyncratic interpretations"[18]. Furthermore, we improved the data analysis process by interacting with the research team and accessing a compilation of skills, expertise, and diverse perspectives.

Ethics

Ethical approval was obtained from the Research Ethics Review Board at the University of Alberta, Canada for our secondary analysis [Pro00097128]; both Study A conducted by Richter, Vallianatos, and Toosi (2017-2020) [Pro00075943] and Study B conducted by Vallianatos, Richter, Ansu Kyeremeh, and Aniteye (2014-2015) [Pro00049130_REN1] have received ethical approval. Informed consent has been previously obtained from participants of both studies. Secondary analysis presents no anticipated risk of discomfort or harm to the participants[19]. The audio files and transcripts utilized for our research were not fully de-identified; we eliminated identifying information and accessed all data through a secure server to maintain participant confidentiality.

Rigor

If researchers do not participate in collecting data, the chances of a dataset clearly addressing the research questions in a secondary analysis is low. Trustworthiness can be affected by the use of previously collected data, as it is possible that the findings do not accurately reflect the participants' viewpoints and are influenced by the researchers' perceptions; this also affects the transferability of the findings[18]. The University of Alberta's Memorandum of Understanding with the University of Ghana allowed for discussion and feedback about emerging interpretations with Ghanaian scholars as a form of member checking. Obtaining their feedback on the preliminary findings via virtual platforms allowed for the integration of their perspectives in the data interpretation. The Ghanaian scholars assessed and validated whether our team's thematic analysis was an accurate representation of the participants' realities[18].

We individually maintained a reflexive journal to continuously record our perceptions of how prior experiences and knowledge affected our inquiry. Additionally, we identified our personal biases that could interfere with the data analysis process, in an attempt to account for reflexivity; see Table 2. Ongoing debriefing, involving external validation with the intent to review aspects of the study, occurred with our research team. This exposed us to academics experienced with the phenomenon being analyzed, methods of constructivist inquiry, or both[18].

Table 2: ***Identifying Our Personal Biases***

● Prior to initiating the research process, we identified our own biases and examined our preconceptions that could potentially influence the research. We are first-generation immigrants to Canada, therefore, are able to relate to certain aspects of the research discussions; with this at the forefront we are able to discern our lived experiences from those of the migrants. The main drive for our migration to Canada was safety, aspirations for higher educational prospects in a higher income country and aiming to live in a culturally inclusive environment.
● Performing a secondary analysis on two ethnographic studies and analyzing individuals' lived experiences calls for the identification for our emic and etic perspectives.
● Our emic perspective: we identify ourselves as female, first generation migrants who potentially experienced similar adjustments when moving to a new country. We discussed the distinctions between the local culture and our challenging experiences with accessing health care services.
● Our etic perspective: includes our proficiency in the English language, not migrating independently, and receiving constant familial support throughout the migration process. We are of different ethnic backgrounds than the participants, are both receiving higher education, and with this study being a secondary analysis, we are not the primary investigators who conducted the interviews.

Findings

Five themes were identified from the participant interviews: influence of migration on health outcomes, barriers in accessing health services, level of formal education and health knowledge, influence of socioeconomic status on accessing health services, and cultural beliefs and perceptions towards migration. To maintain participant confidentiality, quotes were assigned pseudonyms as identifiers; data from participants is presented under each thematic category, with findings from internal migrants discussed first followed by external migrants. The findings are presented under their corresponding themes, view Table 3 for details on the coding framework.

Table 3: *Themes and Sub-themes Identified in the Coding Framework*

Themes	Sub-themes
Influence of Migration on Health Outcomes	Altered Working Conditions Decline in Health Resulting from Occupational Hazards Transportation Influence of Migration to Canada on Health Lack of Social Support Systems Effects of Leaving Family Members Behind
Level of Formal Education and Health Knowledge	Level of Formal Education Sources of Health Knowledge
Influence of Socioeconomic Status on Accessing Health Care Services	Income, Employment, and Expenses Health Insurance Financial Constraints Societal Perceptions Regarding Remittances
Cultural Beliefs and Perceptions towards Migration	Influence of Gender on Migrant Health Gender Barriers in Accessing Health Services Utilization of Herbal Medicine Cultural Shifts Upon Arriving to the Destination Region

Demographic Factors

The demographics of both sample groups consisted of all female participants with disclosed ages ranging from 25 to 66 years of age. All family units discussed in the interviews were large in size and encompassed both direct and distant family members. We noted that the women, both in Ghana and Canada, who willingly discussed their marital status were all in heterosexual relationships. Most participants in Study A, who shared their education status, completed their highschool education, and certain women had pursued higher education. The participants in Study B, who disclosed details regarding formal education, did not complete their highschool education and were illiterate. In addition to this inference, the majority of the mothers interviewed had experienced separation from their children as a result of migration.

Influence of Migration on Health Outcomes

Factors surrounding migration were divided into the following sub-themes: altered working conditions, decline in health resulting from occupational hazards, transportation, influence of migration to Canada on health, lack of social support systems, and effects of leaving family members behind.

Altered Working Conditions

The participants pursuing employment opportunities in Accra shared their arduous working conditions. Adoma described her daily work routine, which the translator communicated as: "*Approximately they spend about 12 hours in the market because they leave the house by 6 am and close from the market between 5-6 pm*". Adoma further discussed the difficulty of working in the markets while caring for their children: "*carry*[ing] [her] *baby along when* [she] *was working in the markets … when the baby gets hungry* [she] *take*[s] *food to him*".

External migrants described the employment opportunities in Canada and shared their work experiences. A participant described the difficulty experienced with balancing school and work; she stated having "*had three jobs*" and feeling "*so tired that after* [her] *first class like* [she would] *have to sleep a bit at the library … before* [she] *could go for* [the] *next class*" (Akyea). Another participant shared a similar experience: "*Working and schooling was quite difficult. I tried working somewhere … and I stopped because when … I go to work for one day, I sleep for like three days. It was quite tough*" (Setor).

Decline in Health Resulting from Occupational Hazards

Internal migrants in Accra discussed the impact of seeking employment in the markets. The health consequences suffered were a result of the physical strain caused by lifting heavy goods for an extended period; a participant stated, "*I often get sick here, I get headaches, coughs general body pains which is as a result of the loads*" (Mawusi). Another participant concluded similar health concerns associated with working in the markets, she stated: "*When you carry the things you will feel pains all over your body … Normally it comes at the chest and then to the shoulders and the whole body*" (Serwaa). She discussed her other occupation of working as a cook and described the further exposure to health concerns: "*If we are cooking and the smoke enter them it can cause diseases but they have no choice so we have to do it … The heat and the smoke is not good for their health*" (Serwaa). A participant described the health concerns associated with working and the additional responsibility of caring for her child: "*I have reduced in size a bit. I think this is because of my child. Unless somebody takes her from me otherwise I will have to put her behind my back and carry the goods*" (Asor). External migrants in Canada did not share concerns regarding the occupational hazards surrounding their workplace and its impact on their health.

Transportation

Internal migrants encountered physical barriers when attempting to access health care services; a participant stated, "*my place to the doctor is very far*" when asked why she did not go to the hospital to deliver (Adoma). Another participant described the challenges transportation presented: "*If I have a little money that can cater for my transportation, I will go there for them to treat me and sometimes some of my relatives too can help me so that I can go to the hospital*" (Serwaa). In Canada, external migrants described difficulties with navigating a new transportation system; this is highlighted by one participant's statement "*I didn't know how to even go to the hospital*" (Twumwaa).

Influence of Migration to Canada on Health

External migrants shared their perspective on the Canadian health care system and elaborated on the impact of migration on various aspects of health. Some participants reported improved health outcomes following their migration:

There's more focus on health here than there is in Ghana … For instance things like PAP smear and it wasn't there … but here it's part of your routine. So that's why a lot of people by the time they realize they have an illness it's too late. (Korkor)

Another participant shared her experience with the health care systems in both countries: "*The doctors there* [Ghana]*, anytime I'm sick like I could remember the number of times I was admitted at a hospital, but here* [Canada] *no, I wasn't*" (Akyea). Some women reported a decline in overall health following their migration to Canada. A participant elaborated on the difficulty she faced being separated from her family:

I don't know if it's a mental health thing … I feel sad sometimes because I'm not able to get what I want, and then I get all my kids to [call] me at the same place … I do have that emotional breakdown. (Tutuwaa)

She also discussed her spiritual health: "*Spiritual health I think has been an issue because … we are very religious people, like there's always programs at church … but* [it] *is not the church here*" (Tutuwaa).

Lack of Social Support Systems

The lack of social support demonstrates a consistent finding among both participant datasets; the statements of "*my family is not here to help me*" (Obrago), "*I live here alone with my children*" (Dansowaa), and "*no there is no one to support me*" (Dufie), support this. One participant describes the isolation: "*I do everything for myself and my child*" (Asor). Another internal migrant elaborated on her experience: "*Here when you deliver here you will suffer because there are no relatives to help you care for the child*" (Serwaa). A participant described "*perform*[ing] *the prayer*" as a coping mechanism to attain "*peace of mind*" when experiencing "*a lot of problems*" (Dufie). An external migrant stated: "*back*

home you have family, parents taking care of you, but here you are on your own, so you have to kind of navigate your way around" (Akyea). Another participant shared her experience of leaving behind her church community, she stated:

You go to church sometimes to even see your friends and chat, and catch up and all that. But it is quite different her [sic], so sometimes you [are not even] want[ing] to be able [to] go to church. (Tutuwaa)

Effects of Leaving Family Members Behind

Interview transcripts from internal migrants did not elaborate on the challenges faced with leaving behind family members. An external migrant discussed the impact of immigration on her relationship with her children: "*So* [my daughter] *was the one I was thinking about … she is not willing to sometimes chat with me … she's not happy I've left her*" (Setor). Another participant described the detrimental impact of migration on her relationship with her daughter, explaining:

[The boys] have uncles, cousins, everybody taking care of them … the boys were okay, but my daughter was never forgiving … She's still thinking that Ma, you should've been there for me when I was having my period, you should've been there when I was having my first boyfriend. (Ayeley)

Migration of the mother alters family dynamics and strains the marital relationship, as explained by one participant: "*There is no help, so he also has to struggle to take care of* [the children] *… so at a point he was also getting sad … it was quite tough for me to leave them*" (Setor). A participant explained the emotional implications of migration on her wellbeing as she spoke to the impact of leaving her children behind: she stated, "*it was really hard, and sometimes when I try to remember some of the things, I get emotional*" (Twumwaa). Furthermore, she did not have "*peace of mind*" after leaving behind her children, as "*not having them closer to me, to see what exactly was wrong with them at each moment in time, was really hard*" (Twumwaa). Another participant stated: "*It's difficult especially when you get up in the morning you call and you can't reach them. I become disturbed the whole day till I get in touch with them*" (Sedinam).

Education and Health Knowledge

This theme discusses Ghanaian migrants' level of formal education (grade school and postsecondary inclusive) and the source of their health knowledge. The findings were divided into the following sub-themes: (1) level of formal education, and (2) sources of health knowledge.

Level of Formal Education

The data suggests a commonality regarding internal migrants not completing their grade school education. A participant explained: "*I didn't go. When I wanted to go my dad passed away, so I stopped and got married*" (Mawusi). Illiteracy among female internal migrants was a reoccurring finding, whether the women stated they could not "*write anything*" (Dufie) or did not "*know how to read*" (Obrago). One participant explained her belief that "*it is only when you go to school a little that you can do those things* [read and write]" (Serwaa).

In comparison, fewer external migrants reported not completing grade school and pursuing advanced education. An external migrant stated, "*I didn't have any much education*" (Ayeley). Another participant elaborated on her experience with the education system, explaining that "*when you come here* [Canada] *you have to really work hard and adjust*" (Akyea).

Sources of Health Knowledge

Ghanaian women described the transfer of health knowledge as deriving from family members, friends, health services, and media platforms. Internal migrants emphasized their reliance on family members to provide insight on health queries; Dufie shared: "*I can go to my mother and ask her or I will go to … my sister and ask her*". Social connections are a resource when searching for health knowledge; an internal migrant mentioned that whenever the need for health information arose, she could "*ask your friend*" (Serwaa). The findings revealed that Ghanaian women will reach out to strictly female friends to receive health knowledge. Furthermore, internal migrants received health information from "doctors" (Adoma), "nurses" (Dansowaa), "birth attendants" (Obrago), and "drug peddlers" (Serwaa). A few internal migrants mentioned the use of "phone[s]" (Dansowaa), as well as the radio to receive health information. External migrants did not discuss the sources of their health knowledge.

Influence of Socioeconomic Status on Access to Health Services

This theme discusses Ghanaian migrants' socioeconomic status and its impact on their access to health services. The findings were divided into the following subthemes: income, employment and expenses, financial constraints, health insurance, and societal perceptions regarding remittances

Income, Employment, and Expenses

Internal migrants discussed their living expenses and the significance of rationing income. A participant stated: "*We the migrants cannot buy such expensive foods*" (Serwaa). External migrants in Canada voiced struggles with eating nutritiously when they were unable to access traditional Ghanaian foods: "*If you want the foods that you can get back home, it's expensive … we just made do with what I have here*" (Setor). This was further emphasized by another participant who stated, Ghanaian food is "*very expensive compared to the grocery store … because they import them*" which is a notable deterrent in purchasing them (Akyea). Other expenses included items to cater to their children's needs; this is supported by the following statements: "*You can buy some things to protect yourself and that of your baby*" and "*when the child is born you have to send the child to school and buy foot wear* [sic] *for the child and other things*" (Serwaa).

External migrants described their expenses to include their children's educational costs: "*If you want a good academic for your kids, you have to take them to a private school … It's very expensive*" (Setor). Other external migrants considered their educational costs to be a significant expense; one participant described, "*tuition was increasing instead of decreasing … I had to supplement* [the funding from home]*. It was so expensive … you the international you are paying like three times what the Canadians are playing* [*sic*]" (Akyea).

Health Insurance

Inadequate health insurance, or a lack thereof, infringes on migrants' ability to access health services. When visiting the hospital in Accra, an internal migrant stated "*I pay money"* because she was not registered for a health insurance plan (Serwaa). A participant elaborated on her experience in Northern Ghana: "*We don't pay for anything when we use the health insurance*" (Adoma). A Ghanaian translator explained, "*what normally happens is that those who have money are treated earlier than those who do not have money*" (Serwaa). The findings suggested that if an individual has "*insurance for health*" (Ayeley) it provides them with stability and reassurance; this is emphasized by an external migrant's statement: "*I have an insurance who I know that if I have a medication it could be covered*" (Ayeley).

An external migrant in Canada shared her experience with adjusting to a new health care system and utilizing universal health care coverage: "*I didn't know that after getting the health card you have to also register with the clinic because back home* [Ghana] *once you have your card … you can walk into any clinic around*" (Sedinam). A participant discussed their appreciation for the Canadian health care system: "*You don't have to pay before you are treated*" (Akyea). Another participant explained the downsides of immigrating from Ghana: "*We don't have free health care, we take it for granted over here* [Canada] … *we sit down till we have diseases that go so far, before we start taking care of it*" (Ayeley).

Financial Constraints

Lacking adequate income is a major deterrent to quality health; this is emphasized by an internal migrant: "*When you have money to afford the* [hospital] *bills then they* [the hospital staff] *will take care of you but if you are poor and you cannot pay they are not ready to help you*" (Serwaa). Another participant stated: *Since I arrived, I haven't had enough money, so I did not take him* [her son] *to the hospital. I went to the drug store to get him some medications*" (Adoma). Internal migrants described seeking preventative strategies and "*pay*[ing] *not to be sick*" to allow them to continue going "*to the market and work*" as there is "*no money to go to the hospital*" (Serwaa). An internal migrant stated, "*money is the real problem*" and "*there is money problem at every place*" (Serwaa). The earning wage for the women working in the marketplace approximated "*10 Cedis* [2.23 CAD as of 25 November 2020] *daily*" (Adoma), and some were able to "*save about five Cedis* [daily]" (Obrago). A participant shared she is more financially stable in Northern Ghana: "*In the North we don't buy food and water. Since you have to pay for everything here in Accra, you end up making little profit"* (Adoma).

External migrants in Canada described experiencing financial difficulties in the destination country. Migrating to a new country highlighted the need to start "*working right away*" and "*to work hard*", especially for those that have left families behind (Ayeley). A participant stated, "*the salary I'm giving back home, when I change it into dollars it's nothing … it was quite difficult*" (Setor). Another participant stated: "*I made better money at that time when I worked in Ghana than here* [Canada]" (Korkor).

Societal Perceptions Regarding Remittances

The female migrants described the financial burden of forwarding remittances to family members and their outlook on the migrant's responsibility to provide support. An internal migrant shared: "*It reduces the amount of money that you are able to have. But you also want a better life for your family*" (Asor). Another participant stated: "*since I arrived here I have sent her some money about 4 times*" (Mawusi). One female described: "*several months of hustling to save money to send her family in the North*" (Serwaa). A participant explained her responsibility to provide financial support: "*You will gather the money and when you see that it is a bit plenty then you can … build a house for your mother and father*" (Dufie).

External migrants shared their experiences with providing remittances and the Ghanaian community's perception on external migrant wealth post-migration. A participant described her role in supporting family members in Ghana: "*I have to go pay school fees, send money*" (Ayeley). One immigrant described the community members' expectations when travelling to Ghana: "*If you stay here for long and you go there,* '*What*

did you bring, what did you buy' … when you're going there you need money, you need to be working" (Akyea). A participant shared the financial burden created by societal perceptions in Ghana: "*When you're going back home* [from a] *Western country they think that you are rich … we had to like buy clothes for everybody … that caused us a lot of stress …It hurts you financially*" (Kwartemaa). Contrariwise, one participant stated: "*There's no expectation, when I feel – when there is a difficult situation and I think I have to support*" (Sedinam).

Cultural Beliefs and Perceptions Towards Migration

This theme discusses the cultural beliefs associated with migration and its relationship with Ghanaian women's utilization of health services. Participant interviews revealed the following sub-themes: influence of gender on migrant health, gender barriers in accessing health services, utilization of herbal medicine, and cultural shifts upon arriving to the destination region.

Influence of Gender on Migrant Health

Ghanaian women described the influence of gender roles on their health outcomes. An internal migrant discussed the risks associated with childbirth and compared the health outcomes of males and females: "*Being a woman will affect your health … If I am going to give birth too, the bleeding that I will bleed he will not bleed*" (Asor). Another participant spoke to the health concerns related to childbirth as well: "*You are a young girl your strength is different from an adult woman and when you give birth too*" (Dansowaa). An internal migrant discussed the deterioration of her strength: "*After a number of deliveries you realize that your strength goes down. My state now and when I was born is not the same*" (Mawusi). A participant associated the decline in health with not "*have*[ing] *anyone to take care of* [her]" (Dufie). The interview transcripts from external migrants did not discuss the influence of gender roles on migrant health.

Gender Barriers in Accessing Health Services

Ghanaian women shared the process of accessing health facilities as females and the associated cultural implications. Regarding seeking permission from the male figure of the house to access health care services, one internal migrant stated, "*I need to seek permission first … I have to tell my husband that I am sick … If I just get up and go and hospital bill comes, who will pay*" (Mawusi). Some participants in Accra spoke to their independence in accessing health care services:

When I am sick I can just go to the hospital but if I don't know the place I will ask someone in order to get the direction … If you think going to hospital when you are sick will get you better you can go. (Adoma)

Ghanaian women explained their response to being deterred from seeking medical assistance; one participant stated, "*He did not agree but I did it behind his back*" (Obrago). External migrants in Canada did not discuss the influence of cultural perceptions on their access to health care.

Utilization of Herbal Medicine

The use of herbal medicine is customary in Ghanaian culture. Internal migrants described their reliance on herbal medicine, "*yes … at the North*" (Dufie), "*I tried some herbal medicines*" (Dansowaa), and "*the traditional healers we go to them*" (Asor). Participants explained that "*when you use it* [herbal medicines] *and it doesn't work for you, you can also go* [to] *the hospital*" (Adoma) while others may visit both "*the hospital and … the herbalist for treatment*" (Dansowaa). A prevalent finding amongst migrants in Ghana was the selection of herbal medicines as a primary treatment; a participant stated, "*if you are sick and you do not have money you only have to use the herbal medicine*" (Serwaa). Another participant elaborated on her preference of seeking care from a doctor compared to an herbalist: "*They* [herbalists] *are just selling their medication. But as for the doctor he has gone to school and was taught everything*" (Obrago). An external migrant explained the contrast between the countries regarding herbal medicine use: "*In Ghana, when you cook all your herbs and drink it … you are okay, which is not here* [Canada]" (Ayeley).

Cultural Shifts Upon Arriving to the Destination Region

Internal migrants did not experience cultural shifts upon migrating, as they remained within Ghana. External migrants experienced a cultural shift when arriving in Western society. One participant identified the "*cultural difference*" in Canada compared to Ghana (Twumwaa). A participant described the cultural shift she experienced following her migration:

It was quite different from home … the culture is also different ... I also had to adjust to that culture … And then one other thing was the language, because I realize that both written and spoken language was quite different. Yes, so when I talk, it's difficult for people to understand what I was saying and then when they talk, it was also difficult for me to get it. (Setor)

The findings reveal accessing health care as a significant adjustment; one participant explained how she "*could have gone to the clinic and … be treated. I didn't know you have to even book an appointment that you want to visit today … now I have adapted* [emphasis added]" (Twumwaa).

Discussion

Literacy and educational levels varied amongst internal and external migrants, as did the sources from which female migrants accessed health information. Information accessibility includes the right to locate, receive, and convey ideas and information regarding health concerns without compromising the confidentiality of personal health data[20]. Evidence shows that literacy levels and language barriers negatively impact health care access in migrant populations[21]. The level of formal education is not the only educational factor that impacts overall health; health knowledge is a critical resource that influences health outcomes in a magnitude of ways. Adjei and Buor[10] associate a lack of health education with poor utilization of health services. Migrant populations need to receive health education and gain health literacy abilities. Information received on effective health behaviors while abroad is transferred among family members, which facilitates a better understanding of concepts, such as sanitation practice, contraceptive practices, nutritious dieting, other lifestyle behaviors[22]. The World Bank's study in Guatemala, Mexico, and Morocco concludes that migrant women's advanced health literacy, independent from their level of schooling, has benefited children's overall health outcomes and declined mortality rates[22].

Internal migrants emphasized the importance of health insurance in accessing necessary health services. Affordability is the ability for individuals to pay for the services received without the occurrence of financial hardship, with the consideration of health services' pricing and indirect costs[20]. To ensure equal access to health care between migrant and non-migrant populations, health insurance for all is crucial[23]. Internal and external migrants working without social security and adequate wages, described being exposed to vulnerabilities. Insufficient income combined with low social status is the greatest influential factor to ill-health as the impoverished individuals are described to have greater exposure to personal and environmental risks[10].

Self-directed female migration is a strategy to maximize income generation through which financial support can be extended to family members. Participants from both datasets described difficulty in balancing income and expenses in the destination region while accounting for remittances. Female migration, whether circular or international, increasingly molds household-level economics, as the migrant women financially contribute to their household via remittances[23]. Migrant women sacrificed their health to accumulate substantial amounts of remittances, resulting in deteriorating health outcomes.

Financial constraints restricted internal migrants from seeking adequate health care, resulting in their use of alternative therapies in managing health concerns. Migrants may possess strong beliefs in non-medical interventions, such as traditional folk medicine or a higher religious power, which could result in a reluctance to access health services[24]. Participants' described their reliance on herbal medicine as a means to access affordable treatment regimens; this may act as a barrier in accessing health services and thereby deter improved health outcomes. Ghanaians residing in higher-income households demonstrate a higher probability of utilizing modern hospital facilities in comparison to households with lower socioeconomic status who are more likely to rely on self-medication and herbal medicines[25].

External migrants in Canada encounter double the probability of experiencing difficulties in accessing health care when compared to Canadian-born individuals; this raises the issue of inequalities in access noted within vulnerable populations[21]. Cultural barriers included perceived societal gender roles and cultural perceptions of health and illness. The social construct of gender dictates norms surrounding expectations, behaviours, and familial roles related to masculinity and femininity[5]. Migrants' exposure to diverse cultural norms and practices influences their personal beliefs and values. With this, women need to practice autonomy over health, and this is highly dependent on their access to and control of health resources. Ferdous, et al.[26] describe how certain female migrants require familial sanctions to access health care presents as a significant deterrent in maximizing health outcomes. Migrants' exposure to diverse cultural norms and practices influences the alteration of personal beliefs and values. Cultural perceptions of health and illness, as well as traditional beliefs regarding health care, are major predisposing impediments to the use of health services among migrant populations[27]. Health care providers' inability to deliver patient-centered care considerate of the patients' diverse cultural values and health practices imposes detrimental health outcomes on their recipients.

Internal migrants experience strenuous work activities, in the markets of Accra, as head porters (kayayei). In the study by Lattof, et al.[23], female migrants self-reported declined health status upon arrival in Accra. Significant health risks accompany the kayayei as it is a physically demanding occupation that demands agility, strength, and endurance. Additionally, kayayei experience notable physical hardships, including starvation, deteriorating health, sexual violence, and illness[23].

Participants in Canada recognized the influence of their new environment on their overall health. External migrant's health outcomes can be ameliorated following integration into the destination country's health care system; however, certain instances demonstrate a negative impact on their health[28]. The healthy immigrant effect (HIE) refers to the phenomenon that immigrants arrive healthier than their Canadian-born counterparts and as the length of stay increases their health inversely declines[29]; the immigrants develop the same or potentially worse health status than that of the Canadian-born population[30].

Participants shared the challenges they encountered after leaving their home; many described the feeling of isolation and vulnerability emerging from moving away from family members as they associated it with lack of social support. It is common for migrants to experience social isolation, as well as decreased social support post-migration[24]. Female migrants are at higher risk of developing adverse psychological and physical health effects as a result of familial separation and deteriorated social support systems. Immigrants from visible minority groups with lower education and socioeconomic status are more susceptible to negative mental health consequences[31]. The decline in psychological health has been attributed to stressors of the immigration and settlement process, and racialization faced by the visible minorities[24].

Impaired access to health care services related to cultural and linguistic barriers have resulted in inadequate health care delivery, delay in health-seeking behaviors, and negative health outcomes for migrants. The Canadian health care system lacks appropriate levels of respect and accommodation for the cultural and traditional beliefs of immigrant patients[26]. Conveying health information via culturally appropriate videos and written resources will improve knowledge and preventive health practices among vulnerable migrant populations. Culturally competent care must be integrated throughout all health services within the system to improve migrant experiences in accessing care. Woodgate, et al.[30] recommend information sharing via educational materials in multiple languages focusing on accessing health services to reduce linguistic barriers in migrant families.

Our research demonstrates how the interactions amongst gender, culture, education, and socioeconomic status significantly impact female migrants' health outcomes. Internal and external migrant women are a marginalized population who face adversity when accessing health services which poses detrimental effects on their psychological and physical health. The negative overlap of these social determinants of health catalyzes inadequate quality of life, social isolation, and compromising health behaviours.

Limitations

The utilization of secondary analysis presented limitations in the collection and the analysis of pre-existing data since the primary data was collected to address distinct questions. Ruggiano and Perry[32] suggest that the interpretation of qualitative data is determined by the evident cultural, political, and social circumstances at the time of data collection. This may create discrepancies when the data is re-interpreted under a different context. The scrutiny of existing datasets presented the challenge of answering our research questions effectively as a result of the data lacking depth. The interpretation of the findings is influenced by the researcher's interaction with particular respondents in the location of data collection. With this, we acknowledged the relationship between researchers' social environment and their approach to the data.

Implications for Health Care Delivery

Our research will allow for the development of new knowledge in areas surrounding the impact of an individual's socioeconomic status, education, and culture on their access to health care. This advancement will support further research on women's health and the impact of female migration on the family dynamic. Our study will further inform research which focuses on the social determinants of health and a better understanding of maternal health, how people within or across cultures share the same understandings of health, what it means to be healthy, and practices for maintaining health.

The new knowledge will inform health care systems to provide services that consider the impact of the social determinants of health on individuals' quality of life and will allow for the provision of culturally competent services. Furthermore, it will provide evidence-based knowledge to address the unmet health needs of female migrants, thereby targeting gender health disparities on a local, national, and international level. The reorientation of health services will facilitate the promotion of and advocacy for migrant health, as well as encompass cultural competence and sensitivity in health care delivery practice. According to Woodgate, et al.[30], migrant families hope to discover strategies to address their social determinants of health, including access to health services; this emphasizes the need for governments, health care providers, policymakers, and researchers to enact a more proactive role in developing these strategies. Interventions that ensure cultural competence and awareness may be utilized as evidence-based guidelines to mitigate barriers and promote positive health outcomes in vulnerable migrant populations.

Conclusion

Female migrants in Ghana and Canada continue to face challenges in accessing health services and maintaining quality health outcomes. The aforementioned challenges consist of literacy, social, financial, and cultural barriers. Overall, our research presents potential methods for improving female migrants' health outcomes and access to care. An initiative to promote migrant health must design health services to be inclusive, affordable, accessible, as well as linguistically and culturally appropriate. Further research is needed to develop appropriate delivery models of care to meet these requirements.

Declarations

Ethics Approval and Consent to Participate

Ethical approval was obtained from the Research Ethics Board 2 at the University of Alberta, Canada for our secondary analysis [Pro00097128]. Study A conducted by Richter, Vallianatos, and Toosi (2017-2020) [Pro00075943] received ethical approval from the Research Ethics Board 1 at the University of Alberta, Canada. Study B conducted by Vallianatos, Richter, Ansu Kyeremeh, and Aniteye (2014-2015) [Pro00049130_REN1] received ethical approval from the Research Ethics Board 3: Health Research Ethics Board - Health Panel at the University of Alberta, Canada.

Consent for Publication

Not applicable.

Availability of Data and Materials

The datasets analysed during the current study are not publicly available due confidentiality, but are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests" in this section.

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Authors' Contributions

M.M. and L.R. analyzed and interpreted the participant data and performed a literature review to support the research findings. M.M. and L.R. equally contributed in drafting the final manuscript. S.R. substantively reviewed the research. All authors read and approved the final manuscript.

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