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ORIGINAL PAPER

Mothers in a 'Strange Land': Migrant Women Farmers' Reproductive Health in the Brong-Ahafo Region of Ghana

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Abstract: As a coping strategy towards climate variability, smallholders from the Upper West Region (UWR) migrate to rural farming areas in the Brong-Ahafo Region (BAR) of Ghana in search of better livelihoods. Although previous migrations were seasonal and male-dominated, recent migrations have become permanent and involve more women migrating. Despite these changing dynamics, little is known about the effects of internal migration on women's reproductive health in rural migration destinations. Using qualitative methods, we explored migrant women farmers' reproductive health experiences in BAR. Findings from our study reveal that migrant women face limited autonomy in family planning decisions, lack access to maternal and general health care services, and have limited social support in the migration destination. Our findings contribute to the migration literature and highlight the unique reproductive health challenges of agrarian migrant women in rural receiving societies of Ghana.

Key words: Gender, migration, reproductive health, Brong-Ahafo Region, Ghana, sub-Saharan Africa.

This study explores women's reproductive health in the context of rural-rural migration in Ghana. Reproductive health as used in this paper denotes the ability to have a safe and satisfying sex life and the autonomy to make reproductive decisions.[1] Access to health care services is considered a major determinant of women's reproductive health, yet access remains a huge challenge confronting many women in sub-Saharan Africa (SSA). The region is still plagued with high maternal mortality rates due to low health facility availability and use. For example, only 46% of women in SSA give birth in health facilities compared with East Asia, Latin America, the Pacific, and

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the Caribbean, where about 90% of births occur in health facilities.[2] According to the 2018 WHO report, maternal mortality in Ghana stands at 319 per 100,000 live births, significantly higher than that of developed countries which record an average of 12 per 100,000 live births. These mortality rates are higher for rural dwellers and might be greater for migrant women in rural areas.

The importance of reproductive health to development is emphasised by the Sustainable Development Goals (SDGs), which aim to address inequalities and promote the health and wellbeing of populations across the world. Understanding the reproductive health experiences of women farmers who migrate due to climate change and extreme poverty is therefore crucial and timely, as 11 out of 17 SDGs relate directly or indirectly to migration as a social determinant of women's reproductive health and wellbeing.[3,4]

In Ghana, increasing climate variability and land degradation have intensified north-south migration, with many farming households relocating to the forest and transition zones in search of better farming opportunities.[5,6] The UWR in particular has witnessed extensive outmigration of residents to the BAR of Ghana.[7] Although north-south migration in Ghana has been happening since the colonial era due to geopolitical factors that left the three northern regions relatively less developed,[8] recent migrations differ in a number of ways. First, most migrants are moving to the middle belt of the country in search of arable farms, in contrast to previous migration patterns which were to mining towns in southern Ghana. Second, migration patterns have shifted from rural-urban to rural-rural as migrants are now relocating in search of farmlands.[7] Third, unlike the previously seasonal patterns, recent migrations are becoming permanent as climate change is the major push factor in UWR. Consequently, recent migration trends have seen the movement of more women as entire families relocate to BAR.[9]

The International Organisation for Migration (IOM) recognises migration as a social determinant of health.[4] The evidence suggests migrants' health tends to be affected by structural factors such as poverty and inequality as well as environmental, economic, social, cultural, and behavioural experiences of the migration process. For instance, as most people migrate in search of better livelihoods, migration could lead to health inequalities in receiving areas, as migrants may have limited access to good quality health services due to their outsider status and poor socioeconomic conditions.[4]

These migration dynamics may be more complex for women. For instance, migration has been shown to delay age at first marriage, lower fertility, produce smaller family sizes, and increase the risk of sexually transmitted infections (STIs) especially among women.[10] This is in part due to the mobility associated with migration, and the limited autonomy of migrant women to negotiate safer sex with their partners. Migrant women are also reported to record low patronage of reproductive health services and contraceptive use, compared with non-migrants in receiving areas.[11] Consequently, the ineffective utilisation of these reproductive services can result in severe negative health outcomes among migrant women including poor health of mothers, pregnancy complications, low birth weights, and maternal and infant mortality.[11] Furthermore, settling in remote locations affects migrant women's access to maternal and general health care services, basic social amenities, and social capital and support.[12]

Even though more women in rural areas of Ghana have begun taking part in migration, most scholarly work continue to focus on men's experiences. The few studies on

women and migration largely focus on the experiences of non-migrant women in migration origins, and women in urban destinations.[7,13] However, like other gendered phenomena, rural-rural migration affects women and men differently. According to Ganle and colleagues, although skilled births in Ghana have increased, some women—particularly in rural areas—still lack access to health facilities.[2] Several factors including poverty, and infrastructural and sociocultural barriers account for this.[12,14] Moreover, women in rural areas are cut off from health facilities due to the poor nature of roads connecting migrant communities, and the lack of transportation to and from such areas. Even in situations where health facilities exist in remote communities, the service is usually of substandard quality due to poor, malfunctioning equipment, lack of motivation on the part of health workers, and inadequate monitoring of health personnel.[15,16] In the case of migrant women in BAR, economic factors compel them to settle in some of the most secluded areas of the region to be able to farm, further inhibiting their access to health services.

Notwithstanding interventions such as the National Health Insurance Scheme (NHIS) and the Maternal Exemption Policy (MEP) aimed at encouraging health care utilisation by reducing maternal and general health care costs to the barest minimum, other hidden costs still make access challenging for women in rural areas. These include transportation fares, registration fees, and the opportunity cost of foregoing economic activities.[17] These outcomes are pronounced in a largely patriarchal society where women do not control sources of income despite contributing towards them. For the migrant woman in rural BAR, the situation is worse as the absence of social support means that the opportunity cost of seeking health care is even greater, juxtaposed with little financial support coming her way.

Furthermore, sociocultural factors are salient determinants of women's health care utilisation.[2] These sociocultural factors include religious beliefs and cultural norms that require women to seek permission from household heads before any decision can be made—including travelling to seek health care. Researchers argue that women's patronage of maternal and child health care services is strongly influenced by women's autonomy.[18] Women from UWR exemplify this, as the region's patrilineal system of inheritance reinforces patriarchal tendencies, contributing to less autonomy among women. Similar to other SSA countries, an important indicator of women's reproductive autonomy in Ghana is their ability to negotiate safer sex with their spouses and make family planning decisions. Most women in Ghana are still unable to ask for condom use in conjugal relationships, due to fears of being accused of infidelity or distrust.[19] This is problematic as married women in SSA are more likely to contract HIV than never-married women.[19] Moreover, the ability to make family planning decisions is important in helping women plan their lives and families.[20] Yet, due to the sociocultural importance placed on childbirth and the expectation that men decide when and how many children to have, most women in Ghana are disempowered regarding sexual negotiation and planning their families. This is even more pronounced among the people of UWR, as it is culturally upheld that payment of bride price confers a woman's reproductive privileges on her spouse.[21]

In rural areas of BAR, it is likely that because most migrant women farmers have low levels of formal education and are engaged in peasant farming, socioeconomic

factors may play an important role in their (in)ability to negotiate for safer sex and access maternal and reproductive health care.[22] This might be compounded by the fact that migrant women live away from family and kin, as studies suggest that migrant women's economic livelihoods and consequent health care utilisation tend to depend on their social capital as well.[23,24] This study therefore explores the perceptions of factors that influence the reproductive health of migrant women in BAR and makes recommendations on ways of promoting women's reproductive wellbeing in rural migration destinations.

Theoretical perspectives. This study draws insights from the Andersen's Healthcare Utilisation model in explaining health-seeking behaviour among agrarian migrant women, and the factors that promote or inhibit their effective use of health services in a migration context in Ghana.[25] Andersen's model has evolved over the years in response to critiques of earlier versions that failed to include the complex mosaic of social and structural determinants in understanding health access and utilisation.[26] This study therefore uses the fourth phase of the model developed in the 1990s, as it presents a more comprehensive analysis of factors influencing health-seeking behaviours than the earlier versions.

The fourth phase of Andersen's model posits that use of health services is influenced by three groups of factors: predisposing, enabling, and need factors. Andersen explains predisposing factors as those relating to sociocultural characteristics of an individual prior to ill health.[25] Within this group are social structural elements such as ethnicity, education, and occupation; demographic characteristics including gender and age; and health beliefs. These factors shape perceptions of health and health care. Enabling factors provide an individual with the means to access health needs. These enablers include wealth stock of individuals or financial support available to reduce the cost of accessing health care. For instance, Ghana's pro-poor national health insurance has been acclaimed as a key enabling factor of health care utilisation.[27,28] Others include health facilities and road infrastructure, which influence physical access to health care, and social support from family and friends, which cushion women economically and psychosocially. Lastly, need factors denote circumstances such as health issues that cause an individual to require health care services. Need may be perceived based on an individual's experiences of ill-health or evaluated from a professional standpoint.[29]

In this study context where migrants settle in rural locations for farming, understanding their health care access and utilisation experiences requires examining perceptions of health and health care, how decisions to seek health care are made in households, physical and financial dynamics in accessing health care, and the stock of social support available to support health care access and needs. Andersen's model, therefore, provides a lens for examining the influence of these factors on migrant women's reproductive health in rural BAR.

Study context. The Brong-Ahafo Region is the second largest of 10 regions in Ghana. It is located in the middle belt of the country with an urban population of 44.5% compared with UWR, where just 16.3% of the population is urban.[30] The region has a Forest-Savannah Transition vegetation, a biannual rainfall season, and better soil fertility than UWR. According to the 2010 Ghana Population and Housing Census report, in-migration accounted for 457,571 (about 20%) of the total 2,310,983 population of

BAR, with people from UWR making up 23% of migrants in the region.[30] The BAR is a popular destination for migrants from UWR due to its relative proximity to UWR, biannual rainfall season which allows for all-year cultivation, and the availability of arable land in the region.[5]

Due to their low socioeconomic status and the need to secure land for farming, most migrants from UWR settle in remote areas of BAR.[7] Consequently, these rural peripheries have become so popular among migrant settlers that some of them have been (re)named after communities in UWR (e.g., Nadowli). Settling in such remote areas has implications for migrants, especially women and children, as they are cut off from health care and other social amenities such as schools, roads, and electricity. Moreover, migrant settlements are dispersed, making access to social networks and capital challenging. Finally, despite years of in-migration and the subsequent creation of migrant niches in BAR, these niches tend to attract people from different ethnic groups (even among migrants from the same region), which has implications for communal bonding.

Methods

Research design. This research was conducted between September and December 2016. Given our objective of exploring the lived experiences of migrant women in BAR regarding their reproductive health, we used a qualitative approach. This was to facilitate our understanding of the reproductive health experiences of migrant women as an ongoing process negotiated by their positionality (gender, ethnicity, socioeconomic and migrant status) in relation to others in their sociocultural contexts.[31,32] Specifically, we employed in-depth interviews (IDIs) and focus group discussions (FGDs). According to Guba and Lincoln, qualitative methods are suitable for understanding phenomena beyond face value.[33] A qualitative approach also allows for the use of more than one method, which produces rich data and deep meanings of experiences, and also allows for data triangulation.[33]

Study sites. Participants were selected from six communities in three districts of BAR. These communities include Tanokrom and Gyebiri in the Techiman-North district, Beposo and Kokuma in the Kintampo-South district, and Dwenewoho and Alata Line in the Nkoranza-North district (see Table 1). In addition to their rural nature and relative proximity to one another, the selection of these communities was informed by anecdotal evidence that identified these locations as preferred destinations for migrant farmers from UWR. During data collection, it emerged that apart from being in the peripheries of BAR, these migrant hubs tend to be far away from health facilities as well. Thus, of the six migrant communities selected for the research, only one had a health facility within a 5km distance, with most migrants resorting to seeking health care outside of their communities.

Participant selection. Respondents were selected using purposive sampling since the target population was women who had migrated from UWR either alone or with their families to rural BAR. Details about the research, such as the purpose of the study and the inclusion/exclusion criteria for selecting research participants were explained to community leaders. We sought to include migrant women aged 18–80. While 18 years is the legal age of consent in Ghana, we set the upper age limit at 80 to ensure

Table 1.

COMMUNITY CHARACTERISTICS OF STUDY SITES

			Health Facility	
District	**Community**	**Proximity to road**	**In Community**	**Outside Community (<5km)**
Nkoranza-North	Dwenewoho	On main road	No	No
	Alata-Line	None—Remote	No	No
Kintampo-South	Beposo	On main road	No	No
	Kokuma	Side road	No	No
Techiman-North	Tanokrom	Side road	No	No
	Krobo	On main road	Community Health Post	Yes

that we captured the nuances of reproductive activities within UWR culture (e.g., extended family systems). We interviewed participants who had been resident in BAR for at least two years or more to ensure that they had a wealth of lived experiences in the migration destination. The contact information of the lead author was circulated to communities, and interested participants were asked to contact the researcher directly. Interviews commenced once the first five women got in touch. Subsequently, participants were asked to recommend the study to other migrant women.

Regarding key informant interviews, letters were dropped off at the offices of governmental and non-governmental organisations and interested participants were asked to contact the lead researcher. A total of 80 respondents took part in the study. These included 40 migrant women in five different FGDs, 30 migrant women for IDIs, and 10 key informants. Although more women are migrating individually from UWR, women who settle in rural areas of BAR tend to migrate as a family since farming is the main purpose for migrating. A few migrant women were widowed or separated. Migrant women in rural areas tend to be older on average and have lower levels of formal education, as younger, more educated women prefer to settle in urban areas of BAR to engage in non-agricultural jobs.[9]

Data collection. Two methods (i.e., IDIs and FGDs) were adopted to ensure triangulation and comparison of emerging themes across the board. Different participants were recruited for FGDs and IDIs. Focus group discussions (n=5) comprising between six and 10 women in each group, and IDIs (n=30) were conducted with migrant women farmers to understand their reproductive health experiences in BAR. Ten IDIs were also conducted with key informants (community leaders and officials of governmental and non-governmental organisations [NGOs]). Two FGDs were conducted in the Nkoranza-North and Kintampo-South Districts, and one in the Techiman-North District. A minimum of three and maximum of seven IDIs were conducted in each community. Some characteristics of the study communities are presented in Table 1.

Interviews were held in community centres closed off from non-participants or in the homes of participants, based on their preference. This was to ensure confidentiality of participation. In-depth interviews lasted between 15 and 45 minutes, whereas FGDs lasted between one to two hours. Semi-structured interview guides were used to facilitate discussions. Questions included motives for migrating to BAR, intra-household dynamics, and women's health-seeking and child-raising dynamics in BAR. Questions were designed to encourage participants to talk at length. However, some interviews were cut short because participants either lost interest in discussions or had to leave to perform domestic or farm work. In-depth interviews with key informants asked questions on migrant population characteristics, health and wellbeing concerns of migrant women, and the state of local and national interventions for addressing migrant women farmers' reproductive needs. Interviews were conducted in English, Dagaare, Sissaali, and Twi (the major languages spoken by migrants in BAR). Except for Sissaali interviews which were conducted by a trained research assistant (RA), all other interviews were conducted by the lead author.

Ethical considerations. Ethics approval was obtained from the Non-Medical Research Ethics Board (NMREB) of the authors' educational institution. The lead author hails from the migration origin and speaks the local languages of the study context. RAs underwent extensive training during which they were advised about the research expectations including their responsibility to advise all participants of their rights and roles and keep all interactions with study participants confidential. Written and verbal informed consent was obtained from each participant before interviews commenced, and all interviews were audio recorded with permission from respondents.

Data analysis. The lead author transcribed all interviews. Recorded interviews were translated into the English language using both literal and creative/contextual translation techniques. It was necessary to do both literal and contextual translation as some local terms/expressions could not be lexically captured through verbatim translation alone.[34] Translated transcripts were proofread and cross-checked with audio recordings to ensure that meanings were not distorted. NVivo, the QSR software for analysing qualitative data was used as an organisational tool for coding transcripts.[35] Open-coding, which involves the assignment of ideas to text beside sentences as they emerge[36] was carried out line-by-line to extract emerging themes. Results were thematically analysed based on their prevalence, the research questions the study sought to answer, and relevant theoretical underpinnings. During analysis, reference was also made to notes taken during fieldwork, to better contextualise data. In-depth interviews and FGDs were analysed using the same coding scheme to identify similarities and differences.

Results

The findings are structured around three major themes that emerged from the analysis: women's autonomy in family planning decisions, women's access to maternal and general health care services, and strategies employed in managing reproductive health issues. Direct quotations from IDI and FGD transcripts have been used to illustrate themes, alongside methods of data collection, pseudonyms, and age of participants.

Migrant women's autonomy in family planning decisions. Most migrant women farmers indicated that they did not enjoy much autonomy in issues regarding contraceptive use and family planning. Further probing revealed that women's lack of control over contraceptive use and family planning centred on sociocultural reasons. Among the Dagaaba and Sissala of UWR, payment of bride price confers a woman's reproductive privileges on her spouse. Although this tradition is not as pronounced among non-migrants of the migration destination (BAR) due to its matrilineal culture, migrants from UWR who settle in BAR still uphold this tradition. This produces unequal power dynamics in relationships, which in turn affects migrant women's ability to negotiate (safer) sex, as well as spacing and number of children. Most women agreed that even though they knew condoms were useful for family planning and preventing STDs, they could not request that their spouses use protection since their partners could interpret this to mean that they (women) were cheating or accusing their husbands of extramarital affairs, which sometimes led to intimate partner violence. Some migrant women spoke to these issues:

> The man marries the woman and not the other way around. He therefore decides everything . . . (Gata, IDI, 32).

> We know condoms prevent pregnancy. When we go to the hospital, the nurses tell us to use them. They say it prevents HIV. But who are you to bring condoms home? If your husband catches you with them, that'll be the end of the marriage. Because he'll say you're either cheating or implying he is (FGD 5).

Due to migrant women's inability to negotiate sexual activity with their spouses, most women also explained that they are unable to decide when to have sex. This limited autonomy sometimes led to unplanned pregnancies. Furthermore, migrant women explained that they felt pressured to have more children because they lacked extended family/communal support for farm labour in their new settlements. However, despite the cultural prestige and economic benefits of having many children for migrant families, a larger family size has implications, as shown in the following account:

> Giving birth to many children is good. Your husband will not have to beg or pay people to come and help on the farm. But if the children are many, the mouths to feed are also many. So are the school fees, hospital bills, and others. If you do something for one child, you must do it for all of them (FGD 4).

Tied to migrant women's inability to decide family size is the lack of autonomy in negotiating spacing of birth. Women generally agreed that given the option, they would allow more intervals between childbirths. However the decision was not theirs to make as doing so could cause tension between them and their spouses. On the other hand, not heeding the advice of health workers to use contraceptives led to migrant women getting queried by health workers when they went for antenatal (ANC) check-ups:

> We get tired and burdened. Immediately this girl stops breastfeeding, I will get pregnant again. When you go to the hospital, the nurses get angry and ask how you got

> pregnant again in just one year. They say we don't listen to their advice on contraceptive use. But if you heed the nurses' advice, your husband will chase you away (Angelina, IDI, 29).

Key informants also recounted that their efforts to get women in rural BAR to use contraceptives were met with resistance. They indicated that although the uptake of contraceptives was low among all rural women, it was pronounced among the migrant women that they engaged with:

> We understand why it is difficult for women to come for contraceptives on their own. But it is worse with migrant women. Some of them tell you that in their culture they cannot do anything without permission from their husbands. But efforts to get their husbands to even talk to you prove difficult. And if the women think you're worrying them, they just stop coming to the health centre (Midwife, Ghana Health Service [GHS], Kintampo-South District).

The lack of autonomy in family planning decisions was also due to prevailing social expectations on women to produce children of a particular sex or gender. Some women observed that they were sometimes compelled to have more children if they had children of only one sex. Traditionally, among the people of UWR, men are considered heads of households and the source of lineage continuity. Women on the other hand are regarded a source of wealth, as they can be married off for their bride price. Thus, although boys are typically preferred because of the sociocultural privileges they confer, if a couple has no or few children of one sex, they keep trying until they get their preferred one. Migrant women added that the expectation to give birth to children of both sexes was more pronounced in BAR than in UWR. They explained that because of the extended family system practiced back in UWR, children were communally raised. Hence, even when they did not have biological children of a particular sex, they still had the privilege of parenting other relatives' children. These are elaborated in the quotes below.

> I have six strong young men and their father is happy. But when they're ready to marry where do we get the cows to secure their wives? My husband wanted us to keep trying but I couldn't give birth anymore (FGD 2, mother of six boys).

> Back home, children don't belong to one person. So if I have three boys and my sister-in-law has three girls, together we have six children of both sexes. But here, you are on your own (Kaunsob, IDI, 49).

Many respondents lamented that the burden of combining housework, farm work, and childcare in these remote locations often led to distress. Unfortunately, such distress is not considered serious enough to warrant medical attention. Some women indicated that this extreme fatigue often leads to decreased libido. Yet, due to their inability to negotiate sex with their spouses, they cannot refuse to have sex even when they are not in the right frame of mind:

> You wake up some days and feel the aches right down to your bones. But you must ignore them and go to the farm. You come back home and have to cook. By the time

> you finish, you're so exhausted and wish you could go straight to bed but no, your husband expects you to perform your duties in bed as well (Ziem, IDI, 41).

Overall, migrant women agreed that the challenges associated with their reproductive activities are exacerbated because they have left the comfort of their home region. They observed that back home in UWR, relatives or older adults in the household could easily intervene in intra-household issues. However, being alone in BAR increases the vulnerability of migrant women:

> Back home if your husband is worrying you (chasing other women or doing something wrong) you can plead with an elderly family member to help. They'll sit him down and talk to him because even though he's an adult, he's still their child (FGD 4).

Apart from the concerns about negotiating safer sex and planning families with their partners in a rural migration context, women also talked at length about some of the structural and cultural factors that affect their ability to seek health care.

Structural and sociocultural challenges to accessing reproductive health services. The inability to access maternal and general health care emerged as a strong issue in interviews with migrant women. Research participants agreed that several factors including financial, infrastructural, and sociocultural barriers hindered their ability to access and use reproductive health care. In the few communities where health facilities are available, the participants describe the quality of health services as poor:

> There is a small hospital here, but when you go, all they give you is paracetamol. They wait for the situation to get worse before they refer you to the big hospital. If we were indigenes, we could also afford to live in town, close to the hospitals. But since we're strangers, we have to hide in the bush and earn our livelihoods (FGD 1).

Even when migrant women want to seek health care outside their communities, they are unable to because of distance to health facilities, poor transportation, and the bad nature of roads. Women added that, even though they faced accessibility barriers prior to migration, it was easier to seek transportation help from other members of their community back in UWR than in BAR:

> If you decide to go to the hospital, you either must walk the entire distance which takes almost half a day, or you spend the whole day waiting for a vehicle which might not show up. By the time you get to the hospital your sickness is worse. (FGD 3).

> Even though back home our house was far from the hospital, you could easily ask someone with a bicycle to give you ride. Sometimes you don't even ask. When they see you in pain, they immediately offer to. But here, when they see you walking, they pass in silence. No one knows you (Nomu, IDI, 37).

Besides the infrastructural challenges that make health care utilisation difficult, some women indicated that even when they managed to overcome some of these barriers and made it to health centres, they were still required to pay some fees despite the NHIS. Raising this money proves difficult for most migrant women in rural BAR

due to their poor economic background. As a result, some women resorted to home delivery and herbal medicine as this was less expensive and tedious than trying to access formal health care.

> After all these struggles to get there, they will either say your health insurance is expired or doesn't cover some drugs. So you must either pay to see the doctor or go back home. Won't I just treat myself at home? (FGD 1)

For migrant women in remote areas, there was also an absence of other enabling factors such as social support, as migrants live away from friends and kin. This lack of social support further limits women's ability to actively seek health care, even when they need it:

> In UWR, you could beg an extended relative for money to go for ANC or ask a neighbour to come watch over your home while you go to the hospital. But here, we are in a strange land. Are you going to beg your landlord for money? Or tell his daughter to come and work for you? (FGD 5).

Due to the absence of these enablers of health care, most participants reported that irrespective of their health needs, farm-work had to be prioritised as there was no one to help shoulder their labour burdens. In the comment below, Ayo explains how this often led to a delay in first ANC visit, which is considered essential to the health of both mother and baby:

> You can't leave farm-work and go to the hospital. Unless, of course, you want to starve that day. If you choose to go to the hospital instead of working, you will still come back home to the same workload. So, even when you suspect you're pregnant, it's better to work and only go to the hospital when the pregnancy advances or if it starts disturbing you (Ayo, IDI, 33).

In effect, migrant women are denied the much-needed rest or health care required of pregnant women, which sometimes leads to pregnancy complications:

> No one cares if you're pregnant. If you used to go to the farm at dawn and come home at night, they expect you to continue in the same way even when you conceive. I lost my third pregnancy four months into my term because the work was just too intense (Vida, IDI, 31).

Speaking to the reproductive health challenges of migrant women, key informants explained that their inability to provide migrant women farmers with appropriate health care was mainly due to a lack of funds to secure the logistics needed to do their work.

> We know that most migrants live in secluded areas. So the best practice would have been to go to their communities, roam door to door and attend to them. But how do you do that? We don't have motorbikes and sometimes we don't get fuel allowance for a whole year. It's tough (Community health worker, GHS, Techiman-North District).

Another key informant added that some health centres that were set up in rural locations had to be shut down due to a lack of resources, reluctance of health personnel to accept postings there and the tensions that sometimes arose between health workers and community members.

> Most of the nurses we post there refuse to go. Look at a place like Alata Line—no electricity, no water, poor roads. Many nurses want to live in town. The few optimistic ones who agree to go usually run away within a few weeks. This girl, she went to Nadowli but came back crying after a month, she said that most of the time she either had to prescribe paracetamol to patients or refer them to bigger health facilities. And the community members were always blaming her for these poor conditions even though it wasn't her fault. (Key Informant, District Office, GHS).

Amid these challenges faced by migrants and health workers, migrant women had to devise mechanisms to manage their health needs/outcomes and ensure that what was expected of them daily as farmers, wives, and mothers was accomplished.

Coping strategies amid reproductive health challenges. Practicing time-management and multitasking were some of the coping mechanisms that migrant women farmers employed in addressing the challenge of juggling multiple roles as farmers, wives and mothers. This may be considered a counterproductive coping mechanism as women had to work longer hours to satisfy work commitments and make additional time for other activities such as seeking ANC/general health care. In doing so, migrant women end up with no leisure time, which has implications for their health and wellbeing. A quotation from an FGD illuminates this point.

> Sometimes what you do is to go to the farm earlier than you usually do, so that you can finish sowing early and come home. But even when you get home, you'll find other tasks lingering (FGD 3).

The limited avenues for health support led to migrant women's dependence on non-health related community groups and programmes for help. For instance, many participants reported being involved in the *susu adaka*—literally translated *savings box*—initiative. The *susu adaka* is a community-based initiative which encourages groups of women to save. This enables women to pool together resources that they could borrow from to support household and farming expenditure and pay back with little interest. The *susu adaka* was, therefore, a good source of economic capital for migrant women. However, despite being an association initially tailored for economic (particularly farming) needs, women reported soliciting non-financial help—such as health advice, babysitting, and other forms of support—from other members:

> You have no option. Sometimes if you (or a family member) are not feeling well, you ask your colleagues if they have any herbs or barks you could boil and drink (FGD 1).

This effort, though commendable, still falls short of meeting women's reproductive health needs due to its economic orientation. Further, as the *susu adaka* is a savings

group, it implies that migrants who are unable to raise enough funds to join the group remain excluded from the social support (albeit limited) offered by the group.

The most significant theme among migrant women was relying on divine intervention. Many migrant women cited a supreme being as their source of relief when faced with reproductive health challenges. Thus, when asked about the last time they received maternal or general health care, the popular response was, "By God's grace we have never been sick" as illustrated by the quote below.

> I gave birth to all my children at home. And by God's grace I have never had complications in the years we've been here. If one of us has a headache or fever, we boil some herbs and drink. The next day, by God's grace, we're strong enough to go back to work (Kaunsob, IDI, 49).

From the above quote, it is evident that migrant women do not consider pregnancy and some other ailments conditions that require medical attention. Although religion and spirituality may have a positive influence on mental health and general wellbeing, the reliance on spiritual or divine intervention results in some sicknesses going undetected or worsening without the necessary health check-ups:

> They recently told me that I have hypertension when I experienced severe headaches and got hospitalised. But this comes as a shock because from childhood I have always been a very healthy person. If you ever saw me at the hospital, then I probably escorted someone there. Now, I can't care for my grandchildren like I used to (Jane, IDI, 65).

Jane probably did not realise that the elevated levels of stress she was experiencing in BAR possibly resulted in her being hypertensive. Furthermore, although Jane's hypertension was not pregnancy related, this medical condition subsequently affected her ability to perform her reproductive roles as wife, mother, and grandmother. It was also evident from discussions with migrant women that a major reason most of them preferred to commit their problems to a divine being rather than seek help from friends, neighbours, or professionals was because of a general feeling of mistrust. Most migrant women considered themselves outsiders in their communities and as such did not trust that people they confided in would care enough to help their situation or keep information they provided confidential:

> If you narrate your problems to someone you consider a friend, they'll expose you to outsiders. Isn't it better to just leave all your problems to God who takes care of you unconditionally? (Atame, IDI, 47)

Interviews with key informants revealed that apart from generic programmes such as the NHIS which cover everyone in BAR, there are currently no interventions at the local level targeted at promoting the reproductive wellbeing of migrant women farmers.

> Well, I can't say that we have any special services for migrant women. We have general services for both male and female migrants and non-migrants. But that's it (Key informant, GHS, Techiman-North District).

Notwithstanding these obstacles affecting migrant women's reproductive health in BAR, the majority said that residing in the migration destination was more favourable than returning to UWR, as BAR experiences relatively better rainfall and has more fertile farmlands.

Discussion

This study explored the reproductive health experiences of migrant women from UWR in BAR of Ghana in a rapidly evolving environmental and sociocultural context. The findings reveal that in rural receiving societies, migrant women face limited autonomy in negotiating for safer sex with their spouses, deciding on the number of children to have, and independently making decisions to access and use reproductive health services. In cases where migrant women decide to seek health care, they encounter physical and economic barriers. Poor service delivery at health centres, limited social support, bad road networks and lack of transportation also impede migrant women's reproductive health care utilisation in rural BAR. However, regardless of these limitations, many migrant women did not intend to return to the environmentally fragile UWR.

Andersen's Healthcare Utilisation model helps to situate the ways in which migrant women's gender and sociocultural characteristics predispose them to reproductive health issues and shape their perceptions of health and health care. Further, as need is considered an important component and driver of health seeking behaviour, the belief that certain conditions such as pregnancy, fatigue, or stress do not require any form of medical attention ultimately reduces migrant women's chances of seeking health care until complications occur. Moreover, even when there is the active need to seek reproductive health care, the absence of enabling factors such as financial resources, transportation, and spousal/communal support serves as a barrier for migrant women farmers.

In addition to highlighting the structural dimensions of reproductive health, our findings also emphasise how sociocultural understandings of health affect women's reproductive outcomes in the context of migration. For instance, many women frequently attribute symptoms of illnesses to fatigue, and to avoid being labelled as lazy by their families and larger community, they tend to ignore these symptoms. This is consistent with studies which found in China that migrant women perceived themselves to be more resilient than non-migrant populations and therefore do not to seek care for 'minor illnesses.'[37]

These sociocultural dynamics further manifest in migrant women's reproductive autonomy. Although women's autonomy in making independent reproductive decisions is generally low in Ghana,[22] this situation is more complex for migrant women in rural areas of BAR due to their low educational and economic status and the absence of extended family support. Migrant women are therefore reluctant to negotiate safer sex or birth control use with their partners due to concerns that, should these requests result in domestic disputes, there would be no immediate/extended family members to intervene. Additionally, older women in UWR traditionally play roles of advancing women's reproductive needs and balancing the power of men in the household.[2] Because

this is mostly missing in migration destinations, migrant women feel disempowered in negotiating for reproductive rights in the household. This supports findings by Moyer et al. who assert that decisions by women in rural areas to use reproductive health services are largely influenced by husbands, mothers-in-law, and other household members, with women themselves possessing limited autonomy to influence this decision.[22] This situation is worse for migrant women because of the cultural desirability of larger family sizes, preferably with male children, which is seen as expanding family labour and building social capital.

For migrant women in rural Ghana, these sociocultural dynamics are compounded by economic and social vulnerability. Thus, in instances where there is the urgent need to seek health care, the lack of enabling factors discourages migrant women from seeking care. These challenges are amplified in the study context as migrant communities in BAR are located in remote areas that have no health facilities.[12] Moreover, these infrastructural challenges are reinforced by migrant women's poor social networks and the absence of specially tailored interventions to meet their reproductive health needs. Although local support networks in rural areas may be weak, they are still extremely useful during crisis, (e.g., for help reaching a health centre). The possibility for migrant women to build new ties in destination communities is rendered ineffective due to limited leisure time and emerging contentious social issues such as competition for farmlands, which cause mistrust in settler communities.[24]

Consequently, the coping strategies employed by migrant women in managing these challenges are counterproductive. Timely and regular ANC visits are important in the early detection and prevention of pregnancy related complications, low birth weights, as well as maternal and newborn mortality.[38] The *susu adaka* forms just one aspect of the enabling factors that encourage women's utilisation of reproductive health care, and might be exclusionary for migrant women who are not members of the group. Also, while spirituality provides migrant women farmers with some form of emotional support, it could be detrimental to their long-term health, as it reduces women's perceived need and motivation to seek health care. In addition, working longer hours leads to increased stress which could create health challenges or worsen existing health conditions.

Given these findings, it could be argued that migrant women's reproductive health and wellbeing are quite worse off in BAR as findings further revealed the absence of health facilities within five kilometres of most migrant settlements. This finding is problematic as the WHO recommends that for effective, quality health care delivery, health facilities are to be located within a five-kilometre radius of residential communities.[39] In comparison, due to the deprived state of the migration origin, government efforts are being channelled towards promoting health access, including the setting up of Community-based Health Planning and Services (CHPS) compounds in remote areas of UWR that previously had no health facilities. Consequently, the recent annual report of the GHS showed that 77% of CHPS in UWR were functional, compared with 72.9% of CHPS in BAR.[40] Additionally, CHPS contributed 34.7% and 8.1% to ANC and delivery, respectively, in the migration origin location, compared with 6.6% and 2.4% in the migration destination.

These findings are also supported by the recent maternal health study in Ghana, which found that 276 per 100,000 maternal deaths were recorded in the northern zone/migra-

tion origin, compared with 296 per 100,000 in the middle zone/migration destination.[41] These findings speak to the marginalisation of rural dwellers in BAR regarding health care, and the added vulnerability of migrant women as they are more predisposed to settling in the peripheries of BAR. Further, considering migrant women's prolonged hours on the farm (in addition to household chores), little time can be devoted to seeking health care—particularly if it involves travelling long distances. These findings have implications for Ghana's ability to meet its SDG objectives given that the country did not achieve its MDG targets of reducing maternal and child mortality.

Despite these reproductive hardships, most migrant women preferred to remain in BAR as agricultural productivity in the migration destination was still relatively better than the migration origin. This is consistent with studies that report that migrant farmers from UWR do not return home because they perceive opportunities in their destination communities as better and may also want to avoid being labelled as failures if they returned without significant economic achievements.[42]

Our study thus reinforces the findings of earlier research which show that the reproductive health of women in rural Ghana tends to be inhibited by sociocultural, economic, and infrastructural barriers.[2,12,27] It, however, departs from previous studies by highlighting the ways in which agrarian migration and consequent household and societal restructuring affects the reproductive health of migrant women. This added perspective is particularly important and timely, as ongoing climate change in UWR and similar agrarian contexts in SSA will continue to propel the outmigration of women, with consequent effects on their reproductive health.

Limitations and directions for future research. Data were gathered during the farming/harvesting season of BAR, hence most migrant women were busy with farm-work. This made participant recruitment quite difficult and slowed down the data collection process. Second, this research might have gathered richer insights if the experiences of migrant women were compared with those of non-migrant women in rural BAR and UWR. However, this was not possible due to our scope and limited time and budget. Finally, although the later version of Andersen's model used in this study highlights the role of sociocultural factors on health—and was therefore useful in exploring migrant women's predisposition, needs, and enablers of reproductive health care use—it does not fully capture the nuances of women's reproductive health experiences in Ghana.

There is the need for larger mixed-method studies which examine the experiences of both migrant and non-migrant women in migration origin and destination regions, in order to compare the experiences of women across the board. Moreover, although issues of mental/emotional distress and the use of spirituality as a coping mechanism emerged during interviews, these could not be probed in-depth. There is therefore the need for a study which examines the mental health experiences of agrarian migrant women and the influence of spirituality in these experiences.

Recommendations. The Andersen's Healthcare Utilisation model helps to highlight some recommendations on ways of improving the reproductive health experiences of migrant women in rural areas. First, given the importance of sociocultural factors—a key enabling factor of health care—for migrant women's reproductive health in rural areas, it is critical to implement reproductive health strategies targeted at addressing challenges embedded in sociocultural norms. In patriarchal settings, these measures

could include involving migrant men in educational and sensitisation campaigns aimed at promoting women's reproductive health. In addition to reducing skepticism about the purpose of reproductive health interventions, these measures could also make migrant women more willing to use existing reproductive health services. Similarly, engaging migrant men in these processes would make them more inclined to support their partners in their domestic duties, so that migrant women can make time to seek health care. Furthermore, governmental and non-governmental organisations working in rural areas could hold routine social programmes that provide health information and resources and bring together migrants and non-migrants in settler communities as a way of promoting access to services, networking and bonding. This would help to improve migrant women's social capital and promote their enabling factors of health care utilisation. At the structural level, policies that protect women's rights and wellbeing need to be better implemented to address issues of intimate partner violence and labour/wage equity. Improving migrant women's economic dispositions would better enable them to overcome financial barriers to reproductive health care utilisation such as health insurance renewal, transportation and other hidden costs. One way of doing this is to train women in trades such as craft making, dressmaking, or hairdressing to ensure that they have sustainable livelihoods outside of farming. As observed by scholars,[23] financial autonomy better positions women to negotiate (safer) sex with their spouses and partake in family planning decisions.

Infrastructural development in settler communities would also help to improve migrant women farmers' reproductive health and wellbeing. Building good roads will ease the burden of accessing health care in urban centres, particularly during medical emergencies/complications. Furthermore, providing settler communities with basic amenities would make health personnel more willing to work in these communities and also make the communities more accessible. Equipping health workers with the needed logistics would help them to better leverage this accessibility by conducting door-to-door reproductive health visits with migrant women and men who might be unable or unwilling to visit health centres. Finally, engaging with migrant women in rural areas about the need to seek health care during pregnancy/for conditions considered minor would aid to change their perceptions of health care. This would help to promote preventive reproductive health care use among migrant women in rural areas.

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