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

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Abstract: Increased migration rates demonstrate a rise in women seeking relocation as a means to access employment or academic opportunities; this 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 are deprived of due to various social, cultural, political, and economic factors. A secondary analysis design was implemented to explore the impact of social determinants of health, specifically socioeconomic status, culture, and education, on health outcomes and health care access of Ghanaian internal and external female migrants. Interviews collected from two primary studies were analyzed using thematic analysis and an intersectionality approach. Ghanaian female migrants experienced cultural, financial, social, and health accessibility related barriers in accessing health care services. Our findings will serve as a foundation for improving health outcomes for female migrant populations and support health care professionals' practice of cultural competence.

Keywords: women; migrants; Ghana; delivery of health care; health services accessibility; culture; education; socioeconomic factors



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1. Introduction

The World Health Organization reported approximately 763 million internal migrants and 258 million external migrants in 2019 [1]. 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 2690 migrants from Ghana to Canada, with 24.7% residing in Alberta [3]. This Albertan-based study focuses on female migrants within Ghana and from Ghana to Canada; it highlights Alberta as housing the highest number of Ghanaian immigrants in comparison to the rest of Canada [3].

International Labor states that 50% of the global migrant population consists of women [4]. This trend marks the feminization of migration, which defines the global increase in independent female migration to acquire opportunities for themselves and their families. Female migrants accounted for 47.8% of international migrants from sub-Saharan Africa [5]. Women migrate internally across provinces, states, or municipalities, or from urban and rural settings within their country of origin, or externally across national borders to maintain permanent or temporary residence in the destination country [6].

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 [7]. In sub-Saharan Africa, there is insufficient research regarding the intersection between socioeconomic status and access to health care.

The purpose of this study is to explore how the social determinants of health impact access to health care and health outcomes of Ghanaian migrants in Ghana and Canada, to outline barriers encountered by female migrants irrespective of whether they migrated internally or externally. We particularly report on the influence of the migration process, level of education, socioeconomic status, and cultural perceptions on access to health services of female migrants.

2. Ethical Considerations

Ethical approval was obtained from the Research Ethics Review Board at the University of Alberta, Canada for our secondary analysis [Pro00097128] to access the primary studies' audio files and transcribed interviews. The secondary analysis presents no anticipated risk of discomfort or harm to the participants [8]. 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. Informed consent has been previously obtained from participants of both primary studies.

3. Materials and Methods

3.1. Secondary Analysis and Intersectionality Approach

We employed a secondary analysis design which consisted of examining data, collected by another researcher, to answer questions different from those posed by the primary study [9]. We analyzed unexplored concepts gathered from the existing data of two primary focused ethnographic studies, for more information on primary studies, refer to Table 1. Study A [10] focused on exploring 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 of Study B [11] was to examine how female migrants in Accra, Ghana understood health and how this shaped their health behaviors for their self-care and their family's self-care; furthermore, the research investigates how place and culture intersect and shape health beliefs and practices.

Table 1. Primary Study Details.

	Study A	Study B
Purpose	Economic female migrants to Canada Access to health care and outcomes	Ghanaian women understanding of health and health outcomes
Method	Focused ethnography design	Focused ethnography design
Setting	Conducted in Edmonton, Alberta, Canada	Conducted in Accra, Ghana
Sampling	Purposive and snowball sampling technique Sampling data has 19 women (10 from both South Africa and Ghana, and 9 from Nigeria)	Snowball sampling technique Sampling data has 44 women (23 migrated to the city and 21 stayed in rural villiage)
Inclusion Criteria	Low socioeconomic status female migrants from Ghana, Nigeria, and South Africa; migrated from 2007 to 2017 to Canada; classified as economic class; and between 20 and 60 years of age	Moved independently, from Northern region in Ghana to work in the market in Accra

We applied the intersectionality approach to our theoretical framework for this study; intersectionality refers to the interactions between categories and particular in our study gender, institutional arrangements, cultural ideologies and outcomes, and other aspects that formulate an individual's life [12]. 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.

3.2. Sampling

The inclusion criteria for the secondary analysis consisted of Ghanaian female participants, within 20 to 70 years of age, migrants who relocated for quality of life improvement, interviews with a duration of at least one hour, clear audio recordings with minimal background noise, and interviews conducted by various members of the primary research teams. From the participants who met the inclusion criteria, a subsample of fourteen interviews were selected at random by Dr. Richter, seven from each primary study.

3.3. Data Collection and Framework of Analysis

Data were collected in the primary studies via semi-structured narrative individual interviews. The participants were allowed to have the interview directed in the language of choice which was transcribed verbatim by local researchers to maintain accuracy. 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. Data cleansing and back translation were performed in the primary studies to confirm the accuracy of the data. The translations were reviewed by Ghanaian researchers, to assess for quality and credibility.

We conducted a thematic content analysis [13]. Our team had access to the original audio files, verbatim transcripts, 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 detailed coding framework, refer to Table 2. Initial codes were manually formulated via a line-by-line analysis of the transcripts and further examined for patterns. Categories were developed from a comparative analysis of the codes which facilitated the identification of themes and sub-themes emerging from the selected participant transcripts.

Table 2. Coding Framework.

Themes	Sub-Themes
Influence of behavioral and environmental factors on migrant health outcomes	Altered working conditions Decline in health from occupational hazards Transportation difficulties in accessing services Perception in health care Lack of social support systems Effects of leaving family members
Education and health knowledge	Level of formal education Sources of health knowledge
Influence of socioeconomic status on health	Income, employment, and expenses Adequacy of health insurance Financial constraints Societal perceptions Remittances
Cultural beliefs and perceptions towards migration	Influence of gender on migrant health Gender barriers in accessing health services Use of herbal medicine Cultural shifts on arriving to destination

3.4. Rigor

We incorporated investigator triangulation by utilizing two individuals from the research team to code the data and reached consensus regarding analysis decisions; by collaborating in our efforts, we “reduce[d] the possibility of biased decisions and idiosyncratic interpretations” [14]. Furthermore, we improved the data analysis process by interacting with the research team and accessing a compilation of skills, expertise, and diverse perspectives. We discussed the emerging interpretations with a Ghanaian scholar associated with one of the original studies, as a form of member checking. The Ghanaian scholar assessed

and validated whether our team's thematic analysis was an accurate representation of the participants' realities [14].

Performing a secondary analysis on two ethnographic studies and analyzing individuals' lived experiences call for the identification of internal biases. Before initiating the research process, we identified our individual biases and examined our preconceptions that could potentially influence the research. These include our identification as female, first-generation migrants who potentially experienced similar adjustments when moving to a new country.

We individually maintained a reflexive journal to continuously record our perceptions of how prior experiences and knowledge affected our inquiry. Ongoing debriefing, involving external validation with the intent to review aspects of this study, occurred with our research team.

4. Results

Four themes were identified in the participant interviews: Section 4.1: influence of migration and health outcomes; Section 4.2: education and health knowledge; Section 4.3: influence of socioeconomic status on health, and Section 4.4: cultural beliefs and perceptions towards migration. To maintain participant confidentiality, quotes were assigned pseudonyms as identifiers.

4.1. Influence of Behavioral and Environmental Factors on Migrant Health Outcomes

Migration has a profound impact on the women irrespective of whether they migrated internally or externally. The environmental factors migrant women faced directly influenced health services accessibility, therefore altering their overall health. Factors surrounding migration were divided into the following sub-themes: altered working conditions, decline in health resulting from occupational hazards, transportation difficulties in accessing services, perception and attitude in health care, lack of social support systems, and effects of leaving family members behind.

4.1.1. Altered Working Conditions

The participants pursuing employment opportunities in Accra shared their arduous working conditions and the subsequent health outcomes. Adoma described her daily work routine, which the translator communicated as: "Approximately they spend about 12 h 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] [my] baby along when [I] was working in the markets . . . when the baby gets hungry [I] take 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 [my] first class like [I would] have to sleep a bit at the library . . . before [I] 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).

4.1.2. 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 [and] 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 [the lungs] 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.

4.1.3. Transportation Difficulties in Accessing Services

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).

4.1.4. Perception and Attitude in Health Care

An internal migrant 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).

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 [Ghana] . . . but here [Canada] 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.

4.1.5. Lack of Social Support Systems

Both participant groups report a lack of social support systems. The statements by internal migrants reported, “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), emphasizing 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). 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)

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”. (Akya)

4.1.6. Effects of Leaving Family Members Behind

Internal migrants did not elaborate on the challenges faced with leaving behind family members. Only external migrants discussed the impact of immigration on their relationship with their children; as Setor elaborated: “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 well-being 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).

4.2. Education and Health Knowledge

This theme explores Ghanaian migrants’ level of formal education (grade school and postsecondary inclusive) and the source of their health knowledge. Levels of formal education vary vastly among the internal and external migrant groups which influence their perception on health and their practice of health behaviors. The findings from this theme were divided into the following sub-themes: level of formal education and sources of health knowledge.

4.2.1. Level of Formal Education

The data suggest 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 recurring theme, 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” (Akya).

4.2.2. 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. The participant group of external migrants did not elaborate on their sources of health knowledge.

4.3. Influence of Socioeconomic Status on Access to Health Services

This theme analyzes Ghanaian migrants’ socioeconomic status and its impact on their access to health services. Circumstantially, socioeconomic status positively or negatively transformed the migrants’ quality of life, which, respectively, affected their accessibility to community services. The findings were divided into the following sub-themes: income, employment and expenses, adequacy of health insurance, financial constraints, and societal perceptions regarding remittances.

4.3.1. 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).

4.3.2. Adequacy of Health Insurance

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 internal 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).

4.3.3. 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 [my 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 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).

4.3.4. 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 four 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 external migrant 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).

4.4. Cultural Beliefs and Perceptions towards Migration

This theme explores the cultural beliefs associated with migration and Ghanaian women's utilization of health services. The internal and external migrants had differing perspectives on female migration, which were contingent on the migrants' social environment. 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.

4.4.1. Influence of Gender on Migrant Health

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 [the] 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[s] . . . If you think going to [the] 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.

4.4.2. 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).

4.4.3. Cultural Shifts upon Arriving to the Destination Region

Internal migrants did not experience cultural shifts upon migrating, as they remained within Ghana; however, external migrants have experienced a cultural shift when arriving in Canada. 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).

5. Discussion

Our research demonstrates multiple factors that influence the experiences of female migrants irrespective of whether they migrated internally or externally. The intersections of gender, culture, education, and socioeconomic status significantly impacted female

migrants' health outcomes. Internal and external migrant women are marginalized populations who face adversity when accessing health services; this 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 behaviors.

Internal and external migrants experienced different demands on their health, related to their new working environment. Internal migrants encountered demanding working conditions in the markets of Accra and vigorous working hours, which consisted of strenuous activities, to earn sufficient wages. Lattof et al. describes female migrants to have a self-reported decline in health status upon arrival in Accra [15]. Internal migrants experienced associated health consequences and exposure to disease-bearing environments. Certain employment occupied by most of the internal migrants, such as kayayei [head porters], was physically demanding, requiring agility, strength, and endurance. Additionally, kayayei experience notable physical hardships, including starvation, deteriorating health, sexual violence, and illness [16]. External migrants did not describe facing substandard work environments or any resulting detrimental health effects.

Participants in Canada recognized the influence of their new environment on their overall health. They expressed challenges with balancing the educational requirements of their schooling and the responsibilities of their employment. 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 [17]. External migrants described the benefits of health promotion strategies integrated into the health care system as they promoted early disease identification and treatment options. Migration significantly impacted the mental and spiritual health of female migrants as a result of their separation from family and community members. External migrants experienced changes in familial dynamics post-migration resulting in altered gender roles and responsibilities of family members, distanced relationships, and emotional implications on children left behind. 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 [18]; the immigrants develop the same or potentially worse health status than that of the Canadian-born population [19]. The importance of expanding health efforts to all aspects of migrant health, including spiritual and mental health, is important, as it improves the overall quality of life and allows for the provision of holistic care.

A notable physical barrier to accessing health services was transportation methods. Both internal and external migrants experienced challenges in accessing transportation or navigating the transportation system. Similarly, Bangladeshi immigrant women in Canada found the distance of health facilities and transportation availability to be common barriers directly related to the under-utilization of health services by migrants [20]. Our research highlights transportation to be a significant barrier faced by Ghanaian migrant women, irrespective of the residing country.

The findings demonstrated a consequential lack of support, amongst internal and external migrants. Participants residing in Ghana and Canada described feelings of isolation and vulnerability emerging after moving away from family and community members. Supporting research states it is common for migrants to experience social isolation, as well as decreased social support post-migration [21]. External migrants from visible minority groups with lower education and socioeconomic status are more susceptible to negative mental health consequences [16]. Our findings reflect how 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. The decline in psychological health has been attributed to stressors of the immigration and settlement process, and racialization faced by the visible minorities [21].

Information accessibility includes the right to locate, receive, and convey ideas and information regarding health concerns without compromising the confidentiality of per-

sonal health data [22]. Evidence shows that low literacy levels and language barriers negatively impact health care access in migrant populations [23]. Literacy and educational levels varied amongst internal and external migrants. Internal migrants generally received lower levels of formal education consisting mainly of grade school education, in comparison to external migrants who primarily described receiving advanced education. 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. A World Bank 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 [24]. Internal migrants relied heavily on family members to gain health knowledge and utilized their female social connections to advance health understanding; external migrants did not elaborate on their source of health knowledge in Canada. Based on our findings, information received on effective health behaviors is transferred among family members and facilitates a better understanding of concepts, such as contraceptive practices and nutritious dieting. Adjei and Buor associate a lack of health education with poor utilization of health services [25], emphasizing the need for migrant populations to receive health education and gain health literacy abilities globally.

Internal migrants struggled to cover necessities, such as nutritious foods, with their inadequate wages, which leads to the exacerbation of negative health outcomes. External migrants described challenges with accessing nutritious food due to a lack of or increased pricing of traditional Ghanaian food in Canada. Their expenses include paying for children's schooling and international fees to access advanced education for themselves. 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 [25].

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 [22]. To ensure equal access to health care between migrant and non-migrant populations, health insurance for all is crucial [15]. Health insurance is categorized as a barrier in accessing health services as financially stable individuals receive priority care by the Ghanaian health system, which further undermines the health outcomes of internal migrants. In comparison, Ghanaian migrants in Canada did not experience barriers surrounding access to health insurance. However, adjusting to a new health care system and understanding how to maximize the registration for and usage of universal health coverage was a challenge.

Self-directed female migration is a strategy to maximize income generation through which financial support can be extended to family members. Both women that have migrated within Ghana or to Canada 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 [15]. According to our research, migrant women experienced heightened financial burdens resulting from the societal pressure of providing financial support to family members in place of origin. The stressors related to the expectation of remittances resulted in the migrants sacrificing their quality of life and encountering deteriorating health outcomes.

Internal female migrants reported a decline in health outcomes associated with their biological sex, centered around the physiological impact of childbirth on their health. Internal migrants outlined the limitations faced in accessing health services based on the societal gender norms which dictate the need to seek support from the family's male figure. Ferdous et al. describe how certain female migrants require familial sanctions to access health care presents a significant deterrent in maximizing health outcomes [26]. Cultural barriers include perceived societal gender roles and cultural perceptions of health and illness. The social construct of gender dictates norms surrounding expectations, behaviors,

and familial roles related to masculinity and femininity [4]. The ability for women to practice autonomy over health is highly dependent on their access to and control of health resources. External migrants did not discuss any experiences with gender barriers and their impact on their health.

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]. 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 potentiates reluctance to access health services. Internal migrants relied on herbal medicine as a means to access affordable treatment regimens; financial constraints are a barrier to accessing health services and thereby deter improved health outcomes. Ghanaians residing in higher-income households demonstrated a higher probability of utilizing modern hospital facilities in comparison to those with lower socioeconomic status, who are more likely to rely on self-medication and herbal medicines [28]. In our study, external migrants participated less in the use of herbal medicine in comparison to modern medicine.

Internal migrants do not experience cultural shifts as they are migrating within the same country. External migrants underwent a noteworthy cultural shift when arriving in Canada; the language is not the same as their mother tongue and the health care system is structured differently. Impaired access to health care services related to cultural and linguistic barriers has resulted in inadequate health care delivery, delay in health-seeking behaviors, and negative health outcomes for migrants. External migrants 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 [29].

Our research aims to contribute knowledge about the impact of an individual's socioeconomic status, education, and culture on their access to health care, with a focus to advance women's health and facilitate the integration of female migrants in their host countries.

6. Limitations

The utilization of secondary analysis presented limitations in the collection and the analysis of pre-existing data since the primary data were collected to address different but associated questions.

7. Recommendations

The Canadian health care system lacks appropriate levels of 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. Woodgate et al. recommend information sharing via educational materials in multiple languages focusing on accessing health services to reduce linguistic barriers in migrant families [19]. Culturally competent care must be integrated throughout all health services within the system to improve migrant experiences in accessing care.

We hope for our findings to inform health care systems to provide culturally competent services and advocate for the consideration of diverse social determinants of health in the delivery of health services. Governments, health care providers, policy makers, and researchers are all urged to enact a more proactive role in developing strategies to promote the delivery of culturally sensitive care and facilitate the mitigation of barriers encountered by vulnerable migrant populations.

8. Conclusions

The conclusion is derived from the 14 interviews of female Ghanaian migrants, 7 of whom internally migrated within Ghana and 7 externally migrated to Canada. Female mi-

grants, irrespective of whether migrated internally or externally, continue to face challenges in accessing health services and maintaining quality health outcomes. The aforementioned challenges consist of literacy, social, financial, and cultural barriers. No comparisons were made with male migrants as we suspected the findings to vary due to the potential distinction in environmental, cultural and social factors between the two genders. Our research presents suggestions for improving female migrants' health outcomes and access to care. An initiative to promote migrant health needs to design health services that are inclusive, affordable, accessible, as well as linguistically and culturally appropriate. Further research is needed to develop improved delivery models of care.

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Informed Consent Statement: Not applicable.

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