UNIVERSITY OF EDUCATION, WINNEBA

ANTECEDENTS OF SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICE UTILIZATION AMONG FEMALE POTTERS (KAYAYEI) IN ACCRA METROPOLIS

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A thesis in the Department of Social Studies Education, Faculty of Social Sciences Education, submitted to the school of Graduate Studies in partial fulfillment

of the requirements for the award of the degree of Master of Education (Social Studies Education) in the University of Education, Winneba

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DECLARATION

Student's Declaration

I, **Ardyce Fafa Ayensu**, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

Signature: ……..….

Date: ……..….

Supervisor's Declaration

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

Supervisor's name: Mr. Cletus Ngaaso

Signature: ……..….

Date: ……..….

DEDICATION

This work is dedicated to my lovely father, the late Francis Kwesi Ayensu of blessed memory, and my sweet mum, Josephine Babah

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ABSTRACT

This study explored the knowledge, awareness, access to, and the utilization of sexual and reproductive health (SRH) services among female porters (Kayayei) in the Accra Metropolis. The study adopted a qualitative case study design. A purposive sampling technique was used to select thirteen (13) participants, and data were collected through in-depth interviews using a semi-structured interview guide. The collected data were analyzed thematically. The findings revealed that Kayayei demonstrated a basic understanding of sexual and reproductive health, largely centered on safe sexual practices, maternal health, and the prevention of sexually transmitted infections (STIs). However, their knowledge was generally limited in depth and scope. Although awareness of SRH service providers within the metropolis was relatively high, detailed knowledge of specific services such as family planning options and STI screening remained low. Access to and utilization of SRH services were influenced by factors including personal health needs, cultural beliefs, social influence, and proximity to healthcare facilities. Nonetheless, significant barriers such as financial constraints, demanding work schedules, stigma, negative provider attitudes, and logistical challenges hindered effective utilization of services. Based on the above findings, the study recommends the implementation of context-specific interventions, including culturally sensitive SRH education delivered in local languages, the deployment of mobile clinics in market areas, and the strengthening of peer support systems to improve access and utilization of SRH services among Kayayei.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The Sustainable Development Goals (SDGs) stress how vital it is to guarantee access to healthcare services related to sexual and reproductive health. SDGs 3.7 and 5.6, in particular, are committed to ensuring that everyone has access to family planning, education, and information, as well as other essential sexual and reproductive health services (UN, 2015). Global education and promotion of sexual and reproductive health among migrant adolescent girls is desperately needed, in accordance with Agenda 2030. Migration raises the risk of negative consequences for females' sexual and reproductive health and is a major global policy issue, thus this is required (Abubakar et al., 2018; Ivanova et al., 2019). Given that there are currently almost 740 million internal migrants worldwide, it is even more critical to meet these health requirements. Adolescent females make up around 80% of these migrants in developing countries' metropolitan areas (McAuliffe & Ruhs, 2017).

The economic differences that exist between countries, regions, or the world, have made migration a necessary component of human social life. According to Lucas (2015), people migrate from one region of the country to another due to the unequal distribution of socio-economic and educational possibilities. Within Ghana, people migrate internally in all directions (Castaldo et al., 2012). However, migration is more prevalent from the north to the south, and is linked to socio-economic and health consequences. Due to the prevalence of internal migration, nearly all northern women are anticipated to go south at some point in their lives in pursuit of a better economic future (Azumah & Onzaberigu, 2018).

'Kayayei', or female head-porters, are a group of women who have moved from their rural communities to commercial or urban areas in pursuit of better economic prospects. According to Abdulai (2016), internal migration is the movement of young women across national borders from their areas of origin, or livelihood to various destinations. These women participate in the informal sector, by carrying bags, items, or a load for a negotiated fee, but they frequently encounter a number of difficulties, including exploitation, subpar working conditions, and a lack of social protection. Some people may experience a rise in their personal incomes, but they may also face several negative repercussions that could impact their health and future (Kuyini et al., 2020). These detrimental effects of migration may also have an adverse effects on their reproductive rights and health. These women are thought to have a higher rate of unsafe abortions, unwanted pregnancies, and unstable sexual relationships than the overall population (Kwankye, 2010). It is also thought that many of them have limited access to adequate sexual and reproductive healthcare services.

According to research, 'Kayayei' typically settled in densely populated, underdeveloped urban areas where they frequently lack safe housing and access to necessities (Awumbila et al., 2011; Owusu et al., 2008). They are more vulnerable to sexual and reproductive health issues as a result of their living circumstances, low income, and inadequate education. Additionally, the stigma and discrimination related to their line of work could discourage them even more from obtaining quality healthcare services.

Odo et al. (2018) state that one of the foundations of sustainable development and a significant public health concern is sexual and reproductive health (SRH). In addition to being free from unintended pregnancy, unsafe abortion, STIs, including HIV, and all types of sexual abuse and coercion, SRH also refers to physical and mental welfare.

Since most people start having sex throughout adolescence, those in this age range are more likely to experience SRH issues (Wakasa et al., 2021). People's sexual and reproductive health (SRH) requirements are frequently neglected and undervalued in many African nations, including Ghana, even though these services are urgently needed and their necessity has been shown (Geary et al., 2014). However, sexual and reproductive health is a basic human rights, and both public health and individual well-being depend on having access to the necessary services. The purpose of this study is to ascertain the variables that affect the use of sexual and reproductive healthcare services by Ghanaian female potters popularly referred to as 'Kayayei'.

1.2 Statement of the Problem

The utilization of sexual and reproductive health services plays a crucial role in averting numerous health issues related to sexual and reproductive health among adolescents (World Health Organization [WHO], 2015). Despite this importance, significant disparities exist in accessing these essential health rights, contributing to adverse health outcomes (Starrs et al., 2018). Such disparities are starkly evident in marginalized groups, including the Kayayei (female potters) in Ghana. This population, characterized by its migratory nature and informal work status, faces unique challenges that hinder access to and use of sexual and reproductive healthcare services. The lack of targeted health interventions, compounded by social, economic, and structural barriers, exacerbates the vulnerability of Kayayei to sexual and reproductive health problems.

Literature shows that various researchers have studied the factors influencing the uptake and utilization of sexual and reproductive health services but this was limited to adolescent (Phongluxa et al., 2020; Abdurahman et al., 2022; Wakjira & Habedi, 2022) and people with disability (Shiwakoti et al., 2021; Diribsa et al., 2022). However, none

of the studies explored the antecedents associated with SRH uptake and utilization among female head porters (Kayayei's). Besides, local studies have traditionally focused on the predictors of contraceptive usage and reproductive experiences among female porters (Kayayei) but failed to investigate the factors influencing sexual and reproductive health service utilization (Dassah et al., 2022; Amponsah-Tabi et al., 2023). Therefore, this study seek to investigate the factors that influence the utilization of sexual and reproductive healthcare services among female potters, also known as Kayayei, in Ghana.

1.3 Research objectives

The main objective of this research was to investigate the factors that influence the utilization of sexual and reproductive healthcare services among female potters, also known as "Kayayei", in Ghana.

Specifically, the study sought to:

1. explore female potters' understanding or knowledge of sexual and reproductive health services.
2. assess female potters' level of awareness of sexual and reproductive health services in the Accra Metropolis.
3. examine the factors that influence the access and utilization of sexual and reproductive health services by female potters in the Accra Metropolis.
4. explore the barriers or challenges faced by female potters in accessing sexual and reproductive health services in in the Accra Metropolis.

1.4 Research Questions

The following research questions guided the study:

1. What is the level of understanding or knowledge of sexual and reproductive health services among female potters in the Accra Metropolis?
2. How aware are female potters of the available sexual and reproductive health services in the Accra Metropolis?
3. What are the factors that influence the access and utilization of sexual and reproductive health services by female potters in the Accra Metropolis?
4. What challenges do female potters faced in accessing sexual and reproductive health services in the Accra Metropolis?

1.5 Significance of the Study

This study is of significance, and will contribute to the body of knowledge on sexual and reproductive healthcare access, particularly within marginalized populations such as female potters (Kayayei) in Ghana. Additionally, by systematically examining the antecedents of healthcare service utilization within this population, the study adds depth to our understanding of the barriers and facilitators to accessing essential healthcare services.

Also, the outcome of this study will hold various implications for healthcare policy and planning in Ghana. By assessing the knowledge and awareness of SRH services among female potters, the study can inform the development of targeted educational interventions. These interventions can aim to improve awareness of available services, promote preventive measures, and empower female potters to make informed decisions regarding their sexual and reproductive health.

Moreover, the study's findings on the barriers and challenges faced by female potters in accessing SRH services can sheds light on systemic inequalities and structural impediments within the healthcare system. Thus, by identifying these barriers, the study can advocate for policy changes and institutional reforms to address these challenges and ensure equitable access to SRH services for female potters.

1.6 Delimitation of the Study

The study focused exclusively on female potters (Kayayei) operating within various markets within the Accra Metropolis. While female potters may exist in other regions and rural settings of Ghana, this study limits its geographical scope to the urban context of Accra due to its significance as a major hub for informal employment and trade, where Kayayei are commonly found.

1.7 Limitations of the study

Despite its relevance and contributions, this study is not without limitations. Firstly, the study was conducted within selected areas of the Accra Metropolis, and as such, the perspectives gathered may not fully reflect the experiences of Kayayei in other geographical locations or rural settings. Additionally, cultural sensitivity and the private nature of SRH topics may have led some participants to withhold information, potentially affecting the depth of responses.

Finally, time and resource constraints limited the size of the sample and scope of fieldwork. These limitations suggest that while the study offers important insights, further research incorporating mixed methods and a broader demographic spread is necessary to build on these findings.

1.8 Organization of the Study

This dissertation is organized under the following five-Chapter headings: Introduction, Literature Review, Methodology, Analysis and Discussions, Conclusion and Recommendations. In particular, Chapter One introduces the study and provides vital background information. It provides the context and motivation behind the research, identifies the research problem, and outlines the proposed objectives of the study. The significance of the study is discussed, along with delimitations and limitations. Lastly, the chapter provides an overview of the organization of the entire dissertation. Chapter Two focuses on the extensive review of existing literature related to the study. It examines previous research and scholarly works that explore the factors that influence the utilization of sexual and reproductive healthcare services among female potters, also known as Kayayei, in Ghana. The chapter reviews literature, highlighting key theories, concepts, and findings relevant to the research. In Chapter Three, the methodology for data collection and analysis is outlined. It covers various methodological aspects, such as the study design, the target population, the sample selection process, ethical considerations, data collection methods, and data analysis techniques. This chapter provides a comprehensive overview of the research methodology employed in the study. Chapter Four presents the data analysis and provides an in-depth discussion of the findings. It involves the analysis of the collected data using appropriate statistical techniques. The chapter interprets the results, relates them to the research objectives and literature, and discusses their implications. The final chapter, Chapter Five, provides the findings, conclusions and the recommendations of the study. Finally, the study and offers suggestions for future research.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Existing literature can be informative on key directions for building best solutions for an identified scientific problem. Every research is born out of an existing work. As a result, a review of vital foundations for any scientific research cannot rule-out the use of existing literature. This chapter of the study focuses on a review of literature deemed appropriate for the study. The structure of this chapter concentrates on a review of key concepts, followed by a formal exposition of theoretical foundations relevant to the study. In addition, the chapter presents on the empirical review and the study's conceptualization.

2.1 Conceptual Review

This section explains the following concepts that form the foundation of this study:

2.1.1 The Definition of Sexual and Reproductive Health

According to Abdurahman et al. (2022), sexual and reproductive health (SRH) encompasses both physical and mental well-being and is free from an unintended pregnancy, unsafe abortion, STIs, including HIV, and any kind of sexual abuse or coercion. Sexual and reproductive health is defined by the UNFPA (2022) as a condition of total physical, mental, and social well-being in all areas pertaining to the reproductive system. Sexual health, as defined by the World Health Organisation (WHO) (2006), is a condition of physical, mental, spiritual, and social well-being with regard to sexuality; it goes beyond simply being free from illness, dysfunction, or infirmity. One may argue that promoting sexual health has a positive impact on people's physical and mental well-being.

In their contribution, Starrs et al. (2018) state that sexual and reproductive health services include not only well-known services such as HIV/AIDS prevention and treatment, but also sexuality counselling, STD prevention and management, and reproductive cancer prevention and treatment. Comparably, reproductive health services cover topics such as safe abortion, infertility treatment, pregnancy, childbirth, intimate partner violence prevention, and reproductive system education. For their part, Odo et al. (2018) believed that teenagers' access to and availability of sexual and reproductive health services were essential to the prevention and management of sexual and reproductive health issues. Additionally, these services are essential for advancing the general sexual and reproductive health of adolescents.

The primary service packages for preventing and minimizing risks and issues related to teenage reproductive health are SRH (Abdurahman et al., 2022). Sexual and Reproductive Health and Rights (SRHR) must be implemented in order to achieve SRH, which is a condition of general health and well-being pertaining to all facets of sexuality and reproduction (Cottingham et al., 2010). Accordingly, everyone has the right to "make informed decisions regarding what happens, and when, to their bodies" (Dune et al., 2022; Cottingham et al., 2010). Choices including whether and when to engage in sexual activity, sexual partners, polite relationships, sexual coercion, marriage, access to contraception and reproductive healthcare, and whether and when to have children are all included in this. According to Dune et al. (2022) and Cottingham et al. (2010), it also entails having "access to the information, services, and resources to navigate these choices free from discrimination, violence, and coercion."

2.1.2 Overview of Female Potters (Kayayei) in Ghana

The name "kayayei", is a combination of the Hausa word "kaya," which means "load," and the feminine modifier "yei," which in Ga means "yoo" in the singular (Kwankye et al., 2007). In markets, the phrase refers to women and girls who, for a fee agreed upon with the customer, carry items on their heads (Awumbila & Ardayfio-Schandorf, 2008). They are essential to trading activities, and travellers, purchasers, and store owners who need to move items across the market use their services (Ahlvin, 2012). In the past, men who moved cargo on hand trucks and carts controlled the head porting or kaya industry. Despite the fact that males still push carts filled with goods in markets, women have taken up the activity in the informal sector due to the rapidly increasing demand for moving things on one's head due to the competition for space between vehicles, goods, and people (Yeboah, 2009).

In pursuit of greater economic possibilities, the majority of the “Kayayei” are migrants from northern Ghana, who migrate on their own to the south of Ghana, particularly Accra and Kumasi in the Greater Accra and Ashanti region, respectively (Awumbila & Ardayfio-Schandorf, 2008; Yeboah, 2009). The Mamprusi, Gonja, Kotokoli, Mossi, Frafra, Bimoba, and Dagomba ethnic groups in Ghana's northern regions, the Northern, Upper East, and Upper West regions are home to a large number of those employed in the kayayei activity. A small number of “Kayayei” are from Burkina Faso and Togo. In order to make ends meet, most “Kayayei” women are compelled to flee to Accra as a last choice. Since they typically have no long-term plans to serve as head porters, their movement pattern seems to be cyclical and temporary (Kwankye et al., 2007). Every few months, some Kayayei return to the north to spend time with their spouses and families, while others return to the cities to earn more money. Others use the kaya business to raise money for other ventures or buy wedding-related items (Ahlvin, 2012;

Awumbila & Ardayfio-Schandorf, 2008). This migratory pattern contrasts with that of their male counterparts, who relocate over an extended period of time and are subsequently joined in the city by their family (Kwankye et al., 2007).

2.2 Theoretical Review

This section concentrates on the theoretical underpinnings that provide the foundation for understanding the factors that influence the utilization of sexual and reproductive healthcare services among female potters, also known as Kayayei, in Ghana. Issues discussed include the following:

2.2.1 The Health Belief Model

The Health Belief Model (HBM) is a theoretical model concerned with health decision-making. A theoretical framework that addresses health decision-making is the Health Belief Model (HBM). The model aims to explain the circumstances under which an individual will pursue personal health behaviors, such as screening for preventative diseases or seeking treatment for existing disorders (Rosenstock, 1966). According to Glanz et al. (2002), the Health Belief Model is thought to be the most widely applied theory in health promotion and education. The 1950s saw the development of this psychological model. Since that time, the concept has gained popularity among researchers and been adopted or modified in a number of ways to explain a range of short- and long-term health practices. Based on a number of social and demographic factors, the theory aims to explain and forecast people's health-related conduct. According to Sheeran and Abraham (2015), the core idea of the original HBM is that health behavior is influenced by a variety of interpersonal factors, including personal beliefs or perceptions about a sickness or condition and the methods available to lessen its impact.

Perceived vulnerability, perceived severity, perceived advantage, perceived barrier, self-efficacy, and cues-to-action are among the fundamental ideas of HBM (Skinner et al., 2015). An individual's belief that they are personally at risk of contracting a disease or illness is known as perceived susceptibility (Harvey & Lawson, 2009). An individual's belief that a sickness or condition could have major repercussions is known as perceived severity (Becker et al., 1978, as referenced in Rollins et al., 2018). Furthermore, perceptions of perceived barriers and perceived benefits relate to ideas about potential roadblocks to action, such as the unfavourable effects of the suggested course of action (Champion & Skinner, 2008). Conversely, self-efficacy is the belief that one can carry out a suggested action (Bandura, 1977). One important factor that influences health behavior is self-efficacy (Sheeran et al., 2016). Lastly, cues-to-action are external or internal elements that can encourage a healthy behavior.

From internal medicine and surgery to public health, HBM has been extensively used in health behavior research (Carmel, 1990; Tordera et al., 2009; Armstrong et al., 2009). Nonetheless, there have been several documented issues with the model. For example, similar to other rational choice models, the health belief model does not indicate the conditions in which people will make a more logical option. Additionally, the model fails to recognise the impact that an individual's emotions, such as worry or accomplishment, can have on rational reasoning and decision-making (Berker, 1974).

In general, the HBM paradigm states that individual views or beliefs about a condition and the methods available to reduce its incidence determine health behavior. The entire spectrum of interpersonal interactions that impact health behavior has an impact on personal perception (Motuma, 2012). Conversely, cognitive theorists place a strong emphasis on the role of people's subjective expectations and hypotheses, holding that

behavior is determined by one's subjective assessment of the issue and the subjective likelihood that a given course of action will result in a favourable outcome. This belief may stem from the notion that mental processes like reasoning, thinking, and hypothesising are essential elements of all cognitive theories (Mengistu & Melku, 2013). Consequently, the use of health services was further defined in terms of the individual's estimations of their own vulnerability to and perceived severity of sexual and reproductive health (SRH) issues, as well as their assessment of the cost-benefit analysis, which involves weighing the expected benefits of a course of action against perceived barriers and the possibility that they can lessen that threat through self-efficacy or personal action. HBM is, therefore, relevant to this study since it can assist in determining the particular views of Kayayei with respect to SRHS, such as their perceived vulnerability to reproductive health problems, their assessment of their severity, and the obstacles they face in obtaining services.

2.2.2 Theory of Planned Behavior Model

The theory of reasoned action (Ajzen & Fishbein, 1980) was extended into the Theory of Planned Behavior (TPB) due to the original model's shortcomings in handling behaviors over which persons have only partial volitional control. The purpose of the individual to engage in a particular behavior is a key component of the theory. Intentions are seen as motivating variables that impact an action; they show how willing a person is to try and how much effort they intend to put out to carry out the behavior. According to the theory, three factors influence intention: perceived behavioral control, subjective norm, and attitude towards the behavior (Ajzen, 1991). A person's positive or negative thoughts about a particular conduct are referred to as their attitude or personal attitude. It is the degree to which an individual has a positive or negative result assessment of the particular behavior. In this sense, Kayayeis' evaluation of the risks

associated with hazardous sexual conduct will appropriately advise people of the necessity of abstinence or safe sex as a way to avoid unintended pregnancy and STIs/STDs, such as HIV and AIDS.

The influence of social pressure that a person perceives to either perform or not perform a specific habit or action is referred to as a subjective norm. Among other people who are referred to as significant individuals or groups from the person's surroundings, parents, teachers, and guardians are the sources of social pressure. Subjective norms are determined by an individual's motivation to follow the demands of these referents as well as their ideas about what each referent believes an individual should do. According to this case study, a Kayayei should believe that their partner, friends, and family will support them in their intentions if they engage in safe sex.

The sense of how easy or difficult it is to show a particular behavior is known as perceived ability or perceived behavior control. It takes into account both anticipated challenges and prior experiences. A person's desire to engage in a conduct is stronger when they have a more positive attitude and subjective norm about the behavior, as well as when they feel more in control of their behavior (Ajzen, 1991). As a result, the person needs to believe that they are capable of changing their conduct. All things considered, the TPB can be used in this study since it can assist in determining the variables affecting Kayayei's behavioral intentions with relation to SRHS utilisation.

2.3 Empirical Review

This section delves into empirical studies nothing the factors that affect the utilization of sexual and reproductive healthcare services among female potters (Kayayei).

2.3.1 Knowledge and Awareness of Sexual and Reproductive Health Services

Numerous research have investigated the various populations' levels of sexual and reproductive health services (SRHS) knowledge and awareness. For instance, on a campus with a diverse student body in terms of race and ethnicity, Martin, Baralt, and Garrido-Ortega (2018) examined the association between religion and sexual and reproductive health (SRH) knowledge and awareness of campus SRH services. 996 undergraduate students from a prominent public institution in California were sampled for the study, which used a 43-item questionnaire to gather primary data. According to the study's data analysis, women who attended more frequently reported having less awareness about SRH than those who attended less frequently, a result that held true across religious affiliations. According to these results, Catholic, Protestant, and Evangelical women who attend religious services more frequently run the risk of having less information about SRH.

According to Tamang et al. (2017), young people in the Kathmandu Valley's cities were asked about their knowledge, experiences, and utilisation of SRH services. As a result, 720 women and 680 men between the ages of 15 and 24 were sampled for the study using a questionnaire. Chi-square or Fisher's exact test analysis of the data revealed that less than two-thirds of the 680 young men and 720 young women who participated knew about the fertile period, and less than half knew about the chance of pregnancy at first intercourse. While more than 75% of young men and women were aware of condoms and tablets, fewer than half were aware of intrauterine devices or implants. Women were much less likely than men to have used any kind of contraception and to have willingly participated in their first sexual encounter, even though their ages at first sex were identical ($p < 0.001$). The majority of both men and women (97.9%) were aware of STIs, although only 8% were aware of chlamydia, the most prevalent STI.

The main obstacle to receiving SRH services, according to more than 90% of young people, is feelings of shame.

In this work, Amankwaa et al. (2018) investigated the degree of SRH-related knowledge, service utilisation, and access among adolescents enrolled in school in Kumasi Metropolis, Ghana. 132 teenagers enrolled in school and six healthcare providers in the city participated in 18 in-depth interviews and 12 focus groups as part of the study. The majority of teenagers had strong understanding of the SRH services that were accessible, with a focus on the various types of contraceptives, according to the data analysis conducted utilising theme analytical framework. The usage of the many SRH services was difficult, though, and was limited to therapy. In their attempt to obtain SRH services, adolescents encountered a number of obstacles, such as social stigma, the attitude of service providers, fear of teachers, and the expected unfavourable reaction of parents because of Ghanaian society's intricate structure. It was taboo to discuss SRH-related topics with elders.

Additionally, in Ghana's Kwadaso Sub-Metropolitan District, Dapaah et al. (2016) investigated the sexual knowledge, attitudes, and practices of young people as well as their levels of use of sexual and reproductive health services. Data from a sample of 170 youth was gathered for the study, using the stratified sampling technique and a deliberate selection of one key informant. The study's findings show a strong correlation between youth service use and their knowledge of the local sexual and reproductive health services.

2.3.2 The Factors Influencing Access and Utilization of Sexual and Reproductive Health Services

Numerous studies have demonstrated that a wide range of factors impact the availability and use of sexual and reproductive health services (SRHS). For example, Abiiro et al. (2022), using the Andersen and Newman model, investigated the factors that encourage and hinder Ghanaian adolescents enrolled in school from using sexual and reproductive health services. The results of the respondents' interview thematic analysis showed that while religious prejudice predisposes teenagers not to utilise SRH services, parental support and a strong peer network predispose adolescents to use SRH services. Additionally, SRH service use is facilitated by adolescent-friendly social groups, SRH corners, and skilled healthcare professionals, but it is hindered by parental disapproval, unfavourable attitudes of healthcare professionals, and the inconvenience of medical facilities.

Additionally, Ninsiima et al. (2021) investigated the determinants impacting youth in sub-Saharan Africa's access to and use of youth-friendly sexual and reproductive health services (YFSRHS) through a systematic review. Using a variety of databases, the study examined research published between January 2009 and April 2019 in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols (PRISMA-P) criteria. According to the inclusion criteria, the results of 20 studies from 7 countries showed that the majority of the factors that facilitated service utilisation were structural in nature. These included health education, community outreach, and policy recommendations to improve the implementation of high-quality health services and clinics that catered to the needs and preferences of adolescents and young people. Additionally, the study discovered that structural barriers included

health workers' negative attitudes and their lack of skills, while individual barriers included youths' ignorance of YFSRHS.

Lumonje et al. (2019) looked at the factors influencing how young people living on the streets used the SRH services that were available to them. Data was gathered from a sample of 150 adolescents living on the streets (YLOS) in Nakuru Town, Nakuru County, Kenya, using a descriptive survey and a mixed-method approach. The results of the data analysis showed that the use of SRH services was related to demographic parameters such the type of work of the parents, whether or not the parents are employed, having relatives living on the streets, and the educational attainment of the young. The study also discovered that economic factors, such as the cost of SRH services and the charges made by hospital staff, were linked to SRH service utilisation.

In a similar vein, Binu et al. (2018) evaluated secondary school students use of sexual and reproductive health (SRH) services and related characteristics in Nekemte town, Ethiopia. Data was gathered from a sample of 768 secondary school pupils using the multistage cluster sampling technique. Bivariate and multivariate logistic regression analysis of the study's data revealed that exposure to information from teachers, prior history of perceived STI symptoms, having ever engaged in sexual activity, and conversations with health professionals were all factors that influenced secondary school youths' use of sexual and reproductive services.

2.3.3 Barriers or Challenges to Accessing Sexual and Reproductive Health Services

There are several obstacles and difficulties in obtaining sexual and reproductive health care (SRHS), many of which have been extensively described in the literature. For example, Badu et al. (2018) investigated the factors that facilitate and hinder visually

impaired women in Ghana's Ashanti and Brong Ahafo Regions from obtaining SRH services and care. The study sampled 21 visually challenged women from four MMDAs, Kumasi Metropolis, Bekwai Municipality, Amansie West District, and Wenchi Municipality using purposive and snowballing sampling strategies. Thematic analysis was used to examine the qualitative data that was gathered for the study utilising a structured interview guide. The findings showed that lack of preferred treatment and financial constraints were the main obstacles to receiving SRH services and care. Nonetheless, the study found that carer support and cordial connections with medical professionals were the enablers that made it easier to receive SRH services and care.

The difficulties that Ghanaian youth with disabilities (YPWDs) encounter in obtaining sexual and reproductive health care (SRHS) were also evaluated by Kumi-Kyereme et al. (2021). A sample of 127 YPWDs who were enrolled in school provided data for the study, which used a cross-sectional design. The main obstacles YPWDs had in obtaining SRHS were the high cost of health services, physical difficulties, and communication issues, according to the results of the analysis of the data obtained using binary logistic regression models.

In their contribution, Akazili et al. (2020) investigated the obstacles and enablers to the efficient delivery of three SRHR services in Ghana: safe abortion/post-abortion care, gender-based violence (GBV), and maternal health. Data was gathered from a group of twelve purposefully chosen people with extensive knowledge of SRHR concerns in Ghana as part of the study using qualitative research. Inadequate funding, the exclusion of certain SRHR services, such as family planning and abortion/post-abortion services, from the health benefits package, and hidden fees for maternal services are major

obstacles to the efficient delivery of SRHR services, according to the data analysis findings. The fragmentation of support services for GBV victims across organisations, inadequate supervision, unequal allocation of logistics and medical staff, and sociocultural and religious attitudes and practices that impact service delivery and utilisation are additional problems.

In a similar vein, Thongmixay et al. (2019) investigated the perceived obstacles that young people in the Lao People's Democratic Republic had when trying to get sexual and reproductive health care. The study used a qualitative research approach and selected 22 people aged between 15 and 25 years, from both urban and rural areas. The study found that, cognitive and psycho-social accessibility were the primary obstacles preventing young people from obtaining sexual and reproductive health care. Cognitive accessibility barriers identified in the study included a lack of sexual and reproductive health knowledge among young people, as well as limited awareness of available sexual and reproductive health services. Also, psychosocial accessibility barriers were largely shaped by fear and cultural norms. Participants expressed concern that their parents might find out about their visits to public sexual and reproductive health facilities due to inadequate confidentiality within the services and among health providers. Additionally, feelings of shyness and shame reinforced by negative cultural attitudes toward premarital sexual activity discouraged young people from seeking care. Furthermore, the lack of youth-friendly health clinics was one of the geographical accessibility obstacles.

Janighorban et al. (2022) investigated the obstacles that vulnerable teenage girls faced while trying to get sexual and reproductive health care. The study used the exploratory sequential mixed techniques, selected 22 key informants from the Iranian cities of

Isfahan, Tehran, and Mashhad, as well as 16 vulnerable adolescent girls between the ages of 14 and 19. Data gathered with semi-structured in-depth interviews revealed that adolescent girls' sexual and reproductive health was neglected due to a lack of a responsible family, the family's disgusting behaviors, and their imitation of their friends' risky behaviors. Additionally, the sexual and reproductive health of the vulnerable adolescent females was threatened by unresolved sexual questions, poor life skills, unintended pregnancy during adolescence, ignorance about risky sex behaviors, cultural norm violations, and psychological trauma. Lastly, the results also showed that the absence of legal, political, and social support in this area, as well as the inefficienced of important organisations in providing sexual and reproductive health services, suggest that society does not prioritise the sexual and reproductive health of young girls.

Similarly, Sidamo et al. (2024) looked at the Gamo Zone of South Ethiopia Regional State's obstacles to receiving SRH services. A semi-structured interview guide and seven Focus Group Discussions (FGDs) were used to collect data from a sample of 75 teenagers and 10 key informants for the study, which was based on a phenomenological qualitative study design. The study's data analysis showed that the biggest obstacles limiting teenagers from obtaining SRH services are associated with the interaction of demand-side and supply-side barriers in each of the five Levesque framework categories. Teenagers' healthcare needs were frequently hampered by a lack of SRH literacy, outreach initiatives, and integration of SRH information in healthcare facilities, despite the critical need for access to healthcare. Their capacity to seek medical attention was further hampered by societal norms, a lack of conversation about SRH difficulties, and fear of stigma from family and the community. Teenagers' access to health care services is further hampered by a lack of supplies and the actions of healthcare professionals. The appropriateness of services for teenagers is further

complicated by the limited participation of adolescents in decision-making and the ineffective coordination.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses the methodology adopted for conducting the study. Its primary objective is to provide a clear plan for the entire research process, guiding the researcher in collecting, analyzing, and interpreting data to address the research questions that have been raised.

The chapter is organized under the following sections or sub-headings: research approach, research design, study area, population description, sample and sampling method, source of data, data collection instrument, data collection procedure, validity and reliability, ethical considerations, and data analysis plan.

3.1 Research Approach

Generally, there are three different approaches to the social science research as identified by researchers. They are qualitative, quantitative and mixed method. The researcher employed the qualitative approach for the study. According to Denzin and Lincoln (2008), qualitative research is a situated activity that locates the observer in the world consisting of a set of interpretive and material practices which make the world visible. Ary, Razavieh and Soreman (2006) also postulate that qualitative research is rooted in phenomenology. As a result, in qualitative research, the social reality is unique; the individuals and the world are viewed as interconnected and cannot be separated. Ary et al (2006) explained that in qualitative research, the researcher can only understand human behaviour through the meaning of events that people are involved in. The researcher employed the qualitative approach to obtain a richer information which also had a deeper insight into the phenomenon understudied. This is

supported by the assertion of Creswell (1998) who noted that using the qualitative approach helps to explore a social or human problem, build a complex holistic picture, analyse words, report detailed view of informants and conduct the study in a natural setting. Similarly, Blumer (1969), Strauss and Corbin (1998) and Denzin and Lincoln (2003) are also of the view that, qualitative research is about interpretation and understanding. It focuses not only on the objective nature of behaviour but also on its subjective meanings: individuals' own accounts of their attitudes, motivations, behaviour (McIntyre, 2005:127; Creswell, 2009), events and situations (Bryman, 1989) what people say and do in specific places and institutions (Goodwin & Horowitz, 2002:35–36) in social and temporal contexts (Morrill & Fine, 1997). With reference to the above submissions by authors and the purpose of the study, the use of the qualitative approach is important as it gives an iterative process in which improved understanding to the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied. The use of qualitative approach also helped the researcher to get a better understanding through first-hand experience, truthful reporting, and quotations of actual explored the knowledge, awareness, access to, and the utilization of sexual and reproductive health (SRH) services among female porters (Kayayei) in the Accra Metropolis.

3.2 Research Design

Research design encompasses the techniques and methods used to conduct research, ensuring high levels of reliability and validity (Levy & Lemeshow, 2013). It plays a crucial role in determining the analysis and outcomes expected from a study. Poorly designed research can lead to errors in the generated results (Levin, 2005).

In line with this, the study adopted a qualitative case study design, which allows for an in-depth exploration of the phenomena within its real-world context. A case study is particularly suitable for investigating complex social issues, such as healthcare utilization among the Kayayei, where contextual factors like migration, economic hardship, and social stigma play a crucial role. Yin (2014) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident.

In this research, the case study approach enables a detailed examination of the experiences and challenges Kayayei face when accessing sexual and reproductive healthcare services. The study focuses on how social, economic, and cultural conditions interact to shape their healthcare behaviors and decisions. This approach also allows for the use of multiple data sources such as interviews, observations, and document analysis to provide a holistic view of the subject matter.

3.3 Study Area

The setting for this study was the Accra Metropolis (AMA), situated within the Greater Accra Region of Ghana. AMA is the second most populous district in the Greater Accra Region, with a population of 5,455,692 (GSS, 2021). The Accra Metropolis epitomizes urbanization in Ghana, experiencing rapid population growth, infrastructural development, and socio-economic transformation. Its status as the capital city and a major economic center makes it a magnet for migrants seeking economic opportunities and livelihoods.

AMA serves as hubs for trade, commerce, and informal employment, making it an ideal setting for studying the antecedents of sexual and reproductive healthcare service

utilization among female potters (Kayayei). The city hosts several bustling markets, including the Makola, Kantamanto, and Agbogbloshie, where Kayayei are commonly found plying their trade as porters. These markets are vital nodes in Accra's economic ecosystem, attracting traders, vendors, and customers from across the city and beyond.

According to Oteng-Ababio (2012), a significant proportion of Kayayei in Accra migrated from the Northern part of Ghana, drawn by the promise of employment and economic opportunities in the capital. The phenomenon of rural-urban migration is a hallmark of Accra's demographic landscape, shaping patterns of informal labor, settlement, and social integration. For many Kayayei, migration represents a means of escaping poverty and seeking a better life, albeit with its attendant challenges and vulnerabilities (Ahlvin, 2012). A map of the Greater Accra metropolis is captured in figure 1.

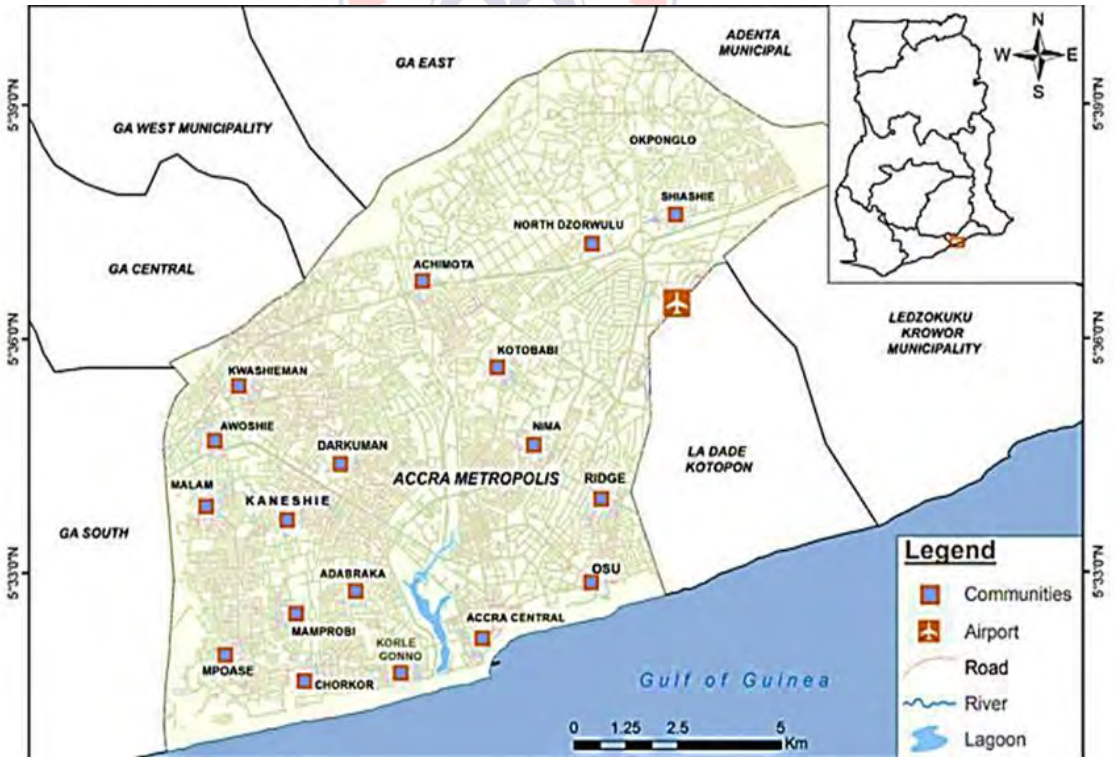

Figure 3.1: Map of Accra Metropolis
Source: Geographic Coordinate system.

3.3 Population

Population refers to any identifiable or unidentifiable group of individuals or elements from which deductions are to be made (Chadwick, 2017). In this context, a study population, as defined by Hu (2014), as a subset of a target population from which a sample is drawn. Therefore, a study population consists of individuals or elements selected based on specific criteria that align with the variables under investigation.

In this study, the target population comprises all Kayayei who plied their trade in the Makola Market, Kantamanto Market, and Agbogbloshie Market. The total population of Kayayei within the Accra Metropolis is estimated to be 85,600 (UNFPA, 2019).

3.4 Sample and Sampling Technique

Sampling, as defined by Blair and Blair (2015), refers to the process of selecting a predetermined number of populations. In other words, sampling, as described by Salkind (2010), involves the researcher selecting a subset of respondents from a larger collection individual from a target population in order to characterize the entire of targeted respondents for a research study. The results obtained from the selected respondents are then used to draw inferences and generalize conclusions to the entire larger population.

In this study, a sample size of 13 participants was used, ensuring that data saturation is reached, meaning that no new information or themes emerge from the data (Guest, Bunce, & Johnson, 2006). The sample included women from different markets and backgrounds to capture a wide range of perspectives.

Consequently, the sampling techniques adopted in this study are non-probability in nature, specifically the purposive sampling techniques in selecting participants for the study respectively. The purposive sampling is a technique by which a researcher makes

deliberate choice of an informant due to the qualities the informant possesses (Lavrakas, 2008).

Since qualitative research focuses on depth rather than breadth, the study employed purposive sampling to select participants. This technique is appropriate for selecting individuals who are most knowledgeable and experienced with the subject matter (Patton, 2002). For this study, the purposive selection of Kayayo as participants hinges on two primary criteria: being at least 18 years of age and having been engaged in the Kayayei occupation for a minimum of six months.

3.5 Sources of Data

Primary and secondary sources are the two basic categories into which research data sources can be generally divided. Salkind (2010) defines primary data sources as original sources from which the researcher gathers data directly from the source for a particular project or research goal. However, according to Malhotra, Birks, and Nunan (2017), secondary data are those that were gathered for a purpose other than the one at hand. Accessibility, relative price, and speed of availability are the main benefits of secondary data. However, because the purpose, character, and data collection techniques employed for secondary data may not be in line with the current research environment, they might be deceptive or irrelevant (Malhotra, Birks, & Nunan, 2017).

In the case of this study, the data was sourced directly from primary sources. Specifically, the primary data was collected from Kayayei's, operating within the Makola Market, Kantamanto Market, and Agbogbloshie Market using a semi-structured interview guide.

3.6 Data Collection Instrument

In this study, semi-structured interview was employed as the primary tool for data collection. A semi-structured interview is ideal for qualitative case studies as they offer a balance between structure and flexibility. According to Kumar (2019), semi-structured interviews consist of open-ended questions that guide the discussion but allow participants the freedom to provide in-depth responses based on their experiences. This format enables the researcher to explore key themes while probing deeper into areas of particular interest or importance as they emerge during the conversation.

The interview guide was divided into four sections (1-4) to cover different aspects relevant to the study based on relevant literature. Section *1* focused on the respondents' background information, collecting basic demographic details about the participants, such as age, place of origin, and duration of work as a Kayayo. Additionally, it explored their migration history and reasons for moving to Accra, providing context for understanding their healthcare needs.

Section 2 contained questions related to Kayayei's knowledge and awareness of sexual and reproductive health services. In this section, participants were asked about their understanding of sexual and reproductive health services, including what services they were aware of and whether they had ever accessed such services. This helped to assess their level of awareness and the accessibility of relevant healthcare options.

Section 3 probed into the factors that impact the participants' ability to access and utilize sexual and reproductive healthcare services. Questions focused on personal factors (e.g., knowledge, attitudes), social factors (e.g., family or community influence), and economic factors (e.g., affordability, distance to healthcare centers).

Finally, Section 4 consisted of questions specifically related to the barriers and challenges faced by female porters in accessing sexual and reproductive health services. Participants were asked to describe the specific barriers and challenges they faced in seeking sexual and reproductive healthcare services.

3.7 Ethical Considerations

According to Saunders, Lewis, and Thornhill (2016), research ethics involves careful consideration of the formulation of research topics, research design, data collection, processing, analysis, and the responsible reporting of research findings. Ethical considerations are critical in qualitative research, especially when working with vulnerable populations like the Kayayei. In this study, particular attention was given to ensure that the rights, dignity, and well-being of all participants were respected throughout the research process (Blumenthal et al., 2019).

The following ethical practices were strictly adhered to in this study. Firstly, before the commencement of data collection, the researcher obtained the informed consent of all participants. The purpose and nature of the study were clearly explained to each participant in a language they understood, ensuring they were fully aware of their involvement in the research. Participants were informed about their right to withdraw from the study at any time without any negative consequences. In addition, the researcher guaranteed the anonymity and confidentiality of the participants throughout the study. Personal identifiers, such as names or contact information, were not collected or recorded during the interviews. Pseudonyms were used to ensure that participants' identities remained confidential, and all data were securely stored with restricted access to protect the privacy of participants.

Moreover, participation in this study was entirely voluntary. That is, participants were not coerced or pressured into taking part in the interviews. The researcher emphasized that there were no consequences for refusing to participate in the study or for choosing to withdraw at any point during the study.

Given the sensitivity of the topic related to sexual and reproductive health, the researcher approached participants with respect and cultural awareness. The interviews were conducted in a manner that made participants feel comfortable and supported, ensuring that they could speak freely without fear of judgment. The researcher also ensured that interviews were conducted in a safe and private setting, minimizing any discomfort or distress. Finally, all data collected during the study were securely stored and only accessible to the researcher. Digital recordings of interviews were kept on a password-protected device, and any transcriptions were de-identified to protect the participants' privacy. The data will be retained for a defined period five years and then securely destroyed.

By adhering to these ethical principles, the study ensured the protection of participants' rights and the integrity of the research process. The researcher remained committed to maintaining the highest ethical standards throughout the study to foster trust and ensure the well-being of all participants.

3.8 Trustworthiness

Trustworthiness criterion is a one-way researchers can convince themselves and readers that their study findings are worthy of attention (Nowell et al., 2017). To ensure the trustworthiness of the interview data collected in this study, several strategies were employed, following Anney's (2014) recommendation that researchers should consider

dependability, credibility, transferability, and confirmability as essential criteria for establishing trustworthiness in qualitative research.

Credibility is fundamental to establishing a study's trustworthiness. It emphasizes the rigor of the research process and the reliability of the interpretations derived from the data (Horsman, 2018). In this study, methods like prolonged engagement, triangulation, and member checking are instrumental in strengthening the credibility of the study's results (Creswell, 2013).

Dependability on the other hand is essential in qualitative research, highlighting the importance of consistency and transparency in the research process (Lincoln & Guba, 1985). Researchers can strengthen dependability by maintaining an audit trail and thoroughly documenting their research procedures (Creswell, 2013). To further support the dependability of the study findings, the researcher consistently asked clear, structured questions during data collection, minimized potential biases, and maintained objectivity throughout the process.

Finally, transferability is an important factor in qualitative research, concerned with the extent to which a study's findings may apply to other contexts (Lincoln & Guba, 1985). Researchers can improve transferability by offering comprehensive, detailed descriptions of the research setting and participant characteristics, which allows readers to evaluate the findings' relevance to their own contexts (Creswell, 2013). In this study, transferability was ensured by providing comprehensive, in-depth descriptions of the research context, participants, and setting. Additionally, clear sampling criteria were documented to help other researchers evaluate whether the study's insights could be relevant to other groups or settings.

3.9 Data Collection Procedure

Data for this study was collected by me using semi-structured interview guide conducted in key market areas in the Accra Metropolis, where Kayayei work, such as Makola Market, Kantamanto Market, and Agbogbloshie Market. Prior to data collection, I collaborated with the local community leaders and guides familiar with the Kayayei population to help identify potential participants and gain their trust.

Upon arriving at each market location, I accompanied by local guides, approached the Kayayei's to briefly explain the purpose of the study, the nature of their participation, and the confidentiality of their responses. Potential participants who met the inclusion criteria were invited to participate in the interviews. Before beginning each interview, verbal informed consent was obtained from each participant, ensuring they understood that their participation was voluntary and that they could withdraw from the study at any time without any negative consequences. Participants were also reassured of the anonymity and confidentiality of their responses.

The semi-structured interviews were conducted one-on-one in locations convenient for each participant, ensuring privacy and minimizing interruptions. Given the potential literacy challenges within the Kayayei population, the interviews were conducted verbally in the participants' preferred language (e.g., Twi or English). This approach allowed me to clarify questions, probe further into participants' responses, and ensure that participants fully understood each question.

Throughout the interviews, I remained flexible, allowing participants to elaborate on their experiences while ensuring that key issues related to sexual and reproductive healthcare access were covered. The interviews were audio-recorded with the

participants' consent and later transcribed for analysis. Field notes were also taken to capture non-verbal cues and contextual details that could enrich the data interpretation.

This personal and direct approach facilitated a deeper exploration of the participants' lived experiences, ensuring that their voices and perspectives were fully represented in the study.

3.10 Data Analysis Method

In qualitative research, data analysis is a critical process aimed at transforming raw data into meaningful insights. As Cooper and Schindler (2014) suggest, raw data holds little value unless carefully analyzed and interpreted to draw conclusions. Accordingly, the data collected from semi-structured interviews were analyzed using thematic analysis to identify patterns and themes related to the factors influencing Kayayei's utilization of sexual and reproductive healthcare services.

The analysis began with me transcribing the interviews and thoroughly familiarizing themselves with the data by reading through the transcript's multiple times. Initial notes were taken to capture key ideas.

The next step involved coding, where significant sections of the data were labeled with descriptive tags representing key ideas or concepts. These codes were then organized into broader themes that encapsulated the main factors influencing Kayayei's access to sexual and reproductive healthcare services. As themes were developed, the researcher reviewed and refined them to ensure they accurately reflected the data and aligned with the research objectives.

Finally, the findings were presented in a narrative format, supported by direct quotes from the participants to illustrate the themes. This analysis provided a detailed

understanding of the challenges Kayayei face in accessing healthcare services, highlighting the social, economic, and cultural factors that influence their healthcare-seeking behaviors.

This thematic analysis provided a detailed and nuanced understanding of the factors shaping healthcare utilization among the Kayayei population, highlighting the social, cultural, and economic challenges they face.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the results and the discussion of the study on the factors influencing the utilization of sexual and reproductive health (SRH) services among female porters (Kayayei) in Accra, Ghana. The data was analyzed using thematic analysis, where descriptive codes were developed, grouped into broader themes, and refined to ensure alignment with the research objectives. The findings are presented in a narrative format, supported by direct quotes from participants to illustrate the themes.

4.1 The Demographic Profile of Respondents

This section sought to provide information about the socio-demographic characteristics of the respondents, including their age, educational background, length of engagement in porter work, and primary sources of income.

Analysis of the study's data showed that the respondents were female porters aged between 19 and 35 years, with varying educational backgrounds. While some had completed Senior High School, others had basic or no formal education. Also, the results revealed that most of the respondents had been engaged in porter activities for one to three years, with income generated from carrying loads, laundry services, or working in shops. The low-income nature of their work often influenced their ability to access healthcare services.

4.2 Knowledge and Understanding of Sexual and Reproductive Health Services

This section examines the respondents' understanding of sexual and reproductive health, as well as their awareness of the available services in the Accra Metropolis. It

seeks to explore participants' understanding of sexual and reproductive health (SRH), revealing varying levels of awareness and interpretation.

4.2.1 Knowledge of Sexual and Reproductive Health

A common response to participant's knowledge of sexual and reproductive health was their perception of sexual health as the ability to prevent sexually transmitted infections (STIs) and unintended pregnancies. This was reflected in comments such as sexual health is having knowledge of safe sex, protecting oneself from STDs and STIs, and unintended pregnancies through the use of condoms. This shows that participants had basic biomedical knowledge of sexual health, indicating a strong awareness of protective practices and risk reduction.

Another common response that emerged was the understanding of sexual health as involving mutual respect and consent in intimate relationships. For example, one respondent said sexual health is having respectful and consensual relationships where both partners feel safe and valued. This perspective highlights an important social and emotional dimension of sexual health that goes beyond biological concerns, pointing to a more holistic and relational awareness.

Another significant response that emerged was based on the fact that reproductive health was often understood in terms of pregnancy, childbirth, and maternal care. Respondents described it as encompassing the ability to conceive, attend prenatal checkups, and deliver safely. For instance, one participant noted that *"reproductive health means getting pregnant, attending prenatal care, and giving birth safely without complication"*.

Another participant highlighted that reproductive *"health is being able to safely get pregnant, carry the pregnancy to full term, and give birth with proper care. These*

responses emphasize reproductive health as closely tied to maternal wellbeing and safe delivery practices.

Additional response that emerged was the recognition of menstrual hygiene as part of reproductive health. Though mentioned less frequently, it was still significant in participants' narratives. One respondent stated, "*reproductive health is knowing how to take care of yourself during your cycle and using clean sanitary products".*

With regard to services, most respondents were aware of SRH services such as prenatal care and family planning. These were the most frequently cited, suggesting that they are widely promoted or more accessible. However, knowledge of services like STI testing, postnatal care, or counseling appeared limited, which may reflect either a lack of awareness or gaps in service delivery.

4.3 Awareness and Access to Sexual and Reproductive Health Services

This theme focused on respondents' awareness of available SRH services and their experiences in accessing these services. It aimed to highlight the level of knowledge about service availability, perceived reliability, and the barriers they encounter during access. Four sub-themes emerged from the data: awareness of the existence of SRH services, awareness of organizations providing SRH services, access to SRH services, and utilization of SRH services.

4.3.1 Awareness of the Existence of SRH Services

The majority of participants demonstrated a general awareness of SRH services. They expressed familiarity with services such as family planning, prenatal care, STI testing, and maternity care. This awareness, however, was mostly functional and based on personal or peer experiences rather than formal education.

One respondent remarked, "*yes, I am aware that there are places where you can go if you are pregnant or need advice on family planning*".

Another stated, *"I know there are hospitals that help when a woman is sick from infections or when she is pregnant".* This suggests that while SRH services are known, the awareness is often centered on immediate and visible needs like pregnancy or illness, with limited emphasis on preventive or counseling services.

However, most respondents had not received any formal education or training on sexual and reproductive health, which limited their ability to fully understand and utilize the range of available services. As one participant shared, "*No, I have not received any formal training"*. Despite this gap, a few respondents mentioned that some educational outreach efforts had been made, particularly within their hostels. These sessions appeared to positively influence service utilization. One respondent recalled, "*I remember some people came to talk to us about sexual and reproductive health at the hostel. That encouraged me to access family planning services*". This suggests that while general awareness of SRH services exists, formal and structured education is limited, and outreach programs, when available can significantly enhance knowledge and health-seeking behavior.

4.3.2 Awareness of Organizations Providing SRH Services

Results with regards to awareness of sexual and reproductive health services in immediate areas revealed that most respondents were aware of sexual and reproductive health services in their immediate vicinity. Facilities of places such as Jamestown Maternity Hospital, Shukura Community Hospital, and Ussher Hospital were frequently mentioned. For example, one respondent stated that "*Yes, I am aware of SRH services in my area, like Jamestown Maternity Hospital and Ussher Hospital*".

Another respondent also confirmed this stating that *"Yes, I know about Jamestown Maternity Hospital and Ridge Hospital"*. The high level of awareness suggests that SRH services are visible and recognizable within the communities where the Kayayei reside. Additionally, when asked about SRH services outside their immediate areas, respondents demonstrated a broader awareness of facilities across the Accra Metropolis. Participants mentioned additional hospitals and clinics, including Korle-Bu Teaching Hospital, Nyaho Medical Centre, and Total House Clinic. For instance, one respondent *noted "Yes, apart from my area, I know about Korle-Bu Teaching Hospital and Jamestown Maternity Hospital"*.

Another also mentioned *"Yes, I am aware of Shukura Community Hospital and Nyaho Medical Centre"*. However, the results also revealed that while some participants were familiar with facilities providing SRH services, others were unaware due to lack of prior health issues. For example, one participant expressed his view on this as follows: *"I don't have any idea about where to access these services"*.

4.3.3 Access to SRH Services

Experiences with accessing SRH services varied among respondents. While majority reported accessing services when the need arose, especially for maternal care and STI treatment, others faced obstacles such as fear, financial constraints, or negative expectations of treatment.

Those who had accessed services shared mostly positive experiences. For example, a participant noted, *"I went to Jamestown Maternity Hospital for prenatal care and delivery, and they were helpful"*. Another also said *"I went to Shukura Hospital for STI treatment. The nurses were kind and explained things well"*.

Peer influence was also a driver of access, as a participant opined *"Encouragement from friends and contracting an STI motivated me to seek out the service"*. However, other participants had never accessed SRH services and expressed concerns about mistreatment or simply did not see the need. One participant stated *"No, because I have never been sick, so I didn't think I needed to go"*. Another said *"No, because I feel I won't be treated well"*. These insights highlight both access and psychosocial barriers that affect utilization, particularly the role of perceived provider attitudes and self-assessed health needs.

4.3.4 Utilization of SRH Services

Respondents reported mixed levels of sexual and reproductive health services utilization. In particular, most respondents reported that ever utilizing the service, and off this group, they reported having accessed SRH services for prenatal care, delivery, or STI treatment. For example, *"Yes, I went to the Jamestown Maternity Hospital for prenatal care"*. Others mentioned utilizing SRH services in response to health emergencies, such as contracting STI. For instance, one participant stated that "Encouragement from friends and contracting an STI motivated me to seek out the service". Another participant also shared, *"Yes, I attended the Shukura Community Hospital for STI treatment"*.

Subsequently, analysis further showed that among respondents who accessed SRH services, the reliability of information provided by healthcare professionals was generally rated highly. One particular participant noted, *"the information I received through the utilization of the SRH services was very reliable; it has helped me take good care of myself during pregnancy"*.

However, analysis showed that several participants had never accessed these services. Among those who reported that they had not utilized SRH services cited reasons such as a lack of perceived need, financial challenges, or fear. For instance, one respondent indicated *"No, because I have never accessed the service before because I have never fallen sick".* Another, interesting reason cited by one of the participants was, *"No, because I feel I won't be treated well".*

4.3.5 Impact of Awareness on Health Choices

Two themes emerged from the data regarding the impact of SRH awareness on health behavior. These are awareness improves health behavior and suggestions for service improvement.

In particular, some participants reported that having awareness of SRH services enabled them to make better health decisions, including early treatment-seeking and adopting preventive practices. This demonstrates that increased awareness can lead to improved personal health management and proactive behavior.

For example, one participant stated "It has helped me understand symptoms and seek early treatment". Another added *"It has helped me practice personal hygiene and avoid STIs".* These responses suggest that awareness does not only inform but also empowers individuals to take control of their health, particularly in the context of hygiene and disease prevention.

While some participants had benefited from awareness, others pointed out that limited information constrained their ability to make informed decisions. As a result, several respondents proposed actionable recommendations for improving SRH education and access for Kayayei. For instance, one participant put forth that local authorities should "Organize free or subsidized health screenings".

Another also noted that local authorities should "Establish mobile clinics in marketplaces". As well as "Educating Kayayei in local languages about SRH".

4.4 Factors that influnces Access and Utilization of SRH Services

This section seeks to explore the various the factors influencing access and utilization of sexual and reproductive health (SRH) services among Kayayei. Six key themes emerged from the respondents' perspectives as to the factors that influence their access and utilization of SRH services. These are health need and concerns; personal values; the impact of cultural/Religious beliefs, distance to SRH services; personal experiences; and social and peer influence.

Health Needs and Concerns

The first theme identified was the health needs and concerns driving respondents to seek SRH services. Health emergencies were the primary reasons provided by participants. In particular, respondents highlighted that condition like pregnancy or contracting an STI prompted them to seek services. For example, one participant noted, *"Encouragement from friends and contracting an STI motivated me to seek out the service"*. Similarly, another participant shared the following, *"I seek services when I am pregnant to ensure safe delivery"*. Furthermore, the role of friends and family as motivators was also evident. Some respondents mentioned receiving encouragement to access SRH services. One said, *"Friends encouraged me to go to the hospital for pre-natal care"*.

Personal Values

The second theme derived on the second research question on factors that influence access and utilization SRH services centers on the influence of personal values. Some respondents held strong personal beliefs that either supported or had no impact on their

use of SRH services. For some, personal responsibility for health motivated proactive care-seeking. One noted, *"My beliefs do not affect my decision to use these services". Also, the analysis highlighted the importance of privacy in their choice of healthcare facilities.* For these participants ensuring confidentiality, especially when dealing with sensitive health issues, was a significant factor in their decision-making process. For instance, one participant said *"I prefer clinics that guarantee privacy, especially for sensitive issues".*

Cultural/Religious Beliefs

Another theme that emerged centers on the influence of cultural values. Cultural or religious values also influenced whether or not respondents used specific SRH services, especially family planning. In some cases, deeply held beliefs discouraged service use. For instance, a Kayayo was of the following view, *"My beliefs and cultural values are against family planning".* Another common response was, *"My culture and believe stand against family planning, so am not able to seek for more information on family planning".*

Distance to SRH Services

The fourth theme centered on the role of proximity in accessing SRH services. Proximity to facilities facilitated access, while long travel times discouraged utilization. For instance, a Kayayo who lived close to a health center shared the following: *"Because the center is within walking distance, I don't have a problem".* Conversely, *long distances discouraged access, especially at night.* One participant noted, *"Traveling long distances, especially at night, discourages me from seeking services".*

Some respondents expressed a preference for mobile clinics, which they viewed as a convenient option because of their accessibility and proximity. These facilities were

particularly valued for reducing travel time and making services available at their doorsteps. A participant noted, *"I prefer mobile clinics because they bring the services closer to us"*.

Personal Experiences

The fifth theme described respondents' interactions with healthcare facilities, focusing on service quality, staff behavior, and waiting times. Positive experiences with staff were noted by some respondents. One participant is of the expressed view, *"The healthcare providers are friendly, and the information they provide is reliable"*. However, long waiting times were a common complaint. A participant noted: *"Waiting for long hours before seeing a doctor is always a problem"*. Moreover, other participant reported, *"At times, fear holds me back, as I'm concerned, I won't be treated with fairness or respect"*. Another participant expressed, *"Embarrassment and fear, because I feel am young to seek a particular kind of service"*.

Social and Peer Influence

The sixth theme highlighted the significant role of social and peer influences in shaping respondents' decisions to access SRH services. Social networks, including friends and family, could serve as both a source of encouragement and a barrier, depending on the nature of the influence.

For some participants, positive reinforcement from friends and family was a motivating factor in seeking SRH services. This support often made them feel more confident about accessing healthcare and taking proactive steps to address their needs. One participant said, *"Friends encouraged me to go to the hospital for prenatal care"*. On the other hand, social influence was not always positive. Stigma and misconceptions within their social circles discouraged some respondents from utilizing SRH services. This negative

influence sometimes led them to consider alternatives, such as avoiding formal healthcare altogether. *"Some friends discouraged me from seeking services, suggesting I should go to my hometown instead".*

Similarly, the impact of accompanying friends or relatives to seek SRH services. This experience often served as an eye-opener for respondents, providing them with firsthand exposure to the services available and reducing any apprehension they might have had about accessing healthcare themselves.

Some respondents noted that accompanying others to healthcare facilities allowed them to observe the process and interact with the healthcare environment, which positively influenced their perceptions. It also reassured them that the services were accessible and beneficial. One participant intimated, *"When I accompanied my friend to the hospital, it made me feel I could visit the center anytime I needed care".* Such experiences helped demystify SRH services and empowered participants to take proactive steps toward seeking care for their own needs.

4.5 Barriers and Challenges to Accessing SRH Services

This section explores the barriers and challenges that limit Kayayei's access to sexual and reproductive health (SRH) services. Participants highlighted several problems that made it difficult to utilize these essential services. These challenges were categorized into key themes, reflecting the respondents' views and lived experiences. The findings revealed that financial constraints, community pressure and judgment, cultural beliefs, personal reasons, work-related challenges, negative experiences with healthcare facilities, transportation and availability of services, and logistical issues were significant barriers.

Financial Constraints

The first theme that emerged from the respondents' views was financial constraints, which were consistently highlighted as the most significant barrier to accessing SRH services. The high costs of medications, lab tests, and transportation were cited as the main challenges. Participants emphasized that the high expense associated with healthcare often make it unaffordable, forcing them to forgo necessary services. For instance, a participant noted, *"The cost of healthcare services is expensive, and I sometimes cannot afford them".*

Others noted that even when services were available, the cost of medications and additional expenses such as transportation were prohibitive. One noted, *"The cost of medications is high, and transportation to the health center adds to the expense".* This financial strain often discouraged respondents from seeking healthcare altogether. A participant also noted, *"Very often, I cannot afford the lab tests or medications, so I avoid going".*

Community Pressure and Judgment

The second theme that emerged was the influence of community pressure and judgment. Many respondents felt discouraged by the stigma and misconceptions surrounding SRH services within their communities. This social pressure often created a sense of fear and discomfort, deterring them from seeking care.

Some respondents felt discouraged by peers and community members. One opined, *"Some friends discouraged me from seeking services, suggesting it's better to handle these issues privately".* Others were fearful of being judged due to their age or marital status. For instance, one respondent indicated, *"There is fear of judgment because I am*

young and accessing these services". These accounts highlight how societal attitudes and community norms can act as significant barriers to SRH service utilization.

Cultural Beliefs and Practices

The third theme focused on cultural beliefs and practices that limited access to SRH services. Respondents described how cultural norms often restricted open discussions about sexual health, creating an environment where seeking SRH services was considered taboo. Some respondents reported that their culture did not support openly discussing or utilizing these services. For example, one respondent noted, *"My culture does not allow us to talk about or use family planning services openly"*. Others shared that the stigma around sexual health made it challenging to seek services. *"Discussing sexual health is taboo in my community, so accessing services feels shameful".*

Personal Reasons (Fear, Embarrassment, and Lack of Knowledge)

The fourth theme that emerged was personal reasons, including fear, embarrassment, and a lack of knowledge about SRH services. These factors were particularly common among younger respondents, who often felt insecure or unprepared to navigate the healthcare system. A respondent expressed her discomfort, stating "*I feel embarrassed because I am young and seeking such services*". A lack of awareness about available services further compounded the issue. A participant shared "*I don't have enough knowledge about these services, so I don't feel confident accessing them*".

These personal challenges highlight the need for education and outreach efforts to empower Kayayei with the knowledge and confidence to access SRH services.

Work-Related Challenges

The fifth theme revolved around work-related challenges. The demanding nature of work as a Kayayo, including long hours and physical exhaustion, often left little time or energy for seeking healthcare.

For instance, a participant explained, *"I am always busy with my customers and do not have time to visit the health center"*. Similarly, three (3) participants are of the same view that '*Carrying heavy loads all day leaves them too tired to seek health services'* These responses emphasize how the nature of their work significantly impacts their ability to prioritize healthcare.

Negative Experiences with Healthcare Facilities

The sixth theme highlighted respondents' negative experiences with healthcare facilities, which further discouraged them from seeking SRH services. Issues such as unfriendly staff, lack of privacy, and long waiting times were common complaints.

Excerpts from one of the participants responses are captured as follows: "Waiting for long hours before seeing a doctor is always a problem". In a similar vein, a participant reiterated that a lack of privacy during consultations further contributed to feelings of unease. She noted, *"There is no privacy during consultations, which makes me uncomfortable"*. These experiences illustrate the importance of creating patient-centered environments that are welcoming, efficient, and respectful of privacy.

Transportation and Availability of Services

The seventh theme focused on transportation and availability of services as barriers to accessing SRH care. Respondents frequently mentioned the cost of transportation and the long distances to healthcare facilities as significant challenges.

Analysis shows that long travel times, particularly at inconvenient hours, posed significant challenges. This was reiterated by a respondent that "Traveling long distances, especially at night, discourages me from seeking services". In addition, the financial burden of transportation was an added obstacle. A participant noted, *"Transportation to the health center is expensive, and this adds to the overall cost of care".* These accounts highlight the need for more accessible and affordable healthcare options within close proximity to their communities.

Logistical Issues

The final theme addressed logistical issues, such as misaligned facility hours and time constraints, which prevented many respondents from accessing SRH services. For instance, for respondents with inflexible work schedules, the limited operating hours of health centers were a major barrier. A participant noted*, "The facility hours do not align with my work schedule, so I miss out on care".*

Similarly, others reported that the timing of services often conflicted with their daily responsibilities. Another participant shared that, *"by the time I finish work, the clinics are often closed".* These logistical barriers point to the need for flexible healthcare delivery models that accommodate the unique schedules and needs of Kayayei.

4.6 Discussion of Findings

This section presents the discussion of the key findings from the analysis of sexual and reproductive health (SRH) access and utilization among female porters (Kayayei) in the Accra Metropolis. The discussion is structured around the four main objectives of the study and is contextualized with relevant literature.

4.6.1 Knowledge and Understanding of Sexual and Reproductive Health Services

The study found that most Kayayei had basic knowledge of sexual and reproductive health (SRH), particularly relating to safe sex, STI prevention, and maternal care such as pregnancy and childbirth. A smaller number of respondents demonstrated broader awareness, incorporating aspects such as consensual relationships and menstrual hygiene. However, the depth of understanding varied, and knowledge of the full spectrum of SRH services, especially long-term contraceptive methods was limited.

This finding is largely consistent with Tamang et al. (2017), who found that among the urban youth in Kathmandu, basic knowledge of SRH services was relatively high, especially regarding condoms and pills, but knowledge of other methods such as intrauterine devices was poor. Similar to the current study, most respondents had heard of STIs, but there was low awareness of specific infections such as Chlamydia. The widespread feelings of shame identified by Tamang et al. as a barrier to service use also reflect the stigma reported by Kayayei in this study.

The results also support the findings of Dapaah et al. (2016), who demonstrated that youth with better SRH awareness were more likely to utilize services. In the present study, those Kayayei who had clearer knowledge of SRH were also the ones more likely to report accessing services, such as for pregnancy monitoring or STI treatment. This suggests that knowledge facilitates access, a relationship echoed in prior Ghanaian studies.

However, unlike Amankwaa et al. (2018) who found that in-school adolescents in Kumasi had good knowledge of multiple contraceptive methods, Kayayei in this study showed less familiarity with long-term contraceptives or broader service options beyond prenatal care. This divergence may be due to the informal and often uneducated

background of many Kayayei, compared to school-going adolescents who may be exposed to SRH education in academic settings.

Additionally, although religiosity was not a dominant theme among Kayayei, the findings can be compared with Martin et al. (2018), who found that frequent religious participation was associated with lower SRH knowledge among female college students in the U.S. While the Kayayei did not explicitly cite religion as a barrier to SRH knowledge, some cultural and moral values influenced perceptions of services like family planning, suggesting a similar pattern of moral framing affecting knowledge and openness.

4.6.2 Awareness of SRH Services

The majority of Kayayei interviewed were aware of the existence of SRH services and could name specific facilities within and beyond their immediate communities, such as Jamestown Maternity Hospital and Korle-Bu Teaching Hospital. However, awareness was not always accompanied by deep knowledge of the range of services provided, such as STI testing, family planning options, or postnatal care.

This limited awareness is consistent with findings from Oppong & Agyei-Mensah (2017), who noted that marginalized urban populations in Ghana often recognize health institutions but lack comprehensive understanding of the services available. Furthermore, while some respondents had received informal outreach in their hostels, the lack of formal SRH education echoed studies by Chandra-Mouli et al. (2015), which argue that structured education programs are essential to promote effective service utilization among vulnerable populations.

4.6.3 Factors Influencing Access and Utilization of SRH Services

The study revealed that a range of factors influenced access and utilization of sexual and reproductive health (SRH) services among Kayayei. These included health needs and social support, personal values, cultural beliefs, distance to facilities, work-related challenges, past experiences with healthcare providers, and accompaniment by peers or relatives.

The finding that health needs such as pregnancy or STI symptoms and social encouragement from peers served as major motivators aligns with the study by Binu et al. (2018). Their work in Ethiopia also found that perceived symptoms of STIs and prior sexual experience were significant predictors of SRH service use. Similarly, Abiiro et al. (2022) identified peer networks and parental support as enabling factors. In the present study, encouragement from friends played a crucial role in service uptake, particularly among respondents who were uncertain or hesitant.

In terms of cultural and personal values, some respondents indicated that their beliefs had no effect on their decisions, while others acknowledged that family planning and open discussion of SRH issues were culturally sensitive or taboo. This is consistent with Abiiro et al. (2022), who found that religious prejudice and parental disapproval hinder adolescents' SRH service use in Ghana. It also resonates with Ninsiima et al. (2021), whose systematic review found that individual-level barriers such as cultural norms and lack of autonomy frequently impeded access to youth-friendly SRH services in sub-Saharan Africa.

The current study also highlighted structural and logistical factors, such as distance to clinics, long waiting times, and lack of privacy, as barriers to utilization. These findings are strongly supported by Ninsiima et al. (2021), who observed that structural barriers

including the negative attitudes and inadequate training of health workers discouraged youth from seeking care. The frustration expressed by Kayayei about long queues and insensitive provider behavior reflects this trend.

Further, economic hardship and work-related constraints emerged as central limiting factors. Many respondents cited lack of time due to their strenuous work and inability to afford transportation or medications. This finding is in line with Lumonje et al. (2019), who found that economic background, affordability, and employment conditions significantly influenced SRH service use among street-involved youth in Kenya. The demanding physical labor and long hours reported by Kayayei mirror these barriers.

Interestingly, the study also found that accompanying friends or relatives to health facilities often encouraged respondents to later seek services for themselves. While this was not explicitly covered in the reviewed literature, it adds a unique contribution to the discourse on informal exposure as a form of peer-led orientation, possibly serving as an unstructured but impactful form of SRH sensitization.

4.6.4 Barriers and Challenges to Accessing SRH Services

The study identified several barriers that constrained Kayayei from accessing sexual and reproductive health (SRH) services. These included financial constraints, community pressure and stigma, cultural taboos, lack of knowledge, fear and embarrassment, work-related stress, negative healthcare experiences, transportation difficulties, and logistical mismatches such as incompatible clinic hours.

The dominant finding that financial barriers limited access to SRH services is consistent with Badu et al. (2018) and Kumi-Kyereme et al. (2021), who both identified cost of services, medications, and transportation as significant challenges for marginalized

groups, including persons with disabilities. Similarly, Akazili et al. (2020) found that hidden charges and the exclusion of certain SRH services from national insurance schemes further discouraged uptake a pattern mirrored in this study, where Kayayei cited the inability to afford lab tests and medications.

The social stigma and community judgment experienced by some respondents particularly young, unmarried Kayayei is strongly supported by the findings of Thongmixay et al. (2019), who described shame and fear as key psychosocial barriers to SRH service use among youth in Lao PDR. Likewise, Sidamo et al. (2024) reported that fear of community stigma and social norms discouraged adolescents from seeking care a dynamic that similarly emerged in this study, especially regarding family planning.

The influence of cultural beliefs, which portrayed SRH discussions or services as taboo, aligns with the findings of Akazili et al. (2020) and Janighorban et al. (2022), both of whom noted that cultural norms significantly hindered young women's ability to access services. These taboos led to silence and secrecy around sexual health further limiting awareness and proactive care-seeking.

Fear, embarrassment, and lack of knowledge also emerged as personal-level barriers. These findings are consistent with Thongmixay et al. (2019) and Sidamo et al. (2024), who noted that limited SRH literacy, fear of disapproval, and internalized shame restricted service utilization. In this study, younger Kayayei particularly reported discomfort and lack of confidence in navigating health facilities due to their limited exposure.

The nature of Kayayei's work involving long hours of physical labor and inconsistent schedules posed additional obstacles, preventing timely visits to healthcare centers.

This challenge reflects the broader category of structural and time-based barriers, similar to those reported by Sidamo et al. (2024), who noted the need for adaptable, adolescent-friendly service delivery models.

Negative experiences with health workers including long waiting times and lack of privacy were widely reported. These findings are in agreement with Ninsiima et al. (2021) and Akazili et al. (2020), who emphasized that provider attitude, privacy violations, and inadequate youth-centered care disincentivize service use. In this study, respondents described how perceived rudeness or exposure during consultations made them uncomfortable and unwilling to return.

Finally, barriers related to transportation, service availability, and logistical mismatches were common. Many Kayayei noted the difficulty of traveling long distances, especially at night, and the mismatch between clinic hours and their work schedules. These findings strongly support Sidamo et al. (2024), who found that geographical inaccessibility, lack of transport, and poorly timed services significantly limited adolescents' ability to access SRH care.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a summary of the findings derived from the research, draws conclusions based on the study's objectives, and provides recommendations aimed at addressing the challenges identified. The focus of the study was to investigate the factors influencing the utilization of sexual and reproductive health (SRH) services among female porters (Kayayei) operating within three major commercial hubs in the Accra Metropolis: Makola, Kantamanto, and Agbogbloshie Markets. The study explored their knowledge, awareness, access, and the unique barriers they face in utilizing these services while working in these high-traffic and informal environments.

5.1 Summary

The objectives of the study were to;

1. explore female potters' understanding or knowledge of sexual and reproductive health services.
2. assess female potters' level of awareness of sexual and reproductive health services in the Accra Metropolis.
3. examine the factors that influence the access and utilization of sexual and reproductive health services by female potters in the Accra Metropolis.
4. explore the barriers or challenges faced by female potters in accessing sexual and reproductive health services in in the Accra Metropolis.

5.2 Research Procedure

The study aimed to investigate antecedents of sexual and reproductive healthcare service utilization among female potters (Kayeyei) in Accra Metropolis. Employing a

qualitative case study design, a purposive sampling technique was used to select thirteen (13) participants, and data were collected through in-depth interviews using a semi-structured interview guide. The collected data were analyzed thematically.

5.3 Major Findings

The main findings of the study are as follows:

1. The study revealed that Kayayei demonstrated a basic understanding of sexual and reproductive health. Most respondents associated sexual health with safe practices aimed at preventing sexually transmitted infections (STIs) and unintended pregnancies. Reproductive health was largely understood in relation to pregnancy, childbirth, and menstrual health. However, this understanding was generally limited to broad concepts, with little depth regarding the full scope of sexual and reproductive health services.
2. While respondents were generally aware of the existence of sexual and reproductive health (SRH) services within their communities, their awareness of specific services was limited. Knowledge of services such as STI testing, emergency contraception, and specialized reproductive health care was low, suggesting gaps in information dissemination and health education targeted at Kayayei.
3. Access to SRH services among Kayayei was influenced by multiple interrelated factors. Proximity to health facilities played a significant role, as respondents living closer to service centers were more likely to utilize them, whereas long distances discouraged service use. Financial stability also emerged as a key determinant, with the cost of medications, laboratory tests, and consultations limiting utilization. In addition, social influences, particularly encouragement

from friends and family motivated some respondents to seek services. Health emergencies further acted as triggers for service utilization.

4. The study identified several barriers to accessing SRH services, including financial constraints, cultural beliefs, logistical challenges, and stigma. Some respondents reported that cultural norms restricted open discussions on family planning and reproductive health. Feelings of embarrassment, fear of judgment, and stigma associated with seeking SRH services further discouraged utilization. Logistical challenges, such as long waiting times, lack of privacy during consultations, and the unpredictable and demanding nature of Kayayei's work schedules, limited their ability to prioritize health needs. These challenges highlighted the need for tailored interventions, including mobile clinics and free or subsidized SRH services, to improve access.

5.4 Conclusions

The study concludes that while awareness of SRH services among Kayayei is relatively high, significant gaps in knowledge about specific services persist. The respondents' utilization of SRH services is influenced by a combination of factors, including financial constraints, proximity to facilities, social support, and cultural beliefs. The findings underscore the need for targeted interventions to address the barriers limiting access and utilization of SRH services among this vulnerable group.

1. In relation to the first objective, the study revealed that Kayayei have a fundamental understanding of sexual and reproductive health, but their knowledge is often limited to basic concepts such as pregnancy and safe sex practices.

2. Concerning the second objective, awareness of SRH services in the Accra Metropolis was high, but it did not always translate into utilization due to various barriers.
3. With respect to the third objective, the study concluded that access to and utilization of SRH services are significantly influenced by financial stability, proximity to health facilities, and social support networks, which either facilitate or constrain service use
4. Finally, in addressing the fourth objective, the study identified financial difficulties, cultural beliefs, logistical challenges, and stigma as the major barriers hindering effective access to and utilization of SRH services among Kayayei

5.5 Recommendations

Based on the findings and conclusions drawn from the study, the following recommendations are made:

1. In order to enhance female porters' understanding of sexual and reproductive health (SRH) services, the Ghana Health Service (GHS), in collaboration with relevant NGOs and community health workers, should develop and deliver targeted educational programs in local languages. These programs should focus on safe sex practices, menstrual health, STI prevention, and family planning options. Furthermore, outreach efforts should involve community-based campaigns and interactive sessions to ensure that information is both accessible and comprehensible to Kayayei.
2. The study found that most respondents had limited knowledge about specific SRH services in their communities, have the study recommends that to increase awareness of available SRH services, healthcare providers and local authorities

should conduct targeted awareness campaigns. These campaigns should utilize community leaders, NGOs, and social media platforms to disseminate information about the types of SRH services available, their locations, and their benefits. Efforts should also include distributing flyers and posters in public spaces where Kayayei gather, as well as hosting health fairs and information sessions in collaboration with trusted community stakeholders.

3. Since financial instability significantly affects access to and utilization of sexual and reproductive health (SRH) services among Kayayei, it is recommended that the Ministry of Health (MoH), in collaboration with the National Health Insurance Authority (NHIA), develop subsidized health insurance schemes specifically tailored to low-income populations, such as Kayayei. These schemes would help alleviate financial barriers to accessing SRH services. Additionally, because health facilities are often not located near Kayayei communities, the Ghana Health Service (GHS), in partnership with Metropolitan, Municipal, and District Assemblies (MMDAs), should facilitate the establishment of mobile clinics in busy marketplaces where Kayayei work, in order to bring services closer and reduce logistical challenges. Furthermore, community-based organizations (CBOs) and NGOs working with urban poor women should be engaged to implement social support mechanisms, such as peer health advocate programs among Kayayei, to reduce stigma and encourage utilization through a supportive network.
4. To reduce barriers such as cultural stigma and logistical challenges, the Accra Metropolitan Assemblies (AMA), in collaboration with the Ghana Health Service (GHS) and local NGOs, should organize community dialogue sessions to foster open discussions about SRH issues in safe and inclusive settings. In

addition, healthcare facility administrators under the GHS should prioritize reducing waiting times and ensuring privacy during consultations to create a more welcoming environment for Kayayei. Furthermore, the Ministry of Health and GHS should implement training programs for healthcare providers on cultural sensitivity, aimed at improving interactions with Kayayei and enhancing their comfort and trust in utilizing SRH services.

5.6 Suggestions for Further Studies

Future studies could employ quantitative or mixed-methods approaches to measure the level of sexual and reproductive health knowledge and service utilization among Kayayei, allowing for broader generalization of findings. Additional studies could explore in greater depth how cultural beliefs, stigma, and social norms influence decision-making related to SRH service use, particularly among unmarried female porters.

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APPENDIX

UNIVERSITY OF EDUCATION, WINNEBA

DEPARTMENT OF SOCIAL STUDIES

Dear Respondent,

Thank you for considering participating in this study titled "***Antecedents of Sexual and Reproductive Healthcare Service Utilization Among Female Porters (Kayayei) in Accra Metropolis***." This research is being conducted by a student pursuing a Master's degree in Social Studies at the University of Education, Winneba. Your participation will provide valuable insights that will help deepen understanding of healthcare service utilization among female porters.

This interview will be conducted in a conversational format, and there are no right or wrong answers. We are simply interested in your experiences, perceptions, and challenges related to accessing sexual and reproductive health services. To ensure your privacy, please avoid mentioning any personally identifying information, such as your name or contact details, during the interview. We assure you that your responses will be treated with full confidentiality, and any findings from this study will be anonymized and used solely for academic purposes.

If you have any questions or concerns about this study, please feel free to contact **Ardyce Fafa Ayensu**, the Lead Researcher, at 0242716965.

Thank you once again for your willingness to participate and share your experiences. We appreciate your valuable input in contributing to this important research.

Please, indicate your consent for participation here: ☐ *I agree* ☐ *I don't agree*

Section 1: Demographic Information

1. What is your age?
2. Highest level of education
3. Number of years working as a potter
4. Main source of income and other sources if any.

Section 2: General Knowledge of Sexual and Reproductive Health Services

1. How would you explain the term sexual health?
2. What do you understand by reproductive health?
3. Are you aware of any sexual and reproductive health service in the area you stay?
4. (a) Apart from where you stay, are you aware of any sexual and reproductive health service available elsewhere in the Accra Metropolis?

   (b) If so, list them……

Section 3: Awareness and Access to Services

1. Are you aware of any organization that provide sexual and reproductive health services here in Accra?
2. (a) Have you ever utilized sexual and reproductive health services since you arrived here in Accra

   (b) If yes, which ones?

   (c) If no, why?
3. Have you received any formal education or training in sexual and reproductive health.

4. In your experience, how reliable do you find the information you receive about these services?
5. What types of sexual and reproductive health services are you aware of in your area (e.g., family planning, STI testing, prenatal care)?
6. (a) Are there services specifically for women like you (Kayayei)?

   (b) If no, who else?
7. What additional information or service do you feel is necessary for you as a head potter regarding sexual and reproductive health.
8. Any suggestions as to how local authorities can put in place to help head potters access sexual and reproductive health services in the Accra metropolis?
9. How has your awareness of these services influenced your health choices?

Section 4: Factors Influencing Access and Utilization of SRH Services

1. What motivates you to seek out sexual and reproductive health services?
2. How do your personal beliefs or cultural values affect your decision to use these services?
3. (a) Do you feel that your financial situation affects your ability to access SRH services? If so, how?

   (b) If no, explain.
4. Are there specific times when you are more likely to access these services, such as when you have more income or free time?
5. How far are the SRH service centers from where you work or live?
6. How does the distance or travel time to these centers affect your decision to seek these services?

7. How would you describe your experience with healthcare facilities (in terms of service quality, staff behavior, and waiting times)?
8. Are there specific health facilities you prefer for SRH services? Why or why not?
9. Do friends, family, or colleagues encourage or discourage you from using SRH services?
10. Have you ever accompanied a friend or relative to access these services? If so, how did that experience influence your view of SRH services?

Section 5: Barriers and Challenges to Accessing SRH Services

1. Can you describe any financial difficulties you face when trying to access SRH services?
2. How often do financial constraints prevent you from accessing the services you need?
3. Do you feel any pressure or judgment from your community regarding the use of SRH services?
4. Are there any cultural beliefs or practices that make it challenging for you to use these services?
5. Are there personal reasons, such as fear, embarrassment, or lack of knowledge, that discourage you from accessing SRH services?
6. Do you think discussion of sexual and reproductive health is important? Explain.
7. How does your daily work as a Kayayo impact your ability to make time for health services?
8. Have you ever had a negative experience with SRH providers or facilities? If yes, please describe it.

9. What specific challenges do you face within health facilities, such as long waiting times, unfriendly staff, or lack of privacy?
10. Are there any issues with transportation or availability of SRH services that make it difficult for you to access them?
11. Have you ever attempted to access SRH services but could not due to logistical issues (like time constraints or facility hours)?