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RESEARCH ARTICLE

Are internal migrants (head porters) sexually vulnerable due to the coronavirus pandemic? A qualitative study of the situation in Ghana

Elvis Junior Dun-Dery[1], Frederick Dun-Dery[2], Mary Eyram Ashinyo[3] and James Avoka[4]

[1]Oregon State University, Corvallis. 97330, OR. USA, [2]University of Calgary, 2500 University Drive NW Calgary, AB T2N 1N4, Canada, [3]Ghana Health Service, Quality Assurance Directorate. Greater Accra Region, Accra, Ghana and [4]Birim Central Municipal Health Directorate, Ghana Health Service, P.O.Box 429, Akim Oda, Eastern Region, Ghana
Corresponding author: Elvis Junior Dun-Dery; Email: dunderyejunior@yahoo.co.uk

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Abstract

Head porterage, popularly known in Ghana as Kayayei, has been an old economic venture for young girls and women who migrate from the northern to the southern part of the country. Even though Head Porters view Kayayei as a source of livelihood, conditions such as the outbreak of the 2019 coronavirus disease (COVID-19) further worsened their sexual vulnerabilities, as well as their autonomy to make decisions on contraceptive use. Head Porters, as a term defined in this study, refers to women aged 15 years or older who carry loads from one point of the town to another for a fee. The study is qualitative and used both purposive and simple random sampling in recruiting 120 Head Porters for focus group discussions. The study was planned and implemented in three zones in Kumasi, the Ashanti Regional capital of Ghana, during the lockdown period (between March and April 2020). Factors such as access to contraceptives, self-reported sexual desire, and partner desire to use condoms, sexual demands, and the impact of the COVID-19 pandemic on contraceptive access were assessed. Sexual demands increased during the COVID-19 period, with most Head Porters indicating they used fewer condoms and contraceptives during the same period. The desire to use a condom was limited among both Head Porters and their partners, and access to contraceptives was hampered by fear of getting infected by COVID-19 from a health worker at family planning clinics. The COVID-19 pandemic significantly increased the sexual and economic vulnerabilities of Head Porters in Ghana and impacted their access to family planning services. Governmental and international organizations need to start developing intervention programs for vulnerable populations such as Head Porters before future disease outbreaks.

Keywords: Sexual vulnerability; internal migrants; 2019 coronavirus disease

Background

Globally, over one billion people are estimated to live in urban slums (Corburn *et al.,* 2020; Lu *et al.,* 2024), yet only a limited number of such population have access to proper health services (Makins *et al.,* 2020), including access to contraceptives (Townsend *et al.,* 2020). Meanwhile, previous data available suggest that adverse life events like the coronavirus pandemic and other disease outbreaks can increase the chances of delinquent sexual behaviors and health risks among Internal Migrants and marginalized populations (Hindes & Urry, 2024). For instance, the COVID-19 pandemic exposed and worsened the already risky sexual behaviours of marginalized populations

(Kumar *et al.,* 2021). Anecdotally, one group of people whose sexual acts and livelihoods affected by COVID-19 are Internal Migrants (Head Porters), popularly known in Ghana as 'Kayayei' (Ziblim *et al.,* 2020). For example, Montanaro *et al.* (2024) suggest that COVID-19-related stress increased sexual desires and risky sexual behaviors such as lack of condom use, multiple sexual partners and sexual abuse, especially during the lockdown period. Additionally, internal migrants were exposed to COVID-19 and sexually transmitted infections, exacerbated by poor sanitation, overcrowded living settlements and intimate sexual coercion resulting from the COVID-19 lockdown (Hargreaves *et al.,* 2020). More specifically, Vanbenschoten *et al.* (2022) posit that increased sexual violence and risky sexual behaviors associated with a limited social network, isolation and increased unintended pregnancies were reported among teenage girls during the COVID-19 pandemic (Ungruhe, 2020). Yet, several studies reported limited contraceptive use among women and their partners during the COVID-19 (Caruso *et al.,* 2020; Benson *et al.,* 2020; Masoudi *et al.,* 2022), especially in Ghana (Biney *et al.,* 2023).

Generally, Head Porters (Kayayei) are women of age 15 years or older who migrate from rural towns of Ghana to central business districts of the country to carry loads from one destination to another, primarily for financial rewards (Asante & Mills, 2020; Komesuor & Meyer-Weitz, 2023). Within such business districts, Head Porters are mostly crowded in slums, lack basic social amenities and have limited access to healthcare services, including contraception (Akanle & Chioma, 2013; Blija *et al.,* 2024). While Head Porters are known to have limited access to contraceptive services (Fruzzetti *et al.,* 2020), literature indicates that more than 50% of women discontinued the use of contraceptives during the coronavirus pandemic (Caruso *et al.,* 2020) but continued to engage in sexual activities (Makins *et al.,* 2020). In the case of Head Porters and other migrant groups, access to contraceptives was almost impossible due to fear of COVID-19 infection at the facilities, making Head Porters sexually vulnerable to their male counterparts (Rivillas-García *et al.,* 2021). Despite these challenges facing Head Porters, previous studies have focused on social and economic vulnerabilities, with a lack of available data on their health and family planning challenges during disease outbreaks. More specifically, urban slums are primary targets for family planning services in Ghana. However, most studies on Internal Migrants (Head Porters) in Ghana are skewed towards migration and livelihood challenges, with little or no information on the sexual vulnerabilities of Kayayei. Sexual vulnerability is defined in this study as any actual or attempted abuse of a position of vulnerability, differential power, coercion, or trust for sexual purposes without the power of the victim to resist such attempt (Groenewald *et al.,* 2022). Furthermore, research is limited in contraceptives and sexual challenges faced by Internal Migrants (Head Porters) due to the worsening impact of the coronavirus pandemic. The current study, therefore, aimed to assess the sexual vulnerabilities and contraceptive access of Head Porters in Ghana during the coronavirus pandemic.

Methods

Study setting

The study was conducted in the Kumasi Metropolis between March 18 and April 22 during the lockdown period. Kumasi is the capital of the Ashanti region of Ghana, with an estimated population of 3,903,480 (GSS, 2021) and many slum settlements (Boateng *et al.,* 2017). Most slums in Kumasi have limited access to quality health services and transportation compared to other parts of the city (Opoku-Boateng *et al.,* 2024; Boateng *et al.,* 2017). It is Ghana's second-largest and most populous city after Accra (Adom *et al.,* 2020). Kumasi presents greater opportunities for young men and women migrating from the northern part of the country to the southern part in search of better economic and employment opportunities (De *et al.,* 2023; Komesuor *et al.,* 2024). Apart from that, Kumasi is a diverse business hub, making it favorable for petty trading and an eventual destination for Head Porters in Ghana (Ansong, 2022).

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Study population

The target population for the study were internal migrants (Head Porters) between ages 15 and 45 who had resided in the Kumasi metropolis for at least 6 months. Though the number of Head Porters in Kumasi is unknown due to their high mobility rate (De *et al.,* 2023), it is estimated that 23,000 Head Porters reside and work in Kumasi at every point (Boateng *et al.,* 2017). This population was selected because they are mainly known to engage in Kayayei business than any other age group (Opuni *et al.,* 2023). Again, this group of young women are considered sexually active, exposed to the risks of sexual violence, and are more likely to exchange sex for shelter (Boateng *et al.,* 2017). They are also known to be more vulnerable to sexual health services and contraceptives access challenges (Bakesiima *et al.,* 2020). The study excluded all Head Porters under 15 or above 45 years or who have lived in the Metropolis for less than six months. This age group was selected because they were within the reproductive age and are likely to have adapted to their surroundings with some form of sexual/marital relationship or knowledge of the locations of family planning clinics within six months.

Sampling and recruitment procedures

The study was qualitative and used a purposive sampling method to select 12 Head Porters for each section of the focus group discussions (FGDs) according to steps by Ganle & Dery, (2015). The FGDs were used as an appropriate approach to diversify respondents' profile and reduce the cost of conducting the study. The participants were recruited into the study if they met the following criteria: 15 or older but less than 45 years, lived in the study area for at least six months, self-identified as Head Porters, and agreed to have been in a sexual relationship. Head Porters were randomly assigned to ten (10) FGD sessions. A total of 120 Head Porters were identified through direct observation while they were on their active work routines and invited to participate in the FGDs orally. The FGD in each of the three zones (Kejetia, Aboabu, and Asafo) was held at the central converging points of Head Porters, where most daily businesses were carried out. Though this period was the lockdown period, Head Porters continued their work as a means of survival. A simple random sampling method was used where Head Porters were randomly assigned to different groups by selecting pieces of folded paper pre-numbered 1 to 10, indicating the groupings. Each participant was given a written consent form. For those who could not read the consent form, it was read and translated to them in their native language before they consented or disagreed to sign or thumbprint it. Different researchers separated and conducted focus groups in each zone to allow for potentially different perspectives. Additionally, authors wanted to validate the fear of COVID-19 infection as a research objective, though participants were seated 6 feet apart and provided with a medical nose mask and hand sanitizers (according to ethical approval guidelines).

Participation in the study was voluntary, and de-identification and confidentiality were ensured by assigning codes 1 to 10 to the focus group discussions. Data saturation criteria were used to establish the required number of FGDs, that is, when additional group discussion no longer added new insight to the collected data, FGDs were stopped on that theme under investigation. Ten (10) FGDs were conducted over three days (4 FGDs on the first day and 3 each on the subsequent days) in the three zones (Kejetia, Aboabu, and Asafo). FGDs lasted a minimum and maximum of 68 minutes and 90 minutes, respectively. Researchers stopped inviting Head Porters for FGDs when interviews reached the information saturation point, giving 120 participants and 10 FGDs, with each FGD consisting of 12 participants according to steps set out by Krueger and Casey (2015).

Data collection

Focus group discussion guides with broad and open-ended questions were used for data collection and covered three main themes: (1) sexual behaviors and sexual demands from partners; (2) access

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to and desire to use contraceptives such as condoms and fear of COVID-19 infections; and (3) economic hardships and contraceptives purchasing power. Additional sub-sub-themes were added to subsequent interviews as and when they were noted from the ensuing discussions. Researchers also employed participatory and active listening techniques during FGDs to validate participants' responses and to elicit more information from participants. Focus group discussions were conducted in Twi language, the predominant language across the three zones and digitally recorded on ten separate recorders, to ensure data integrity and group independence. The digital recordings were played repeatedly and independently translated and transcribed by two transcribers from the study area into English, back transcribed into Twi, and back into English to ensure no information loss. The primary researchers (authors) compared and verified the final transcripts. The FGDs were conducted by trained female research assistants (two assigned to each FGD session) under the strict supervision of the female co-investigator. Female research assistants were used to maximize the effect of gender in obtaining detailed and accurate responses, as all Head Porters were females.

Data analysis

Thematic content analysis as described by Kweku *et al.,* (2020), Braun *et al.,* (2006) and Sieleunou *et al.,* (2017) was used as the method of data analysis. This process involved reading the transcribed text to identify similar patterns and categorizing texts into main themes. The first step involved repeated reading of transcribed scripts and identifying words and phrases with the same or similar meanings. Words and phrases identified were then used to develop codes and put into broader categories as they relate to the relevance of the research question. Coding was independently done by the principal investigator and an independent researcher and later compared to ensure consensus in interpretation and consistency. Researchers mind-mapped codes (mentally arranged according to similarities) throughout the text until major categories emerged with no similarity between them. The researchers finally deduced answers to research questions from the respondents' views captured in descriptive themes, resulting in more abstract analytical themes. The categories were grouped to form major themes and ranked according to research objectives. Analysis was conducted using the Dedoose version 9.0 software.

Ethical considerations

No personal identifying information was collected, and all recordings were identified with numbers. Ethical approval was granted by the Institutional Ethics Committee of Research Web Africa (IRB-RWA-EC-1055), and the Ghana Health Service office in Kumasi granted institutional permission. All participants consented to voluntary participation in the study. Participants under 18 years were recruited with parental consent from a biological parent or self-identified guardian. Respondents who could not read and/or write were made to thumbprint after the consent form and objectives of the study were read and explained to them in their native language. Completed study forms were collected from research assistants after each FGD session for secured storage.

Results and discussions

Participants' characteristics

A total of 120 Head Porters were recruited for this study: 108 were in regular and active sexual relationships and the rest had occasional sexual relationships. Most participants reported being single, living with a partner, or sharing a common living space with another Head Porter. Of the 120 participants sampled, 112 indicated they were from the northern part of the country, and 103 self-identified as Muslims. Majority of the participants had no formal education, while the rest attained the highest primary education.

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COVID-19 has an impact on sexual behaviors, and contraceptive use

This theme captured information on respondents' sexual behaviors during the COVID-19 lockdown period and highlighted the desire to use or not to use contraceptives, especially condoms. The theme also presents information on the general perception of participants on sexual encounters and how their partners influenced their choice of contraceptives. In this study, all respondents expressed similar opinions about their sexual behaviors, indicating why they decided to use or not to use certain contraceptives. One had indicated:

> *'If you want to have sex with your husband, the two of you cannot use a condom, but if it's your boyfriend then you can use a condom. Some men too are there, if they want to impregnate you intentionally, they will create a hole in the condom before they use it on you. I only heard about that, but I have never done it myself'* [RP2, 21 years old, Asafo]. This is further confirmed by one other respondent saying: 'My *previous boyfriend was not using condoms because he wanted a child, and I got used to it* [not using condoms], *but this person I have now, don't try him at all* [participant laughs]. *He wants to do it* [have sex] *every day, and that forced us always to get a condom ready'* [RP13, 25 years old, Kejetia]. Another respondent added: *'When a man uses a condom on you, he has worried* [punished] *you. I will not allow a man to use a condom on me. If I don't have other contraceptives, I always want to use a condom, but most men don't care even if you don't agree to do it* [have sex]. *All they need is the sex and no long talk about COVID-19 or whatever they call it'* [RP5, 32 years old, Asafo].

These findings are similar to a previous study among migrants on sexual and reproductive health emergencies during the COVID-19 pandemic, which concluded that the COVID-19 increased the risk of gender-based sexual violence and limited condom use among sexual partners during quarantine (Tang *et al.,* 2020b). Sexual and contraceptive challenges, especially among Head Porters, require policy reformation towards future outbreaks and the general protection of the sexual autonomy of vulnerable women. As further indicated by Aly *et al.* (2020), the COVID-19 pandemic exacerbated the discontinuation of contraceptive use among vulnerable populations, leading to an increase in sexually transmitted infections and sexual violence.

The dislike for condoms as expressed above [*'they are understood to deny partners the natural pleasure of sex'*] seemed common among Head Porters. Respondents prefer other contraceptive methods in the absence of condoms, which allow them to '*enjoy sex*', other than using a condom. For example, one respondent clearly stated:

> *'To tell you the truth, I prefer the other contraceptives that last three months because you don't have to worry about pregnancy, but you still have to run away* [prevent oneself] *from infections with a condom. I trust condoms, now that we don't even know what this infection is on everyone . . . . . what is the name again? COVID-19 or 20?* (participant is interrupted by RP4, 29 years old with an answer)' [RP 12, 19 years old, Aboabu]. *'I will rather use other contraceptives and still enjoy sex if I don't want to get pregnant or infected, and the men want that too because they tell me all the time. The problem is, because he prefers other contraceptives, he comes for sex anytime he wants without asking if I have taken one* [a contraceptive]. *So, you see that having a condom around helps at that time'* [RP 9, 22 years old, Kejetia]. Similarly, other respondents felt that sex is best enjoyed without protection: *'I will allow raw* [without condom] *sex because I want to enjoy it. If a man is doing it* [sex] *with a condom, the pleasure of sex is not always there, and you do not feel it. You have to enjoy it (sex) before you think of COVID-19 because he will keep demanding for sex until he gets it, and if you talk about COVID-19 or condoms, he will get angry and leave you for another girl. I prefer to take the other contraceptives if I do not want to get pregnant or COVID-19, so . . . .* [participant paused to think], *if a man wants a condom too, then it becomes a struggle to get one, oh why'* [RP14, 34 years old, Asafo].

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Findings from this current study are similar to those of other scoping reviews, which suggest that personal contraceptive desire can also serve as a barrier to contraceptive use during the COVID-19 (Kumar *et al.,* 2021). Results from this study further highlight the importance of promoting long-acting reversible contraceptives (LARC) and other methods of contraception before and during disease outbreaks that require quarantines. Some Head Porters believe that even though some ladies do not like condoms during sex, some men also have their reasons for not using condoms and still prefer the protection offered by condoms. One respondent said:

> *'It is the ladies who prevent using condoms. If we agree to use it* [a condom], *some men will use it during sex and yet avoid pregnancy. Other men too will prefer we use the other types of methods, so they do not have to use condoms, but using the condom is important because this infection that is roaming here . . . . . they call it covid is real'* [RP15, 38 years old, Aboabu].

Similar results from earlier studies confirm the limited desire of migrants to use condoms during the coronavirus period (Agyei-baffour *et al.,* 2015; Zhang *et al.,* 2022). Meanwhile the choice to use contraceptives is an integral part of family planning services and an important component of women's sexual rights and autonomy. Another respondent added:

> *'Some of the men will insist on using a condom no matter the resistance from us because they think the female may have a disease like COVID-19 or sexual infections* [infection]. *Sometimes, we have to go the extra mile to get them from far places . . . . . we even feel shy if we are not buying from a family planning clinic, but you can't do without it because they will still find a way to get their sex anyway'* [RP 9, 22 years old, Kejetia].

Intimate partner violence is a general practice from both partners, but in most sexual encounters, men exhibit autonomy and make most sex decisions (Groenewald *et al.,* 2022), as indicated in this study. Findings from similar cross-sectional studies agree with the findings from this study but iterate the significant contribution of COVID-19 to increasing sexual violence and limited contraceptive decision autonomy for women (Gebrewahd *et al.,* 2020). In the case of Head Porters, sexual and contraceptive decision autonomy is even much more unbalanced due to glaring sexual vulnerabilities between Head Porters and their partners (Nabukeera, 2020). The risk of sexual abuse and contraceptive neglect among vulnerable migrants during outbreaks is almost a universal fact that needs attention and policy interventions (Jones *et al.,* 2022; Groenewald *et al.,* 2022).

Coronavirus pandemic leads to Sexual vulnerability and fear of infection

The results in this section describe participants' fear of accessing family planning clinics because of COVID-19 pandemic. During the coronavirus pandemic, adolescents and women of reproductive age in general were faced with challenges to access many essential health services, including contraceptives and family planning services. This is particularly challenging because most Head Porters (Kayayei) had the perception that family planning sites and health centres are sources of coronavirus infection. For instance, one Head Porter was recorded saying:

> *'Do you want me to get infected with this coronavirus disease? I will not go for any contraceptives, and the health workers will infect me; they even have the disease themselves'* [RP5, 32 years old, Aboabu]. Another respondent was heard saying, *'recently, I heard a girl was infected with COVID-19, and it was when she went to the FP* [family planning] *clinic. Please!! please!! Ooo!! I will not even try going there; contraceptives can wait. If I get pregnant, that is better than dying from coronavirus'* [RP7, 18 years old, Asafo]. *'Even buying condoms from the pharmacy shop is dangerous now because they said anybody can be infected with this*

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condition [COVID-19]. *So, what shows that the people at the pharmacy are not infected already?'* [RP8, 21 years old, Kejetia].

Similar reviews suggest that apart from couples being prone to increased infection through their partners, the fear of contracting COVID-19 from healthcare workers and family planning centers was a significant barrier to contraceptive use (Groenewald *et al.,* 2022). Several other studies conducted in Kenya, Nigeria, and Zimbabwe found that adolescent migrants were hesitant to visit family planning facilities due to fear of being infected with the coronavirus (Malkin *et al.,* 2022). Even though these studies are conducted in different settings, universal policy formulation around mobile family planning clinics during outbreaks will be relevant to minimizing fear and physical contact between health workers and migrants. Additionally, pregnant Head Porters also expressed fear of COVID-19 as a challenge in dealing with their situation:

'As you can see, I am now pregnant, even though I did not want to. I did not go for my family planning again because it expired during this time, and I am afraid of getting infected when I go there [health center] *now I am pregnant. So, I would have gone to abort it if it was not during coronavirus'* [RP15, 38years old, Aboabu].

The fear of getting infected by healthcare workers at the family planning facility is a national problem in Ghana and the African diaspora. As found by similar studies conducted in Ethiopia, access to contraceptives was significantly hampered by the chances of contracting COVID-19 from healthcare workers (Jones *et al.,* 2022). Meanwhile, limitations to contraceptives have been universally noted to expose women to unwanted pregnancies, limited sexual autonomy, and sexual abuse (Lattof *et al.,* 2018). Especially for internal migrants (Head Porters), it is an exclusion from the healthcare system, considering that this vulnerable population are already exposed to daily sexual abuse and limited access to other essential health services in Ghana (Ansong, 2022).

Subtheme 1: Reduced income/financial independence affects contraceptive access.

Under this sub-theme, participants describe their challenges to getting their usual daily jobs due to fear of COVID-19 infection. The theme also captures participants' financial ability and contraceptive purchasing power and how the COVID-19 further jeopardized their sources of livelihood. Kayayei is the main source of income for Head Porters and serves as their purchasing power for food, healthcare services and contraception. Apart from the fear of contracting COVID-19 from FP clinics and health workers, Head Porters' lack of jobs served as economic and financial barriers to accessing contraceptives. This 22-year-old Head Porter had this to say

'I can tell you I am not the only one not working now; many of my colleagues are not going out to work because of fear of getting infected. There is no money even to buy condoms or anything even if we want to do so; so, many of my friends are pregnant' [RP1, 22 years old, Asafo].

This finding concurs with previous studies conducted among Indian and Ghanaian migrants who indicated economic hardships, compulsory lockdowns and lack of jobs during the coronavirus pandemic as barriers to accessing contraceptives (Jesline *et al.,* 2021; Dassah *et al.,* 2022). Contrary to findings of the current study, Murewanhema, (2020) posits that supply chain disruptions, lack of education, and reallocation of family planning resources were major barriers to contraceptive use among internal migrants during COVID-19. Even though these studies were conducted in different settings, it is imperative to note that future disease outbreaks will require socio-economic strategies and internal coordination in response to the family planning needs of internal migrants (Head Porters) in Ghana.

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Furthermore, several of these economic woes were also compounded by customers of migrants who were unwilling to associate with and contract migrants due to fear of being infected:

> *'To add to what my sister is saying, so many of our customers do not even allow us to carry their goods now, because they are afraid that we may also have the disease, how will you even have money for contraceptives?'* [RP5, 32 years old, Aboabu]. Another respondent said, *'For me, I have not gotten any work to do for the past two weeks. Now I have decided to go out once a week because I still do not get work. I will also not use the little money I have saved to go for contraceptives; if my boyfriend will not buy contraceptives or any condom, then he wants me to be pregnant'* [RP3, 16 years old, Kejetia].

Apart from findings from the current study, studies conducted among migrants in Southern Africa also confirm that reduced economic activities and lack of external support during the COVID-19 pandemic greatly impacted the contraceptives purchasing power of internal migrants (Mushomi *et al.*, 2022). This is particularly concerning for achieving the United Nations Sustainable Development Goals (SDGs), since goal eight advocates for decent work and improved economic outcomes for all (Komesuor & Meyer-Weitz, 2023). This again provides the analysis of conditions that make different migrant groups specifically vulnerable to the health impact of the coronavirus pandemic, as well as highlights the lapses in migration program development and interventions in Ghana and Africa.

Sub-theme 2: Head Porters have limited autonomy to negotiate safe sex.

This theme captures participants' struggles to negotiate sex with their partners safely and how that influences their use of contraceptives as well as access. This is largely exacerbated by a lack of jobs in the Kayayei business and sexual demands from their partners. The economic and contraceptive access challenges continue to be aired as one further supported this with a similar opinion, saying:

> *'I will not hide anything, me!! I speak freely . . . . . ' hahaha'* [laughter]*! I do not have money due to the COVID-19 lockdown, and now we do not work. So, all I sometimes do is give in to any man who will give me some small money to survive, and it depends on how he wants it. Some will prefer to use a condom, others too, I can't decide for them when they do not want to use a condom because we don't even have money to use the contraceptives'* [RP4, 29 years old, Asafo].

More important is the fact that, even in the presence of limited access to contraceptives, there was an increasing trend of sexual demands from partners of Head Porters (Kayayei). Her colleagues confirmed this:

> *'Now most of us stay home without working, so what do you think? All my boyfriend does is demand sex all the time, as if he does not get satisfied. I cannot refuse his demands because he supports me now'* [RP14, 34 years old, Kejetia]. Another added: *'My boyfriend left me because I asked him to use a condom, and he refused. So, I also refused to have sex with him. Now, I am pregnant for another man because I allowed him to do it without a condom. They all demand for sex but do not think about contraceptives, so we cannot help but agree'* [RP9, 22 years old, Kejetia].

While the results from the current study agree with the findings of Jesline and colleagues (2021) and those of Shaaban *et al.* (2020), other studies conducted in South Africa among internal migrants suggest contrary findings, which indicates that the power of autonomy to use contraceptives, depends on the socio-economic and job category of the male partner, who is seen

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to have the purchasing power (Mukumbang *et al.,* 2020). The difference in findings can be attributed to varying economic settings, differences in employment opportunities, health education efforts and contraceptive supply. However, what is of relevance or even more critical is the misplaced policy discussions about the place of internal migrants (Head Porters) in Ghana and the fact that most government programs have failed to place internal migrants in the health delivery chain. Increased sexual demand from male partners was experienced by their female counterparts during the coronavirus pandemic, and without condoms, these demands were a constant daily practice even when female partners resisted. Head Porters had no autonomy to decide when to have sexual intercourse with their partners, and even when they (Head Porters) expressed their dissatisfaction about sex, that was rarely adhered to:

> *'I have decided not to allow my boyfriend to have sex with me because I am not on any contraceptives now. The coronavirus has made all of us fear visiting the FP center. I will only have sex when he gets a condom, but he is always pressurizing me for sex everyday'* [RP1, 22 years old, Aboabu]. Another added *'My husband now takes care of every family demand and that comes with sex demands too. He is also afraid to go and buy condoms so he will not get the coronavirus, but you know that will not stop him from asking me for sex. My contraception expired during this time, but I will not even make a mistake to get near the health center for it, I will get covid 19'* [RP11, 20 years old, Asafo].

Even more worrying was the fact that some partners demand for sex on daily basis. This was confirmed by a respondent saying *'For me, my boyfriend wants to have sex with me every day, so sometimes I just give an excuse that I am sick, or I have my menstrual period. When I say that, he will ask again the next day. It's like we do not have options at all, but the contraceptives center is a no-go area at this COVID-19 time'* [RP4, 29 years old, Aboabu].

Several other studies have reported findings similar to the current study's findings among internal migrants in Ghana (Adomako & Adomako, 2017) and Nigeria (Fawole *et al.,* 2021). In other settings, sexual intercourse among internal migrants was used as a coping strategy during the lockdown period (Gillespie *et al.,* 2021). Not only is increased sexual abuse observed in Ghana among internal migrants, it is a well-known experience in other settings and during similar disease outbreaks (Tang *et al.,* 2020a), making this a major concern in sexual health service delivery. Similarly, beyond sexual vulnerability among migrants, it is important always to include the second tier of economic hardships experienced by vulnerable groups during outbreaks. Moreover, pre-existing socio-economic inequalities among migrants in Ghana, such as housing, poverty, employment, and access to social security, can further contribute to higher rates of sexual vulnerabilities and limited contraceptive access. These challenges need conscious and deliberate government measures and the input of international health organizations to address as part of the goal of universal health for all.

Study limitations

Though the study is of high quality, there are limitations to note. The study was a broader project, and this publication is only a part of the project, which may limit the scope of knowledge shared through this publication. The study did not also account for extensive interviewers' demographics because the study was limited to qualitative methods.

Conclusions

The study revealed major vulnerabilities faced by Head Porters due to the COVID-19 pandemic, including limited access to contraceptives, sexual abuse, and unwanted pregnancies as well as socio-economic challenges. These challenges led to limited autonomy of Head Porters to negotiate

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for safer sex with partners, fear of COVID-19 infection and reduced contraceptive use among Head Porters and their partners. These challenges are not only economically draining but have significant psychological implications for the health and well-being of Head Porters. Increased sexual demands and the use of sexual intercourse as a means of compensating male partners for economic support are also damaging to the sexual autonomy of Head Porters. Health and social service programs rolled out during disease outbreaks must target the social, economic, psychological, and empowerment components of Ghana and Africa's women and other vulnerable populations.

Data availability statement. All data sources for this study are included as part of the study results. Any further information can be made available by contacting the corresponding author at dunderyejunior@yahoo.co.uk.

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Author contribution. EJD conceived the research idea and designed data collection tools in consultation with FDD. MEA and JAA offered technical ideas and ethical support on methods and quality of the research process. EJD supervised data collection, analyzed the data, and drafted the manuscript. EDD, FDD, MEA, and JAA reviewed the manuscript for technical input. All authors reviewed the final draft of the manuscript and finalized it for publication.

Declarations. The research was performed following the ethical standards of 1975 declaration of Helsinky, as revised in 2008 and all data were deidentified for the purposes of this research.

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Ethical standards.

Consent issues. Written informed consent was obtained from all participants after the study protocol was read to them. The willingness to participate in this study was purely voluntary, and participants were not given any benefits. To show consent, a participant could either thumbprint or sign the consent form. Privacy and confidentiality of participants during the face-to-face discussion process were ensured by restricting all non-participating individuals from entering the interview location.

Ethical clearance. The institutional review board of Research Web Africa reviewed and approved this study with approval Number IRB-RWA-EC-1055. The Kumasi regional office of the Ghana Health Service also granted institutional clearance. The study protocol, including possible risks/ benefits of participation, was explained in English and the local language to all Head Porter before their consented enrollment. Written informed consent was obtained from eligible participants.

Abbreviations. FP, family planning; FGDs, focus group discussions; LARC, long-acting reversible contraceptives; COVID-19, coronavirus-19; RP; research participant, ERC, ethical review committee.

Author Details. EJD holds a Master of Public Health degree from the University of Ghana and another Master of Public Health Degree from Purdue University, USA. He is currently a Ph.D. student at Oregon State University. FDD holds a Ph.D. in Global Health from Heidelberg University, Germany and is currently a Post-Doctoral Associate at the University of Calgary, Canada. MEA holds a Master of Public Health Degree from the University of Ghana and is currently the Deputy Director of Quality Assurance at the Ghana Health Service. JAA holds a Ph.D. in Public Health from the University of Ghana and is currently a researcher and Director with Ghana Health Service.

Informed consent/patient consent. Respondents signed a consent form, which included permission to publish.

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