CHILD CARE AMONG EWE MIGRANTS IN THE CITY OF ACCRA: CASES OF CRISIS

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Abstract

The general wellbeing of children has become an issue of increasing concern and discussion at international, local, and other levels during the last two decades or so. Children’s health and nutritional status, in particular, have received the attention of both researchers and policy makers, due to indications of survey results and other sources that they have been deteriorating in many countries. Theoretical and other forms of research aimed at understanding the situation identify care as an important factor that either promotes or otherwise affects the health and nutritional status of children. Studies on care have also emphasized that the socioeconomic context within which care is provided, determines the availability of resources for care and the personal capacity of care givers or families to meet their care obligations. The present paper presents a number of cases of crisis of care among Ewe migrants in the city of Accra. It is part of a bigger project that examined care practices and their effects on children’s health and nutritional status among the migrants. The cases, though unique in their own respect, together are a reflection of the general situation of care among the migrants. They also bring to light the complex interrelationship among the factors affecting care and point to the need for more comprehensive approaches in research to understand the problems facing households in providing care for children in the contemporary socioeconomic context.

Introduction

Evidence from research and other sources increasingly indicates that the general wellbeing of children, particularly their nutritional and health status, have been deteriorating markedly in many parts of the world. The situation in the Sub-Saharan African region is one of the worst. Some statistics have shown that the proportion of infants who are malnourished in the region, for example, has increased from 25.8% in 1985 to 31.1% in 1995 and may reach 35% by the year 2020 if current trends continue (Smith and Haddad 1998 cited by Oppong 2001). The 2001 World Data Sheet of the Population Reference Bureau has also shown that Sub-Saharan Africa has the highest infant mortality rate of 94 per 1,000 live births, almost twice the rate of Asia (56) and many times those of Europe (9) and North America (7). An analysis of global trends in child mortality by Ahmad et al. (2002:1) also indicate that on the average 15% of newborns in Africa die before reaching their 5th birthday compared with 3-8% in many other parts of the developing world and less than 2% in Europe.

In Ghana, anthropometric data from the 1988, 1993, 1998 and 2003 Ghana Demographic and Health Surveys (GDHS) and other sources indicate that the nutritional and health status of the average Ghanaian child is poor. The 2003 GDHS, for example, shows that 22% of all children under five years of age are underweight, 30% are stunted and 7% are wasted. The proportion that is underweight is a decline from the 1998 level of 25% and the figure for those wasting is also a drop from the proportion in 1998 which was 10%. The proportion that is stunted rather recorded an increase from the 1998 level of 26%. The infant and under-five mortality rates recorded in the 2003 GDHS had also risen from the 1998 rates. The Infant Mortality Rate (IMR) rose from of 57 per 1,000 live births to 64 while the under-five mortality rate increased from 108 to 111 (Ghana

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Statistical Survey 2004:13-14, 1999:118-122). These rates are not only worsening but are altogether high, considering achievements made in these areas in other developing countries such as Sri Lanka.

The poor nutritional and health status of children in developing countries, including Ghana, has often been attributed to the general high levels of poverty and associated inadequate provision of all kinds of children’s material needs (See, for example, Ocholla-Ayayo 2000, Fayorsey 1999). Urban food insecurity and associated nutritional problems, for example, have been identified as a major problem in sub-Saharan African cities (Maxwell 1999; Morris et al. 1999).

Alternative explanations of the poor health and nutritional conditions of children have, however, been discussed by researchers and others who are concerned with the issues. Consequently, some recent studies and reviews on available knowledge on growth and development of children indicate that variations in the quality of care received by infants and young children is a major factor that either enhances or negatively impacts their nutritional and health status and general wellbeing (Garza 1995, Latham 1995, Zeitlin et al. 1990). For example, in their study on children’s nutritional status in Accra, Ruel et al. (1999:2001-2005) found that there was a strong association between care practices and child nutritional status. The findings of the study also indicate that care practices are stronger determinants of children’s nutritional status than maternal education. Ruel et al. concluded based on the findings of the study that, good care practices could compensate for the negative effects of poverty and low maternal schooling.

Conceptual Framework

Efforts have since been made to develop the conceptual framework within which the subject of care can be examined. Studies on positive deviance in child nutrition such as that of Zeitlin et al. (1990).2 are perhaps the most laudable research approaches that attempt to indicate causality between care practices and nutritional and related health status of children. Such studies report that differences in care giving behaviours exist within and among societies and largely account for differences in nutritional and health status of children and also for what is referred to as “positive deviants”. These are young children of very poor households, uneducated mothers with limited access to food and health services but with high nutritional and health status in a community where most children are malnourished (Zeitlin et al.1990). The notion of positive deviance emphasizes that the high nutritional and health status of such children are explained by the relative importance of all kinds of care resources including psychosocial aspects of care.

There is a body of literature building up on the causes of inadequate child care. Notable among them are a series of works published over the last decade by Oppong (1999, 2000, 2001, 2004). She has demonstrated in these works that care has been a critical determinant of children’s nutritional and health status. She traces the decline in care provision in the African region to its socio-economic transformations that have undermined the social networks that supported child care in traditional African societies. She identifies dispersal of kin due to migration and processes of urbanization and globalization and associated breakdown of family norms and solidarities, among others, as factors that have made babies who were once the darlings of the family now denied their entitlements. Her use of the concept of social capital provides a dimension in which evidence of the problem as well as the policy researches on the subject can improve upon the approaches used hitherto in the demographic and other surveys.

2 It was published with support from a WHO/UNICEF Joint Nutrition Programme and financed by the Government of Italy. The study is also a complementary to the UNU (United Nations University)/UNICEF “Research on the Evaluation of Programmes on Nutrition and Primary Health Care at the Household Level”. The study of Zeitlin et al. (1990: 1) examined and reported the performance of mothers who were successful in maintaining the nutrition and health of their children and families under conditions of poverty when most others failed to do so.
The conceptual framework that has been developed from a 1994 UNICEF-Cornell Colloquium on care and nutrition of the young child\(^3\) (Garza 1995:281) also offers a comprehensive conception of the subject of child care. (See Figure 1.) The framework propounds that care is determined by many factors that may be grouped into household, community and national factors (Armstrong 1995:301). The UNICEF framework also recognizes international conditions that influence care practices. The framework also shows that care for the very young child is shared in many societies and is associated with behaviours that are related to time demands, cultural attitudes, beliefs and knowledge about children’s needs and as such vary within and from society to society (Ramakrishnan 1995:287).

Latham (1995:282), in the overview of the UNICEF-Cornell Colloquium report, defines care for infants and young children as follows:

Care refers to care giving behaviours such as breastfeeding, diagnosing illnesses, determining when a child is ready for supplementing feeding, stimulating language and other cognitive capacities and providing emotional support.

The list can be extended to include the following: having the child immunized, determining when a child is ready to be weaned, choosing appropriate weaning food(s) and the best timing for the child to eat food prepared for the whole household, and providing him security in the home and outside. Moreover, care practices may vary by a number of factors including environmental sanitation, availability of social amenities and facilities such as safe-drinking water, sanitation facilities as well as characteristics of the child.

Also important are cultural practices of child care that result in particular health behaviours, feeding practices, and more so that child care is rather complex and presenting itself with astonishing variety between and within cultures (Yovsi 2002, Deloache and Gottlieb 2000). Generally, traditional or cultural child care practices may enhance children’s health and nutritional status or adversely affect them. While some cultural practices of child care have been continued from generation to generation especially in rural settings others have been abandoned.

Practices such as long period of breast-feeding and postpartum sexual abstinence- supported often with taboos and associated polygynous marital unions in traditional societies, ensure better survival chances for children (Amankwa et. al 2000). On the other hand, cultural practices of administration of water and other complementary foods too early (sometimes right from birth in the case of water and by the second or third month with respect to complementary foods) hamper the benefits that can be realized from exclusive breastfeeding up to four or six months recommended by conventional medicine (Awumbila 2003).

Despite the shortcomings of traditional practices of child care, the problems of care have to a very large extent been linked with socioeconomic transformations typified by urban settings where the present study has been conducted.

The Urban Setting and Child Care

Traditional practices of care, just like many other traditional ways of living, have been threatened mostly by modernization or socioeconomic transformations and wrought mainly through the processes of migration and urbanization. Migration, for example, has brought about disintegration of lineages (as members disperse) and made it difficult for members to provide support for their kin. Writing on this among the Anlo Ewe Nukunya (1969:174,189) noted,

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\(^3\) It was sponsored by UNICEF and Cornell University’s Division of Nutritional Sciences and held at Aurora, New York, in October 1994.
“When lineages were localized … cooperation was much easier and so was the regular expression of their corporate unity”

and, of course, mutual interdependence. Some studies have also noted that urbanization has been associated with “a movement towards monogamy and strengthening of the conjugal bond over all others” (Zeitlin and Megawangi 1995:399), making it difficult for interdependence among members of a lineage. Meanwhile, the nuclear family has not been able to cope with the socioeconomic and other changes and conditions successfully in order to provide adequate care for children. Some of the most prominent ones are discussed below.

**Mothers’ Work Outside Home**

The processes of modernization have continued to require that mothers engage more and more in economic activities while kin support for child care is being eroded. In her conclusion to a work titled “Globalization and the Disruption of Mothercare”, Oppong (2001:20) has warned that:

…African mothers’ work burdens and constraints are increasing more rapidly now, just at the time when many of their traditional kin and conjugal supports are dwindling. These changes are happening in an era of market driven reforms and globalization … many women are having to work more intensively for longer hours and often further away from home – with potentially profound impacts on female time and energy, which rather needs to be devoted to infant nursing, weaning and mothering, if the current high levels of malnutrition in the region are to be lowered.

In urban areas especially, the increasing need for women to work away from home in order to either supplement their families’ income or solely provide a livelihood for their families, makes caring for children more problematic for the family. Here again, an increasing number of women are living alone with their children due to more frequent marital disruption. A significant proportion of women in deprived urban communities in particular are also bearing children outside marriage and sometimes at early ages, at which both mother and child are vulnerable to hunger and disease as they lack support from family and social sources (Apt 1997, Korboe 1997, Population Impact Project 1995, Gyepi-Garbrah 1988).

Some working mothers have had to substitute for or delegate parental care partially or wholly for their children. Though helpful sometimes, affording care for some children who may be denied it by the circumstances of their parents, the practice has adverse effects on the wellbeing of some children as noted by Appiah (2001) and indicated in some earlier studies on fostering (Isiugo-Abanihe 1985). Meanwhile, unlike in traditional societies where fostering or delegation is done by families or adults, parental care is now often delegated to unrelated househelps who in some cases are children or under-age and/or unskilled in child care (Yeboah 1998). Some children are left in the care of untrained childcare attendants working in day-care centres that may not have adequate facilities. Some house helps even have the added task of housekeeping so that they are not capable of giving proper attention to the children in their care. Thus while working mothers who can afford substitute care may be better off than those who cannot, their children may also not be receiving any quality care relatively. We can therefore accept Oppong’s (2001) conclusion that absence of quality care explains the high malnutrition rate among children of high income households too.

**Traditional and Modern Care Practices: The Blend**

Furthermore, urban dwellers tend to abandon some good traditional childcare practices and often do not replace them by modern ones but sometimes maintain some which have adverse effects on children (Douglass and Douglass 2002; Owusu 2002; Castle et al. 2001). Though most nutritionists agree that children need solid food in addition to breast milk between 4 and 6 months in order to reach their full growth potential and children exclusively breastfed for four or six months do not need water, some research findings show deviations from this.
Castle et al.'s (2001:ix) analysis of the 1995-1996 DHS in Mali indicates that only half of mothers interviewed, who had children aged 6-9 months, said they were giving solid foods to their children. Few children were exclusively breastfed, and most were given water or other liquids from birth. A MEASURE DHS+ study on complementary feeding of infants in Kumasi, Ghana also found out that nearly all the children in the study population were given water from the first few days after birth, though the mothers, as they themselves acknowledged, were told by community health nurses not to do so. A large proportion also gave their infants milk, porridge, soup and fruit too early.

A study by Maxwell et al. (2000:94-96) on “Urban Livelihoods and Food and Nutrition Security in Greater Accra, Ghana,” reported that feeding of infants with complementary foods and liquids of all kinds during the first four months was widespread in the study areas. In their analysis, they found associations between care practices and child nutrition and health outcomes. Better nutritional status was found among children who received better care.

**Urban Environmental Sanitation**

Beyond the household level, increasing poor environmental sanitation, pollution and inadequate sanitary facilities are some conditions in urban communities that affect children’s health as well as adult’s (Songsore 1999). These have contributed to the incidence of malaria, diarrhoea, gastro and other intestinal infections and upper respiratory problems which have remained some of the major causes of death among children in Ghana (Ministry of Health 1996).

On the other hand, relatively better provision of social services, such as health and safe drinking water, Maternal and Child Health (MCH) services, in urban areas and higher income of parents may ensure better material provision and good care practices and subsequent high nutritional and health status for children. Higher educational attainment among parents, particularly women, in urban areas have also made it easier for urban children to benefit from Oral Rehydration Therapy (ORT), the Expanded Programme on Immunization (EPI), vitamin and iron supplementation, and other programmes and policies that have contributed to improved children’s health and nutritional status in the country (Maxwell et al. 2000).

**Housing and Transportation**

Inability of government and the private sector to adequately meet the demand for urban social infrastructure, such as housing and transport network and facilities affect living standards in urban areas and such problems are worsened by rapid urban population growth (Nabila 1987). Shortages of housing facilities account for the willingness of many a family to rent facilities that are not furnished with sanitation facilities and other amenities. The Ghana 2000 Population and Housing census results show that there is great inadequacy of housing. Some urban families live in kiosks, shops and uncompleted buildings (Ghana Statistical Service 2004). Moreover traffic jams have become common features in many parts of Accra such that workers spend long period of time to and from work. Problems of urban transport are mainly due to geographical imbalance in the location of workplaces trading centres and residential areas (Stanislas 2002).

Accordingly the inequalities in income and access to social amenities and services in urban areas such as the city of Accra require that our research examine the spatial variations in care behavior that are associated with such inequalities. Variations of care practices among socioeconomic subgroups determined by differences in educational attainment, occupational characteristics, time demands and flexibility of work schedule, coping strategies and many other household factors must be examined, to discover complex relationship among the demographic, socio-cultural and economic factors that determine care giving behaviors of caregivers and associated outcomes. These factors were taken into consideration when the methodology of the
study and the cases of crisis were selected, so that a wide variety of issues affecting child care could be examined.

Methods

This paper discusses a number of case studies that are a part of a study that examined childcare practices and their effects on the health and nutritional status of children of Ewe migrants in the city of Accra. The study investigated the determinants of care mainly at the household level and explored the political economy of factors affecting child care, particularly health delivery, in the country. It examined distinctive patterns among socioeconomic subgroups and spatial categories of the study population within the context of cultural and socioeconomic change.

Objectives of the Study

The general objective of the study was to examine patterns and determinants of child care practices among Ewe migrants in the city of Accra within the context of cultural and socioeconomic change and determine their effects on the nutritional and health status of their children. Specifically, it examined the socioeconomic and demographic characteristics of the children and their parents and/or primary caregivers and the parents’ or primary caregivers’ knowledge, attitudes and beliefs related to children’s nutrition and health. It also examined the children’s living arrangements and related resources for childcare as well as the impacts of residential and urban environmental factors (housing, sanitary and health facilities, sources of water and energy) on childcare practices to determine how they influence them. The variations in care practices at the household and residential levels and within socioeconomic categories were then examined to determine their effects on the nutritional and health status of the children.

Sources of Data

The study collected data from both primary and secondary sources. The main source was primary data collected in households in the city of Accra through interviews, focus-group discussions, in-depth interviews and observation. The main research instrument was a structured questionnaire. It consisted of four modules – child characteristics, household and dwelling/residential characteristics, care practices and socioeconomic characteristics of parents and/or caregiver. The questions were both open and closed, to have the advantage of both methods in the collection of the data.

Both structured and unstructured interview schedules were used to collect information from in-depth interviews. Such interviews covered attitudinal issues such as caregiver’s views about religious and cultural beliefs and taboos about children’s health and nutritional needs. Structured and unstructured interview schedules were used to collect information from a number of ministries and departments including the Ministry of Women and Children’s Affairs, the Accra Metropolitan Area (AMA) and the Accra branch of the Women and Juvenile’s Unit (WAJU) of the Police Force and other departments and organizations that deal with domestic issues including child maintenance.

Secondary data was also collected from relevant sources including libraries, official records, censuses, surveys, and other studies carried out on the subject. The 2000 Population and Housing Census and a 1990 study – Demographic Studies and Projections for Accra Metropolitan Area

Operationalized Variables included the following: Child: Infants and children under five years of age. Care: Both active tasks such as feeding, bathing, etc. and passive tasks such as watching, holding, and socializing through play. Primary care giver(s): any person(s) who is mainly responsible for performing most of the active tasks for the child – cooking for the child, feeding, bathing, playing with the child and passive tasks such as holding, watching the child or providing security for the child inside and outside the house. Multiple care giver applies in situations where this task is performed by more than one person and none of them can be said to be the main care giver.
(AMA) - by Government of Ghana, United Nations Development Program (UNDP), the United Nations Centre for Human Settlements and the Town and Country Planning Department, Accra were major source of current information on residential and other socioeconomic characteristics of the Ewe in the city of Accra.

Research Approach

Both quantitative and qualitative research methods were used to carry out the study to ensure that different types of data and information could be collected. The quantitative method was used to examine patterns of care among the spatial clusters, test the hypotheses and some level of generalizations with respect to the findings to be made. The qualitative method was employed for observation of some phenomena in the field and in-depth interviews, especially regarding the case studies. Observational methods were used to collect information on health behaviours, feeding practices, interaction between children and their parents and/or primary caregivers, etc. Information on the immediate surroundings of households/dwellings regarding environmental sanitation and availability of social amenities and services were gathered mainly through observation.

The Sample Design

Results of the 2000 Population and Housing Census of Ghana (Ghana Statistical Service 2002) and the Demographic Studies and Projections for Accra Metropolitan Area (AMA) study were used to select the study areas from which the sampled population was drawn. These documents provide information on various socioeconomic variables including residential characteristics, migrant population characteristics, employment, housing type and amenities and other socio-demographic characteristics of the population of the city.

Multi-stage cluster and stratified sampling procedures were used to select a sampled population. The following characteristics of the targeted population were taken into consideration with respect to the cluster and stratified units: type of residence, income levels, education and occupational characteristics of parents/primary caregivers. A total of 200 children were targeted for the study to be drawn randomly from 200 households in the study areas. The household is the sampling unit from which a child is selected for the sampling population. Only one child was selected from any household. The households were selected to be representative of the major groups of the Ewe – Anlo, Tongu and Ewedome.

Ten case studies were carried out on children of different ages. The case studies were selected from different socioeconomic backgrounds, household types (with respect to headship, care resources, migration history and other relevant characteristics) and residential areas so as to observe the complexity of the factors affecting childcare and its nutritional and health consequences.

Care for the children and their nutritional and health status were examined with respect to the following: household characteristics (including migration experience such as length of stay in Accra, household/family structure and life-cycle stage); socioeconomic characteristics of the children, parents(s) and/or primary and other caregivers and care resources (time, physical and financial). Information on households’ source of drinking water, source of energy, sanitary facilities and environmental sanitation of dwellings and other conditions that affect care behaviours will be examined. Anthropometric measurements of children were done to generate the following health and nutritional indicators: Underweight (weight-for-age), Wasting (weight-for-height), and Stunting (height-for-age). Health status of the children covered incidence of the major diseases that account for child mortality in the country – malaria, diarrhoea and upper respiratory infections.
Ewe Migration to Accra

The Ewe from the Volta Region of Ghana has a long history of migration into the city dating back to the colonial period (Nukunya 1969). The Ewe community in Accra is one of the largest migrant groups in the city of Accra according to the 2000 Population and Housing Census. The total number of the Ewe residing in the Accra Metropolitan area at the census was 222,766 which is 14.8% of the total population of the metropolitan area (Ghana Statistical Service 2002).

A number of push and pull factors at their origin and destination respectively account for Ewe migration to Accra. The main push factors include a comparatively high rate of schooling but limited economic opportunities in the region. Close proximity to the city of Accra, perceived employment opportunities, greater availability of social amenities and infrastructure have been the major pull factors that have attracted the Ewe to Accra (Ghana Statistical Service 1995).

The Ewe migrants come from a cultural background of strong kin ties and interdependence. Such social factors account for their formation of home-town associations in the city of Accra. New migrants settle in the city with the assistance of older migrants (Field Work Interviews June 2004). As a result, segregated Ewe communities are found in some parts of the city. They are also widely distributed in different parts of the city. The Ewe migrants are found working in both the formal and the informal sector. The Ewe community in the city of Accra therefore lends itself to the kind of spatial analysis that can capture the variations in care practices and determinants and associated effects on the nutritional and health status of children.

Ewe Traditional Child Care Practices

In traditional Ewe society, care for children is the duty of the kin or lineage group though the mother is the primary care giver to the child. Members of the mother’s kin mainly have the responsibility to offer help of all kinds to the mother, right from the period of pregnancy. A number of anthropological studies (Asamoah 1996, Nukunya 1992) and interviews in the field show that some traditional practices surround child care among the Ewe, right from pregnancy and through early years.

Kin Support

Kinship was a vital component of traditional life and was maintained by enforcement of customary sanctions and beliefs (Nukunya 1992, 1969). The residential pattern of the lineage in traditional Ewe society contributes to the shared rights and responsibilities regarding care for children. The lineage is largely a residential unit (Nukunya 1969:28). Land is a unifying force among the Ewe, and was the main property owned and used by lineage members, making them corporate units. In a few cases, some lineage members may not live in the area which bears the name of the lineage due to economic and demographic factors, for example, where the land is too small to support all lineage members. The houses of the lineage members occupy a continuous stretch of land in the section of the ward which bears its name. Such residential patterns provide kin support for the mother that enables mothers to rely on their kin for child care. Mothers usually bear their first born in their natal home where their mothers and matrikin assist in the delivery and care for the child.

Pregnancy and Delivery

Pregnancy is upheld highly among the Ewe. They believe that children are a blessing of Mawu, the Almighty God or ancestors. Barenness is considered a curse and blamed on the woman. It is considered to be a consequence of unacceptable behaviour and a punishment by one’s ancestors. A woman who has never had a child is given a demeaning burial. The Ewe woman will offer anything that she can, including prayers, to be able to conceive. Pregnancy is usually not announced to the public though a woman must tell her spouse as soon as she misses her menses.
This is regarded as very important because the genitor of a child must be known and established. Should a woman refuse to reveal to her parents or family the person responsible for her pregnancy she will be threatened during her labour to do so. If she should have a difficult labour, she is then encouraged to tell the birth attendant and those around her so that she does not lose her life since death, it is believed, may result by her refusal to mention the name of her sexual partner.

Children whose biological fathers are not known are looked down upon and regarded as a shame to their family. It is easier and less problematic if they are females because they will marry and also do not “need” to inherit property or social titles to be able to be part of a family. Boys must have a family name other than her mother’s and inherit their father’s property. Ewe society is patriarchal. A husband is not expected to accept any child and be its pater even when the mother is legally married to him and is living with him. He does so only out of benevolence. Parents therefore desire that their daughters do not engage in premarital sex or have children outside marriage.

The kin support for the mother requires that experienced females of the kin group watch the expectant mother closely. They provide all the necessary ante-natal and post-natal services to her free of charge. When she is in labour, they offer prayers to the gods on her behalf (Nukunya 1969:145). The experience of labour is considered as a war. If a woman does not survive it, she is buried as one who dies in war. With the advent of Western medicine, women who undergo a Caesarian Section are also considered as having been unable to “fight the battle of delivery” well. Even the child may be considered as a wicked one (Field Work May 2003). Care is therefore taken by the pregnant woman and the kin to ensure that the mother has a safe delivery. Among some Ewe the role of grand-mother requires that they stop childbearing as their children begin to bear children, so that they can devote their time and energies to taking care of their grand-children. Should a mother be lost through child birth, the grand-mother may be the most likely person to nurse the child, putting the child at her breast until she can lactate. Stigma is therefore attached to the child or children who are born by a woman whose older children have started bearing children.

Unlike other societies such as the Tallensi, co-wives are not expected to offer help to each other in childbearing. The family of the father of the baby may also not be relied on for some types of assistance, for example, washing of the mother’s clothes and preparation of meals. Water, firewood and some items are usually expected and received from them. Lack of trust among co-wives and in-laws is the main reason offered by people who spoke about this and by anthropological sources such as Nukunya (1969:161-162).

Food Taboos Observed During Pregnancy and Early Childhood

Food taboos are observed for many reasons- the mother’s health, that of the child and care not to eat anything that is forbidden by the clan of the child’s father especially. Foods forbidden by clans for their members are often some type of meat (of their totem) and vegetables (Fieldwork Interviews August 2004). The Ewe are a patrilineal society so mothers observe taboos of the clan of the father of the child during pregnancy.

Some foods are forbidden for other reasons. Okro and ripe plantain are forbidden during pregnancy since they are “slippery” and may cause miscarriage. They are also believed to cause the unborn baby to move upwards instead of downwards during labour and to lead to difficult labour and even death. Okro, again, and snails can make a child salivate too much, therefore pregnant women must avoid them. Crabs are also avoided as they are believed to make children walk in a clumsy manner when their mothers eat some during pregnancy. Pregnant women are, however, encouraged to eat certain foods and substances so that they can have healthy babies.

During early childhood, children are not expected to be given eggs or too much fish or meat since they might become thieves. It is also believed that an infant becomes very weak when it is still breastfed when the mother is pregnant. Mothers are also encouraged to avoid feeding young
children with foods that contain too much carbohydrate so that they do not become weak. An infant that is fed on *fufu* (a local meal made from cassava) is believed to become unable to walk early enough, just as one whose mother becomes pregnant too soon. A child must be walking before the mother conceives.

**Breastfeeding and other Postpartum Practices**

A mother is confined for eight days after delivery and fed on the choicest meat, fish and meals so that she can recuperate quickly. On the eighth day the child is brought out for the first time at a naming ceremony. Ewe children are breastfed up to at least two years or when the child is walking. Taboos about breastfeeding forbid sex for lactating mothers as it affects the quality of the mother’s breast milk and the child’s health consequently (Nukunya 1969:145-146). Mothers may stay with their parents until they stop breastfeeding or the child begins to walk. The first steps of the child signals the mother’s readiness to resume sexual activity. Husbands in polygynous unions are expected to make sure that all their wives are not breastfeeding at the same time. A woman who does not have her births spaced at least two or three years is stigmatized and called “Kpendevino”.

Twins are considered as supernatural beings that can be easily taken back by the supernatural beings. They are therefore integrated with some rituals which are performed by mothers who also have had twins and gone through the rituals. Children of mothers who have lost two or more children also have some rituals performed for them so that they are not easily taken back from where they came from like their siblings. According to Nukunya’s (1969:145) study among the Anlo Ewe such children are given absurd names such as *Ekpe* (stone) *Elo* (crocodile) and *Modzaka* (pastime), names that do not befit human beings so that death will spare them. Some respondents in the field also said that a name such as “Dangbe” (refuse), *Donkor* (slave) are given to some so that they will not be attractive to the powerful beings that take them away. Their hair is not combed at all until they attain some age and some sacrifices are made on their behalf for their integration into society. Twins and such children are treated with a lot of care so that no evil befalls the parents. Abnormal children are also given special care.

**Socialization**

The new-born baby is named by the father in a short simple ceremony. The father also presents some specified gifts to the child and the baby at the ceremony. Throughout the ceremony, the baby is carried by a paternal aunt, that is, a sister or female cousin of its father. Socialization, that is, training of the child and its continuous personality development, starts in the parental home. Peer groups in the immediate clan environment and the wider community are other agents of socialization. Every mature person in the community, whether a relative or not, can correct a child who misbehaves in one way or another. An undisciplined child is referred to as *dzimakpla*. It is a shame for the extended family to have such a child, particularly the biological parents. Every adult in a kin group therefore assume the role of a parent and may not be restrained in doing so. Parents may even exchange their children for fostering if they think their children will be better disciplined when they are away from them.

Women are not usually expected to discipline boys since they must be trained by men to “become” men. A boy that is brought up by a woman may be stigmatized. In cases of widowhood or divorce the mother of boys is expected to give the boys to a couple to be brought up by them or to any other extended family members of the husband’s family or hers. Fostering, of both the institutionalized and crisis types, is therefore an important practice among the Ewe.

Six cases are now described which illustrate the kinds of crises occurring in child care in Accra at the present time. They show the potential impacts a number of factors ranging from household to wider socioeconomic and environmental conditions that affect the capability of parent(s) and/or care givers to cope with task of providing care for their children.
The Cases of Crisis

Case 1: Grace and Peace

Grace and Peace are identical twins and first born of Enyonam, a 27 year-old mother who lives in a suburb of Accra. The area is noted for its lack of basic facilities and heavy traffic.

At this first visit to their home, Enyonam gave me a warm welcome at the entrance of her home and enthusiastically took me into their room. It is a small single room in a long block occupied by several tenants. Enyonam’s room is divided with a curtain to separate the bed from the sitting area. When I entered, I saw three other women, two with babies and one other in her mid-twenties. Enyonam invited these co-tenants to participate in the interview. I found out during the interview with Enyonam that they all expected me to talk to them about how to care for their children. And that was exactly what happened. I decided to put away the normal method of interviewing my respondents and combined the interview with some teaching on child care.

At the first visit Grace and Peace, refused to give me any smiles despite the different attempts that I made. They looked quite weak and their eyes were dull. Taking their weight and other measurements was very difficult.

Grace and Peace were born with almost the same birth weight – 2.5 kilograms and 2.7 kilograms. I first visited them when they were seven months. Their weights were about the same at seven months too – 6.7 and 6.8 kilograms. They were underweight and looked quite pale. Enyonam told me that they had just recovered from diarrhea and that they have been suffering from it quite frequently.

The reasons for their problem with diarrhea became clear during the interview and subsequent visits. Their mother put them on a baby formula just two weeks after delivery because she could not lactate well. She expressed some frustration, took out her breast from her blouse, showed it to me and said: “Notsie mele vava o” (the breast milk is not coming). She added that she could not follow the instructions on the label of the baby formula but diluted the milk for them because of financial constraints. Enyonam said she introduced Grace and Peace to koko, a local porridge made from corn dough, during their second month for the same reason.

Enyonam explained her financial problems during the interview. She is a seamstress but could not resume work because she could not combine work with caring for the children. The husband’s salary, which she said is very low (though she does not know it), cannot suffice for the children’s needs, particularly baby formula. The husband, a sales assistant, drives a taxi-cab after work and over the weekends but they still face a lot of financial problems, she said.

Grace and Peace are bottle-fed. They do not have a kitchen or tap water in the house. She buys water at a very high cost from nearby and does her cooking in front of her room using charcoal. Sterilization of the bottles is difficult under these circumstances. Meanwhile, there is no toilet facility in the house so all the tenants use the nearby bush as a toilet facility. It was for these same problems of lack of social amenities that she could also not arrive at the antenatal clinic early enough to benefit from the lessons.

Enyonam lives in a suburb of Accra that has fame for its traffic jam. One has to get out of here to anywhere latest by 6.30am to avoid the morning rush hours. For Enyonam, who has no toilet facility in the house and therefore walks quite a distance to the bush, and also for safe-drinking water, moving out as early as 6.30 in the morning must be a great task. She also needs to join the long trotro queue with workers.
So Enyonam, at the age of 27 years, had her first born (twins) with very little knowledge about child care. That was why she and her co-tenants took the advantage of my coming and interaction with them to ask me many questions on child care.

She said she needed help to care for her twin babies but her mother could not stay with them beyond two months because her husband said he could not share the single room with his mother-in-law. So two months after delivery he asked her to go back to the village where she lives. Enyonam said a neighbour helps her from time to time but it was not adequate. She told me that this lack of support became critical for her when the children had another episode of diarrhoea during their tenth month. It was so severe that it required admission to the hospital. The husband asked his sister to come from the village and help them.

It was after they were discharged that I went on one of my regular visits to them. Grace and Peace had lost a kilogram each and were so weak and anaemic that I feared Enyonam was going to lose both of them. Enyonam, indeed, looked very worried that day unlike the other time when she greeted me with smiles and excitement. I went through some lessons in child nutrition with her again and suggested a menu for the children. I also told her to treat the anemia by giving them some vegetables, semolina and other foods that are rich in iron. Within a month when I visited them again Grace and Peace had gained a kilogram each. They did not look weak any more. Peace willingly allowed me, not only to carry her but also to play with her. The smile they gave me seemed to say “we have overcome”. To me, the interaction with them and the smiles were expression of gratitude but Enyonam and her cotenants had also decided to show theirs at an opportune time. When I went for the next visit, the women too came together to offer their gifts. After much struggle with them to keep it for the children, I remembered an Ewe word of wisdom which says that one should not refuse a gift. As I walked away, many things flashed through my mind and the one that registered most was the need for Ghana Health Service to strengthen community health services and home visiting.

Case 2: Modernization, Money, and Time

Kekeli gave me a very warm welcome when I was introduced to her the first time by a lady in her neighbourhood. She said she was too busy to grant me the interview that day but assured me that she would be a bit free for it over the weekend. She was indeed very busy as she was frying plantain, selling some with the beans and also keeping an eye on her daughter who was crawling, all at the same time. However, her smile and enthusiasm suggested to me that it might be worth coming back on the appointed day. I was also keen to interview her for another reason: she seemed to be the youngest mother that I had come across. She looked like a fifteen or sixteen-year old girl. I later found out that she had her baby when she was a little over eighteen years old and is now twenty years old.

Kekeli unfolded to me the routine that she and her daughter, Dzifa, go through daily since Dzifa turned four months. Their day begins at 4 am. She leaves home with Dzifa to start boiling the beans which should be ready by the time school children, who are her main customers, come to buy some for breakfast. She explained that her husband also leaves home for work early, latest 7.00 am, to avoid traffic so Dzifa cannot be left in his care for a few more hours of sleep in the mornings. The family is together again at about 6.30pm after her husband has gone through the evening traffic which he cannot avoid as he does the morning one.

Kekeli and the husband have not considered having a house help who can take care of Dzifa because like many other low income families that I have interviewed, they live in a small single room with no sitting room or kitchen where some house helps sleep. Probably, they cannot afford a hall and a chamber financially. Kekeli said she makes C300.00 monthly and the husband’s salary, which she could not disclose, is not any higher. It might be for financial reasons that Dzifa has to stay in the sun and sand in one of Accra’s dirtiest environments instead of being sent to a day care that was just nearby.
Kekeli told me that when Dzifa turns two in about six months she will send her to a day care so that she could go and learn hair-dressing. She however expressed a lot of anxiety about Dzifa because she had tried without any success to introduce her to solid food. At fourteen months, Dzifa is just on breast milk. She has a severe form of anorexia. She is underweight, stunted and wasting as the anthropometric measures that I took on her showed. Though her birth weight was 2.7 kilograms, which indicates that she was not an underweight baby at birth, she weighed only 7 kilograms at fifteen months.

“What opportunities does a day care hold for Dzifa and her mother Kekeli?” was the question that has kept on ringing in my ears since the day Kekeli revealed her intention to send her there. I keep on wishing that she does not send her to the type a parent in a nearby similar deprived community told me about even though I know that this is the type she can financially afford. This day care has one room for 150 children aged between one and five years. There were two teachers taking care of all the children. The children have only one-seater pan latrine and four chamber pots. The teachers dispose of the contents of the chamber pots into the pan latrine when they are full, after the chamber pots are used by several children. She said both of them wished that they could empty them regularly, at least after two or three children have used one so as to keep off the numerous houseflies that come from there to the classroom. They are however too busy keeping their eyes on the children so they are unable to do so. When I asked her why the proprietress could not improve upon the facility she said that the parents are unable to pay the fee – thirty thousand cedis per month (an equivalent of about three dollars at current exchange rates). She tries to improve upon the facility but has been handicapped by this problem. It is for the same reason that she underpays the teachers. They receive a monthly salary of only one hundred and fifty thousand cedis (about sixteen dollars). The children’s meals are neither adequate nor balanced. It was no wonder to me when part of the analysis of the data collected for the general study showed that upper respiratory, skin and other types of infections are more rampant among children who attend day care.

A recent policy by government to make early childhood education part of the Free Compulsory Universal Basic Education is therefore appropriate. It may save these children and Dzifa from the several preventable illnesses and malnutrition that are consequences of the type of care they are provided at day cares.

Case 3: Nanavi’s Family

Nanavi’s mother is a dancer and the father is an unemployed young man in his late-twenties. Her mother’s mother, a forty-five year old woman, was the only adult I met when I visited their home the first time and she told me that there were three children under five years in the house so I could come back and meet them and their parents for an interview.

When I came back I saw that she was breastfeeding Nanavi. The other two children (a boy and a girl) and several other members of the household were also in. Nanavi’s father was also around for a meal. There were a total of fourteen permanent members of the household living in the double-room house.

Nanavi is the youngest at seven months. The boy, Agbesi, is two-and-half years and the last born of her mother who is a sister to Nanavi’s mother’s mother. Agbesi’s father saw him for the last time when he was three days old. He left Agbesi’s mother and their three children, including Agbesi. He has never returned. Agbesi’s mother said he has heard that he has another wife and two children since he left their house when Agbesi was three days old. I asked her if she intends to report him to WAJU. She looked at me with indignation and (said) it is inappropriate for her to send her husband to the police. The third child in Nanavi’s family is Esi. She is four years old and a daughter of another sister of Nanavi’s mother’s mother. Esi’s mother travels frequently to another region of Ghana to buy goods to sell so her sisters take care of Esi in her absence. I never met her.
Nanavi’s mother’s mother told me that she took her from her mother when she was very young (she would not disclose when) and put her at her breast since her mother was not able to give her adequate care. She has since been with her. Her growth pattern has been impressive. She is not underweight or wasting like the other children, especially Agbesi, who though she had a birth weight of 3.1 kilograms, was severely underweight and stunted at two and half years.

Despite the financial and family problems that Nanavi’s family is facing presently traditional practices of care and traditional ways of living have contributed to the ways in which they are coping with their problems. The decision made by Nanavi’s mother’s mother to take her from her mother and breastfeed her and also give her better care has resulted in her being a positive deviant, a child of very poor household, uneducated care giver with limited access to food and health services but with high nutritional and health status in community where most children are malnourished. Esi’s three classificatory mothers and teenage cousins have also provide her care of all kinds which her mother, as a result of her trading activities, is not able to afford her. She, however like Agbesi, is also underweight and looks quite unhealthy.

For Agbesi and Esi and some other malnourished children studied, the safety-net contributes partially to their survival. The most critical ages during which many children experience malnutrition and other health problems, as the analysis of the data shows, range between nine months and four years. The peak years are one and two years. My examination of Agbesi and Esi’s weighing cards reveal that they also began to have problems of weight loss and lack of weight gain and other health problems from six months. Growth monitoring will be needed to correct the problems of such problems.

Case 4: Sweetie and a Mother’s Strategies

Sena, Sweetie’s mother, lost her first pregnancy through a spontaneous abortion. Sena explained, “The doctor said it was due to stress”. Sena however gave me the impression that she doubted if that was really the cause of her miscarriage. She confirmed my suspicion when she said she had worked all along with Sweetie’s pregnancy too and even went to work the day before her delivery. She added that Sweetie even weighed 3.1 kilogram at birth so she doubted why she lost the first pregnancy. There was an expression of joy in her face as she added, “the work takes me out of the house the whole day”.

Sena has a very demanding job with a private company. She resumed work when Sweetie turned three months. As before the delivery of Sweetie, she leaves home by 6.00 am and comes back at 6.30 pm. She said that she could leave an hour or more later and return at least an hour earlier, if not for traffic. She lives at one end of the city and works at another.

Sena was able to breastfeed Sweetie exclusively for four months. She had put her on a baby formula which a friend of hers found to be very good for her baby. Sena does not rely on her house help alone for the care of Sweetie while she is at work. She has two friends who check on the house help in her absence from time to time to see how she is taking care of the baby. She told me that she has also instructed her house help to devote her time to the baby when alone with her.

Sena said she breastfeeds Sweetie a lot after work and in the night but does not let her sleep with her so that she does not have interrupted sleep through breastfeeding her a number of times in the night. She added that she and her husband who is even busier than her, play with Sweetie a lot after work and during the weekends too to make up for the weekdays.

At five months Sweetie weighed 7.3 kilograms and was 65 centimeters long. Her growth pattern has been on an upward trend. Emotionally, she is very mature. But her mother thinks she is too quiet when she meets strangers. That was the only worry she has. The smiles she gave me and the manner in which she interacted with me during subsequent visits made me think that she is just
selective and will probably interact well with any stranger who spends some time with her. On the other hand, I sometimes consider, Sweetie may truly be developing some psychological problem that may result from the long hours of her mother absence and the denial of breastfeeding during the day.

Sweetie’s family has been able to cope with the demands of care because of the resources available to the family, particularly financial and the support of a friend. Her story however suggests that there are challenges arising from the need for mothers to work long hours away from home and to develop their career while bearing and raising children. The policies that have been adopted and implemented to promote women’s income-generating activities will have to be supported by development of policies that can protect rather than compromise children’s need for care.

**Case 5: Big Boy: Today’s Baby**

Big Boy is the second born of Favour who teaches in one of the renowned private schools in the city. She lives in one of the residential areas of Accra where the traffic jam is the norm almost throughout the day. She therefore leaves the house for work by 6.30 am to get to work on time.

Favour has a house help who is 20 years old. But Favour sends the house help and Big Boy to her husband’s mother who lives in Tema every day. She prefers this arrangement to leaving the baby in the care of the house help. The whole family sets out at 6.30. Big Boy and the house help are sent to his father’s mother after his mother and brother dropped at school. His father who is self-employed works mostly from home so he comes back to settle down after the morning drive. He begins the evening trip by picking Big Boy and the house help first and then his wife Favour and son. They are not able to avoid the evening traffic. The family reunites and gets back home by 7.30 pm. After supper, which is around 9 pm, the family begins to prepare for the following day.

At nine months, Big Boy was not yet introduced to solid food. Favour was therefore surprised and happy at the same time when Big boy’s anthropometric measures show that he is above average for weight and height. She told me, however, with dissatisfaction in her voice, “I’m now trying to think about introducing him to solid food. You know my boss is not helpful. That also makes things difficult for me. He will never let me get to work late at all. He does not have any regard for my situation at all. I’m thinking of even taking some leave so that I can be with my baby and care for him better than I’m doing.” In the course of the interview Favour mentioned to me her plans to start a graduate program soon.

When I called Favour to arrange for my next visit, her husband told me that she had traveled. Then I asked him when she will be back so that I could come over for a follow-up visit as Big Boy had just turned one. He replied, “She has gone for a graduate program in the US and will be away for a number of years”. Then I asked him, “Can I come and see you and Big Boy?”. He replied, “I wouldn’t want you to come and remind him of his mother. Right now he needs to settle down. I think you should not come now. In any case he is away at Tema from Monday till Friday and then comes home over the weekends. Just wait and come at a good time.

The increasing graduate unemployment and increasing need for highly skilled labour have driven many young mothers like Favour into graduate programs at the same time as they are bearing children. The study found that a significant proportion of the mothers interviewed who have tertiary education are in graduate programs and they have also reported that their studies take away time that they should have been spending with their family, especially their young children.

The effects of women’s work for their reproductive activities have been studied over the past three or so decades with findings that show that mother’s are over-burdened as they continue to take on more income-earning activities while breakdown of kin support for child care continues. A new area that needs the attention of researchers is women’s further education and child care.
Case 6: People on the Move

After several attempts to have Madam honour her promise to be interviewed, I felt that she has a story that might be worth listening to. I met her in one of the churches I visited to be introduced so that I could have good response in the neighbourhood. She was very enthusiastic about having me come to her home for the interview. Even though she does not have a telephone at home she gave me the number of a communication centre which is close to the place where she fries yam. When I met her the first time she even told me that she was going to contact some mothers who were not in her church for me in her neighbourhood, so that I could interview them too. Then later on all attempts to have her interviewed seemed to fail. On one occasion, she turned me away even when I explained to her that it was not easy to get through the traffic to come over. Finally, with a little persuasion she agreed and told me her story.

“I met one of the Liberian refugees in town some time ago. We became friends and one day I realized that I was pregnant. I told him about it. After some time, I could not see him again. I thought that I’ll see him again when he comes from the refugee camp to town. I never saw him again. I reported the case to the Department of Social Welfare. They asked me to bring C60,000 so that they will take a taxi to the refugee camp at Budumburam to trace my boyfriend. I did not have that money. Even the money needed to have my baby delivered at hospital was not there. I delivered at home. I nearly died. My mother delivered the baby. It was a difficult labour. The nurses told me that the baby was lying horizontally in my womb so I should come for checkup and deliver at the hospital but we could not afford that. In fact, I nearly died. Now, my mother says that God will provide for us so I should forget about the father of my baby.”

Madam also told me that her brothers have promised that they will send her back to school when the baby is one or two years old and her mother’s mother can take care of him. Madam is now 20 years and thinks that she needs to learn some trade and take care of the baby herself.

The story of Madam reflects the processes of socio-cultural change and even globalization and their impacts on the family and consequences such as teenage pregnancy and single-parenting. For teenagers such as Madam, the role of the family in providing support for both the mother and the child cannot be over-emphasized. But there are some who end up in the street.

Conclusion

The cases of crisis examined in the present study provide evidence that a complex of factors determine care practices among the migrants. The cases corroborate findings of earlier studies which show that many factors at the household level, particularly family income, mother’s educational status and work, affect child care and have consequences for child survival.

Beyond these determinants of care, however, are emerging conditions, such as traffic and type of housing and day care facilities available for families, that enhance or negatively affect the ability of households to meet the requisite care needs of their children.

The capacity of households to cope with the needs of children is critical and must not be considered secondary to constitutional provisions such as Ghana’s Children’s Act, 1998 and the United Nations Convention on the Child, which spells out the rights of the child. Even where the family has the resources to provide care for the child, mere traffic jams may take time away from the mother and father at critical times of the day – early morning, when she rushes to work and evening, when it takes her so long to come back from work. Inadequate housing denies some families the possibility of bringing in another hand to help care for the child. What then is the value of rights to children under such circumstances? The cases of crises show that provision of health services and adoption of policies alone cannot ensure children’s wellbeing.
There is an urgent need to strengthen the family so that it can provide care for young children. Children do not have a voice but statistics, stories in the media on child neglect and the ever increasing number of children in the streets are visible evidence that society needs to take research findings seriously and address problems of care for children. The kind of economic policies that have been pursued by governments have probably been assuming that care will be provided by families or individuals. Folbre (2004:13), recognizing the failure of the family to do so as well as the need for economists to contribute to finding solutions to the problems, noted that:

… we need to recognize that institutional alternatives to markets - primarily the family and the state - are also susceptible to failure. Individuals cannot solve the care problem on their own simply by making “rational choices”. … We also need to develop a more unified political strategy.

In Ghana, the failure of the family and the state to provide for children’s care needs has been demonstrated in the present study as in several others. Attempts to address the problem need not be the responsibility of one party alone. When parents, non-governmental organizations and civil society in general and researchers all come together, solutions to some of the problems may be found more easily.

The present study, based on its findings, must note that some of the survey approaches used to study the conditions of care provision and associated factors are not capable of leading us to an appropriate understanding of the issues involved. Indeed our tools such as the concept of the household have to be re-examined, even as evidence of care provision from kin beyond what we define as household is observed to be a coping strategy that has ensured better care for some children. The availability of care has also been ensured through social networking with kin who provide care for others. Again, our perspectives that have laid emphasis exclusively on the mothers’ health, nutritional and other status, will also have to be revised, to recognize the role of grandmothers, - particularly the mother’s mother in the survival of children, as evident in some of the cases presented in this paper and other works such as Oppong’s (2004).

The limitations of the research approaches are a worldwide problem. Waerness (2004:1), in an introductory chapter in a publication resulting from dialogue among scholars representing different countries, disciplines and theoretical contexts, has discussed the need for approaches of research on care that can result in policy-relevant findings and has aptly pointed out that:

The problem of how to carry out research that would really matter in policies and practices of care was and still is, is a challenging one, even in the Nordic context. … Globalization and changes in the cultures of care today represent challenging problems all over the world. How to carry out research that could matter in policies and practices is therefore a general problem and many of the issues around the relationship between practice and applicable research might be similar in very different political contexts all over the world.

Recognizing that the problem of a suitable research approach is worldwide may generate collaboration among researchers as well as policy-makers. When local-specific conditions are taken into consideration in addition to such collaboration a range of policy options may be adopted to tackle the challenges of care in the country.

Again the factors responsible for the failure of some households to meet the challenges of care in the urban setting, for example heavy traffic, substandard housing facilities and attitudes to institutions such as WAJU, also point to new areas of research to determine the effect of these factors which I label as, “invisible” factors.

The case of the Liberian refugee father also points out the call of other works for the examination of such factors as conflict and erosion of family morality, which must be situated...
within the context of the processes of globalization on the cultures of survival and care, not only in Africa but globally (Waerness 2004; Folbre 2004; Oppong 2001).

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