The 'American Baby' Syndrome and the Migration of Ghanaian Women

Peace Mamle Tetteh
University of Ghana

The migration of people from developing countries like Ghana to America, Europe and even to other African countries, where the pasture is perceived to be greener is relatively common. Recently however, there appears to be a shift in the goals of these movement patterns: pregnant Ghanaian women are now migrating to the Western Worlds, particularly the United States to have babies, who become "American babies" by virtue of their being born in the States. This study is an attempt to gain sociological insight into this relatively new phenomenon: to identify the causes and the implications of this phenomenon for society.

INTRODUCTION

This study was borne out of an observation in recent times of several Ghanaian pregnant women travelling to the United States to have their babies. In fact, in recent times particularly among urban dwellers, people would rather ask 'where are you going to have the child' (Ghana or America) instead of the typical age old 'when are you due?' Thus, it is very common these days to ask of a pregnant friend, relation, colleague etc, and be told she has travelled to the United States of America ,usually a few months before they are due to be delivered of their babies. At least I know many women within this category with at least an American born baby. But what intrigues me most is the fact that ordinarily many of these women may never have travelled outside Ghana, but do so only when they are pregnant and about to deliver.

Several questions then come to mind namely: Why has this practice become common? Why would some pregnant women travel at a critical time of their pregnancy, bracing all the risks and stress to have their children in another country? And why do they travel only to the United States of America? Another observation is that many of these women (parents) belong to the middle or upper levels of the socio-demographic strata-usually the highly educated and in relatively high occupations. Could this be the case that these are the cohort officials at the U.S Embassy easily grant visas because their socio-economic status is a guarantee that they would return home? My research interests also related to the financial implications of such trips (in the face of the several complaints of economic hardship and low income levels in the country.

The Problem

While this study takes cognizance of the fact that there are many types of migrations and reasons for migration, it mainly concentrates on women who migrate to the United States to deliver their babies. While it is known that Europe is a common destination for Ghanaian migrants, one wonders why when it comes to childbirth, the U.S is rather the preferred choice.

The health care delivery system in Ghana has seen relative improvements in recent years. For instance, available evidence points to some improvements both in maternal and child health. Maternal care has seen some increases in both ante and post natal care. There has been an improvement in the utilization of antenatal services in the last fifteen years from 82 percent of mothers receiving care for their most recent births in the three year period preceding the survey in 1988, to 92 percent in 2003 (GDHS,2003). Nationally, 46 percent of births are delivered in heath facilities. Postnatal care had also seen some improvements with at least one in four women (twenty-five percent) who had institutional live births receiving postnatal care within 1-2 days of delivery, ten percent in 3-6 days after delivery and one in eight in 7-41 days after delivery.

Despite these seeming improvements, the fact that, more than half (53%) of women deliver at home without any professional medical supervision is quite worrying, as is the fact that about only thirty-five percent (35%) of mothers receive postnatal care in the first week of delivery. A more vivid picture of the health system in Ghana is obtained when one compares the maternal mortality rates in the United States and other developed countries to that of the Third World. For instance, in the developed world (America), the maternal mortality ratio is one in every 1800 births whereas it is 451 per hundred thousand (100,000) births in (Ghana) (Ghana Health Service). Furthermore, though some marked improvements were made in childhood mortality in some previous years (1988-1998), relatively recent data show some decline in child health which may be the reason why mothers choose to have their babies outside to ensure their safety. For instance, there was a decline in both infant and under-five mortality over the last five years before the 2003 survey. There was an increase in the neo-natal mortality rate from 30 per 1000 live births for the 0-4 years preceding the 1998 GDHS to 43 per 1000 live births during the same period prior to the 2003 GDHS. Neonatal deaths account for as much as two-thirds of the deaths in infancy (GDHS, 2003). Thus, indicators for both maternal and child health and mortality substantiate the fact that the health care delivery system in Ghana is really grappling with several challenges. This study sought to achieve three objectives namely: obtain a profile of Ghanaian parents with American babies; identify the motivations (immediate/long term) for having an American baby and examine the implications (immediate/long term) of having an American baby.

An Overview of Migration Patterns in Ghana

Migration of people from one country to another is an ageless practice. In fact, people in Africa and thus, the sub-region have exhibited a high tendency to migrate (Adepoju, 2005). Migration within and without is almost a way of life for the Ghanaian. Hence, the sub-region has seen various kinds of movements, distributions and re-distributions of its population within and without. The patterns of migration have gotten diverse and complex in contemporary times. The contemporary trend has portrayed an increase in the number of women who migrate. Zlotnik (1998) reports a 63% increase in the number of female migrants across the world from 35m to 57m between 1965 and 1990-an increase of 8% higher than that of male migrants. In 1998, 53% of newly admitted immigrants to the United States were women. In contemporary times, women migrate in their own right and not as followers or dependents of their husbands. The two main destinations of international migration for Ghanaians have been Europe and America. Historical and political ties with these countries are said to influence the migration flows to these countries. Besides, the recent changes in the economic fortunes of countries in the sub-region have reduced the significance of intra- regional migration streams in favour of American/ European destinations.

Explaining Underlying Motivations of Migration

Available literature suggests that the motivations for these inter/ intra country movements have basically included economic, political, demographic (overpopulation), environmental disasters or even conflicts and warfare, desire to study abroad, etc. However, just as migration patterns are complex, the motivations for these movements have also become generally more varied and complex. Migration in contemporary times is more voluntary than forced and to a relatively large extent, economically influenced. A report on reasons migrants gave for travelling to America and Europe included travelling

for commercial/mining activities, missionary activities, government officials/diplomats, travelling as spouse and child dependents as well as other dependents, students, holiday, tourism and transit etc. (Twum Baah, 2005). It is important to note that of all the stated purposes for departure, there is no mention of a desire to deliver babies. It is probably preposterous to expect anybody with that motive to even state it. One can thus, assume that many of those who go for the purpose of having their children in the United States state other reasons such as going on holidays or a vacation. We are however, familiar with the practice whereby a few months to delivery, women go 'on holidays' to have their children. There are a relatively large number of Ghanaian parents with at least an "American Baby or even Babies". Some of these women are Ghanaian immigrants (with U.S Passports /themselves American) so it seems quite normal for them to travel to the States to have their child. However, there are many other women who are Ghanaian nationals, who probably may have never travelled anywhere in their lives, but do only when they become pregnant and particularly, when they are almost due. Besides, even though it has been indicated that Europe and America are the two main travel destinations of Ghanaians, it is interesting to note that with regards to travelling for the purpose of having one's child, women travel to the United States.

Theoretical Framework

A number of contemporary migration theories adequately explain female international migration in Ghana. These theories include the structural theory (Sassen, 1988) which views migration as a form of exploitation of the peripheral nations by the "core" nations in the international system.

Another is the Neo-Classical economic theory which postulates that economic factors such as wage differentials, labour demand and supply etc, are responsible for migration. However, female international migration in Ghana is as a result of many socio-cultural factors and as such a model that dwellson GDP and other economic indicators may not adequately explain the patterns of Ghanaian female migration. Obviously, a woman who travels to America to deliver migrates not because she is being propelled by poverty, unemployment or any economic necessity per se. Thus, this model explains some forms of migration but not the one under discussion.

The household strategy theory suggests that migration decisions are made collectively by all members of the household as a way of controlling risks to a households' economic wellbeing-by diversifying the allocation of household resources such as labour. This implies that poorer households will send out more people. But in reality poorer households may not even have the money that is required to undertake these trips.

There are other theories that better explain the research problem and these are the network theory and the need-drive theory of motivation. The Network theory attributes the migration process to personal, cultural and/or other social ties. In receiving countries, immigrant communities often help their fellow men and women to immigrate, find a job and help them to adjust to the new environment. These networks reduce the cost of migration for newcomers which acts to induce further migrant to leave their country. The network theory explains the Ghanaian situation because; the decision to travel to America to give birth to a large extent depends on the availability of friends or relations (networks) in America. Women who do not know anybody or have no networks in America would rarely consider going to America to deliver. In any case, how would one even get a visa if one has nobody in America to invite you in the first place? These networks (contacts) in America host the migrant pregnant women, help them locate a hospital; help them with their babies after delivery etc. Thus, women rely on their personal and social networks in their bid to go to America to deliver. Thus, networks (relations or friends abroad) make it possible for one woman to travel and impossible for another, despite the fact that these women might all dwell within one historical and socio-economic context.

The need drive theory of motivation (A. H. Maslow, 1954), also adequately puts this discussion into perspective. The research problem is first conceptualized within the framework of motivation. Motivation basically is the behaviour that is instigated by needs within the individual and is directed towards goals that can satisfy these needs (Morgan, 1956). Psychologists have classified these needs into physiological needs (e.g. food, sleep, sex, shelter clothing etc) and psychological needs (e.g. affection, achievement,

social esteem, personal security and safety etc). In the need drive theory of motivation, A. H. Maslow (1954) proposed a hierarchy of needs classifying the physiological needs as low level needs and the psychological needs as high level needs. The individual will strive to achieve higher level needs only when the lower level needs have been met. Thus, individuals who have been able to meet basic needs of food, clothing and shelter, would only then have the motivation to seek higher level needs such as personal safety, social esteem, quality health etc. Thus, a parent's (woman's) status has a direct impact on her health and health seeking behaviour. In other words, parents for whom basic subsistence is a challenge: a challenge to provide three meals a day, provide basic clothing for self and dependents and/or even access and afford basic health care, would most definitely have no motivation to want to have their child in America.

For this category of parents, survival *in the present* is what is of relevance and not securing a supposedly better future for their children by having them in America. However, for those parents for whom basic subsistence needs are granted, the motivation to seek higher level needs are most likely. This category of people who most likely have access to healthcare, now have the 'privilege' to think of the quality of healthcare they receive. Thus, whereas parents who do not have the means for basic subsistence would think it is outrageous to spend huge sums of money on air-ticket, hospital bills etc, to have an American baby, the reverse is the case for those who are relatively well-off. Thus, motivation for higher level needs is largely related to affordability. The motivation or decision to have an 'American baby' is largely dependent on one's ability to (satisfy basic subsistence needs) afford the costs that come with having one--- otherwise the thought may rarely be considered.

Defining 'American Baby'

This term as used in this study refers to children born in America (with a U.S passport) by Ghanaian parents, resident in Ghana. The reference is typically to those children whose parents travel solely to the States to have them and bring them back home to Ghana. It does not include those whose parents live in the States (Ghanaian immigrants).

Methodology

This study is an exploratory and descriptive one that sought to provide some insight relating to the health and reproductive decisions by some Ghanaian parents (women) in order to obtain a better appreciation of the nature and implications of the recent increases in the phenomenon of American babies. Information was obtained directly from parents with American babies. Respondents were purposively selected and sampled via the snowball sampling method. The study employed two main approaches for obtaining data namely, in-depth interviews, and questionnaires. The administration of the questionnaire was done on a stratified basis. The stratification was based on age. A deliberate effort was made to get respondents across a wider age range, so as to be able to compare the explanations that both older and younger parents have for having American babies. A sample size of sixty-seven was taken for this study. This was to consist of fifty -two questionnaires and fifteen interviews. The sample size was not too large because the study was largely qualitative. Besides, respondents were not generally dispersed within the population or easily accessible. Forty-one (78.8%) of questionnaires were retrieved whilst all fifteen interviews were done. One reason for relatively high questionnaire mortality was that people claimed they were not comfortable with the study. In fact some persons thought I have links with the American Embassy, and so answering my questions meant 'exposing themselves' to the possibility of being denied visas in future. Interviews were tape recorded and later transcribed for analysis.

Discussion of Findings

The data obtained with the questionnaires are analyzed and supported with information obtained from the interviews. The findings are presented with reference to the study's objectives namely obtaining a profile of parents with American babies, and identifying the motivations and implications of having an American baby.

Profile of Respondents

Education

As anticipated, many of the respondents belong to the middle to upper levels of the socio-economic ladder. Most of the respondents are highly educated as are their spouses. About (78.5%) of mothers have at least first degrees with as many as (21.4%) with higher degrees. Many mothers also have professional certificates as their spouses.

Occupations

Being highly educated then, most respondents are professionals: there are doctors (33.9%), public servants (12.5%), lawyers (12.5%), lecturers (7.1%), Accountants (5.3%), teachers (8.9%) and caterers. However, a significant number were housewives (8.9%) The irony of this picture is that doctors who work in the Ghanaian health sector who should perhaps trust the system are rather in the majority of those who travel to have their babies in the States. Perhaps, it is because they know firsthand what pertains in Ghanaian hospitals and would not risk having their babies there. The spouses of these mothers are also in equally high professions as doctors (22.7%), consultants (18.1%), businessmen (34%), lawyers (15.9%) and contractors (9%).

Income Levels

It is quite a challenge to have people accurately state their incomes. People have the tendency to overstate their incomes probably as a way of looking good. Hence, it may be necessary to take these income levels given by respondents, with some pinch of salt. Respondents reported relatively high incomes for themselves as well as their spouse; incomes that can support a trip to the U.S to have a baby. Most (50%) respondents earn between six hundred and a thousand cedis ($600-$1000) a month. About 41% also earn more than a thousand cedis ($1000) but less than two thousand Ghana cedis ($2000) a month. Only 5.3% and 3.5% earned less than five hundred cedis ($500) and more than two thousand cedis ($2000) a month respectively. Housewives explained that their incomes were allowances from their spouses. These were in the range of $200-$500 a month. Respondents reported that their spouses earned higher incomes. As many as 62.5% of spouses earned more than two thousand cedis ($2000) a month, with about 16% earning between six hundred ($600) and a thousand cedis ($1000) a month. No spouse reportedly earned less than five hundred cedis ($500) a month.

Nationality/Ethnicity

It is quite reasonable to expect that parents who are American citizens will want to have their babies in the States. Hence the need to investigate whether parents with American babies were American. Interestingly, only two respondents were Ghanaian-American. The overwhelming majority (96.4%) are fully Ghanaian as were their spouses. Many (23.2%) of these women had never travelled outside Ghana until they went to America to deliver. Additionally, as part of the effort to document respondent's profile, their ethnic backgrounds were investigated. The data indicated that Akans were in the majority (55.3%) followed by Ewes (19.6%), Gas (16%) and Hausas (8.9%). Though this data portrays Akans to be most involved in this phenomenon, it may not necessarily be the reality. In fact this outcome may possibly be as a result of the sampling method used which made respondents identify friends and relations who most likely were of the same ethnic group as them.

Respondent's Age

In relation to age, a deliberate effort was made to pick women across various age categories from 23-47 years. The data suggests that (53.5%) of respondents were between the ages of 35-39 years, (23.2%) from age 30-34 years, (14.2%) between ages 25-29 years and (8.9%) between ages 40-45 years. It is important to note that the majority (76.7%) of respondents were aged between 30-45 years; the ages when pregnancy is considered high risk for both mother and child. This, most of these mothers explained, was

the reason why they needed a health care delivery system that provides qualitatively better service than what pertains in Ghana to ensure their own safety and that of their babies.

Respondent's Marital Status

Ones marital status to a relatively large extent determined whether a woman would have her baby in America or not. At least being married made available the income of a spouse in addition to a mothers' to meet the expenses of having an American baby. For instance, one respondent said she went to America to have her baby at the insistence of her husband. She says;

> 'Left to me alone, I would have delivered in Ghana. But my husband insisted I go to America. I guess he just wanted to give me a treat.'

The data indicate that the majority of respondents (78.5) were married whilst (21.4%) were single, specifically as never married (8.9%) and divorced (12.5%). The divorced respondents, divorced before "American baby"

Number, Age and Nationality of Respondent's children

Respondents have between one and four children, aged between 4months and thirteen years. About (35.7%) respondents have a child, (44.61%) have two children, (14.3%) have three and (5.3%) have four children. All the respondents with one and or two children had them all in the States. Two of the parents with three children had only the last two in the U.S. They explained that their experience with having their first children in Ghana was unpleasant, hence the decision to travel to have their other children in the United States. Thus, of the total respondent's children (72), only two are not "American babies". There was one unborn baby-a potential "American baby" because the mother intends to have 'him' (she had checked by an ultra sound scan) in America. One respondent had all her four children in the U.S and gave a myriad of reasons to explain why. According to her;

> 'Once you have your first child there, you become 'obliged' to have all the others there. This is because you do not want any of your children growing up and feeling unloved or kind of 'cheated' because they were not born there. You do not want your children to spite you nor do you want to bring rivalry between siblings because of this. Secondly, after experiencing a high quality of care with the first child, one just cannot compromise on the health care of other babies.'

Respondent's Intentions to have more children and where they would have them

Respondents were asked if they intend to have more children and whether they would have them in America. Interestingly, about 53.5% categorically stated that they do not intend to have any more children even though they did not have more than two children. In fact two of these respondents actually had only a child each. About 26.7% were also certain they were going to have about one or two more children because they had only one at the time of the interview. The remaining respondents did not clearly indicate any intentions of having more children. Obviously, among this class of women, small family size is the norm.

One thing was certain though, all respondents but one were sure that if the opportunity ever presented itself for them to give birth again; they will surely do so in America. This covers those who are yet to have more children and those who said they are over and done with giving birth. In relation to the latter, this is to emphasize that they consider delivering in America one of the best decisions they ever made so that should they be faced with similar circumstances, they will still make the same decision.

Motivations for Migration

'Migration in Africa and in West Africa especially- and this includes Ghana-has always been a core feature of survival and advancement strategies' (emphasis mine). (H.E Arie van der Wiel, Ambassador of the Royal Netherlands Embassy in Ghana, *Quoted in "At Home in the World?" Manuh, 2005).*

The motivations for having an "American baby" are numerous and complex. These motivations can be categorized into manifest (intended) and latent (unintended). It is important to note that motivations vary depending on the individual such that what is manifest or latent depends on the individual. For instance,

whereas obtaining a U.S citizenship may be a manifest (real intent) reason for having an American baby for one individual, it may be a latent consequence for another individual, whose manifest or real intent was to obtain good medical care. This is very well captured in the explanation by one respondent:

> 'I had an American baby just by chance. I had just gone through a rough divorce. My friends and relations abroad invited me over as a way of helping get over the pain of divorce. I was pregnant then. Thus, my going to America, was purposely to get away from my divorce problems, but in the end, I had access to good health care and got my baby U.S citizenship**.'**

Another said:

> 'You know, I was a worship leader in my church. Thus when I became pregnant but was not married, I felt so ashamed especially when the man did not want to come forward to marry me. So I just travelled. Couldn't stand the disgrace especially in church, you know. Church people talk!'

The research evidence have identified the motivations of parents for having "American babies" to include mainly the desire to obtain good medical care for self and baby (62.5%), obtain an American citizenship for babies (26.7%), prestige (3.5%), travelling as an escape from a bitter divorce (1.7%) and the disgrace of being pregnant without being married (1.7%). For some, it was just an opportunity to take a vacation (1.7%) and visit relations and part of preparations needed to migrate in the future to the United States (1.7%). Many respondents explained that having a baby in the U.S was the best thing to do especially if the pregnancy is a high risk one. As one respondent explained;

> 'I had my baby in the States at my husband's insistence. His first wife died during childbirth. He thus vowed that if he remarried, his wife shall not deliver in Ghana, but in America. Besides I was 35years and it was my first time.'

Another woman said,

> 'As for the U.S. it is rare for a woman to die at childbirth or lose her baby. In fact, if you die or lose your child, then 'wo fie ye den' (literally translated as there is evil in your house).'

She describes the medical care received as;

> 'Super'. You are treated as a person with rights and your consent is sought about everything relating to you and your baby's health. In fact, among the first documents you receive in any U.S hospital is the patient's bill of rights. This is lacking in Ghana, my sister, she intimates.'

She goes on to describe the care in the hospital saying

> **'**There, I had a fully air-conditioned room to myself, with my own toilet and bath. What I loved most was the bell by my bedside that enabled me call a nurse for my needs. These nurses respond promptly to your call and your needs, seeking to please and treat you like a guest in a hotel. Here (in Ghana), you will only be lucky to get a bed to lie on in a hospital during and after labour. Nurses may not even look in your direction when you call for help'

For yet another respondent;

> 'The materials (literature) I received from the hospital helped me to manage childbirth as well as care for myself and my baby as a first timer. The routine of running a myriad of tests on both mother and child is great because it helped me know a health condition which my baby has now and which I am effectively managing. If I had had my child in Ghana, this might not have been detected until perhaps when my baby falls seriously ill.'

Another also explains;

> 'Besides the care I received in the hospital, upon discharge, community home care nurses checked on me regularly to make sure that I and my baby were doing well, that I lacked nothing

and was not in any way stressed out. They brought food, diapers, clothing and toys for my baby. Who will do this for you in Ghana?'

Obviously, for these women to whom medical care was the priority, getting U.S passports for their children "was just the icing on the cake. However, as is evident from the data, the "American Baby Syndrome" for still many others, is an 'advancement strategy"- to get U.S passport for their children to enable them enjoy all the opportunities and good life that America has to offer – without going through the hassles experienced by Ghanaians applying for visas to travel to the United States.

The Implications of Having an 'American baby'

An attempt is made here to examine the financial, medical, immigration and social dimensions or implications of having one's baby in the States.

Financial Implications

Financial implications are discussed in relation to expenditure and sources of funding. The data suggests that it is very expensive to have an "American baby" as indicated by (87.5) of respondents. At least a mother must have or must anticipate being able to raise between ten and fifteen thousand dollars to be able to have an American baby. Even with respondents' relatively high income, this is still a whooping sum! Considering however that respondents had to recall these expenditures, one cannot be too certain of their accuracy. One can only take them with some pinch of salt! Respondents indicated that the monies spent to have an 'American baby' came from personal savings (64.2%), husband's support (25%), loans (7.1%) and from the hosts, usually relations in the States (3.6%). The percentage of respondents who used their savings and/or took loans to finance these trips is extremely significant (71.4%). One may presume that monies obtained through these means may be put to some major use such as obtaining property. If these women rather choose to spend their monies to go to deliver in America, then this points to the importance they attach to this. This point is succinctly explained by one respondent:

> 'Having my babies in America is an investment for them. A U.S citizenship secures my children's future somehow. They will have the opportunity to school and work there. I have kind of given them a passport to a successful life. If this is not an investment, what is?'

Medical Implications/ Benefits

Respondent's general assessment of going to have their babies in America was that they received the best of health care because of the following; ante-natal screening for mother, access to adequate and qualified health personnel, quality health service (patients' rights), education of expectant mothers (literature), and access to and quality of post-natal care (after birth screenings for baby and vaccinations).

Social Implications

Besides access to quality health care, social menopause is one of the consequences for women who choose to have their babies in the U.S Thus, some women who insist on giving birth in America have had to cease childbirth (after about two children) because their spouses cannot afford to support the birth of more 'American babies'. Some of these women are relatively young though and can have more babies- but for their desire to go to America to deliver. One respondent jokingly said;

> 'My husband is even avoiding sex with me because should I get pregnant, I'll say I am going to America to deliver- and he does not want to spend any more money on that. When I also want to 'dodge' (lovemaking) I teasingly ask him if he now has money for America.'

Another social implication of this phenomenon is that, one 'American baby' in a family has the potential to file for citizenship for at least his immediate family in future. To an extent then, one 'American' is all a family needs to become potential beneficiaries of the American dream. However, on the flip side, the relationship between some respondents and their hosts in the United States has broken down because some of the hosts borrowed money from some respondents and never paid back. Some

respondents also claim they were shabbily treated by friends and in some cases relations they went to live with in America when they went there to deliver.

Concluding Remarks

On the basis of the findings from this study, the following conclusions are drawn. First, though the motivations for having an American baby are numerous and complex the most common reason given for having an American baby is medical—maternal and child health. In this regard, respondents suggested measures necessary to improve maternal and child health in Ghana. These include the need to train and retain medical personnel, improve hospital infrastructural development (maternal and surgical units), provide adequate and sustained supply of logistics in health facilities, improve service delivery in health facilities, expand, resource and ensure efficiency of the National Health Insurance Health Scheme (NHIS).

Secondly, the 'American baby' syndrome was a deliberate move by parents to secure American citizenship for their children which they perceive as an investment to secure opportunities for these children to have access to education, work and live in America without much hassle in the future. This trend definitely has implications for brain drain, just as it does for brain-gain. The latter though might serve the interest of Ghana better because these 'American babies' might gain education, expertise, training and finances which could contribute to Ghana's socio-economic development.

The effort by Ghanaian parents to secure American citizenship for their children as a 'pseudo-insurance' for their future perhaps is indicative of the lack of trust in the educational system and economy of the nation. This calls for efficient political leadership to achieve and sustain accelerated economic growth and development. There is also the need to resource and build the capacity of our educational institutions at all levels to make them globally competitive.

To conclude, globalisation and the emerging middle class in Ghana may result in more people engaging in this practice. However, having an American baby should not be as a result of our failure and lack of commitment to adopt and implement health sector reforms that correct the deplorable conditions in our health care delivery system which affect particularly women and children. To make migration decisions for Africans (Ghanaian) less an issue of 'survival and advancement strategies' there is the need to work towards a sustainable socio-economic development.

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