Chapter 4

Perspectives on Young People's Daily Mobility, Transport and Service Access in Sub-Saharan Africa

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Introduction

Young people's mobility challenges in Western contexts have been the focus of research for some decades, principally – but not only – with reference to the school journey. By contrast, young people's mobility in sub-Saharan Africa is remarkably under-researched, despite the vital significance of mobility (and immobility) to so many children's lives.[1] This is an extremely important omission, given that over half the population of many African countries consists of children and young people. Improving mobility and access to health and education facilities for both girl and boy children has massive implications for their subsequent livelihood potential (Bartlett 2001). It is crucial to many of the Millennium Goals, notably universal primary education, promoting gender equality and women's empowerment, and reduced child mortality (Fay et al. 2005).

In this chapter we review some of the findings from a research study centred on young people's mobility conducted between 2006 and 2010 in three African countries, Ghana, Malawi and South Africa. This study was extensive in scale (24 sites across urban and rural locations and two different agro-ecological zones per country) and innovative in its inclusion of 70 young research collaborators aged from 11 to c.20 years (when they started work on the study), in addition to conventional academic research. Developing this two-stranded research approach and applying it across diverse countries and sites has enabled us to assemble a strong, comparative evidence base. Our aim was to establish an evidence base substantial enough not only to improve policy in our three focus countries but

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[1] Key literature to date relating to rural areas is very sparse, though there is notable work by Katz in rural Sudan (1991, 1993, 2004) and in urban Africa by Grieco et al. 1996, Gough 2008, Langevang and Gough 2009 and Benwell 2009. A review of literature up to 2007 is available in Porter 2010.

sufficiently compelling to contribute to a new recognition among policy makers and practitioners across Africa of the key significance of mobility and physical access to services in building young lives.

Access (i.e. ability and ease of reaching destinations, as in the transport usage of the term; Bryceson et al. 2003) may depend not only directly on transport (vehicles and roads) availability and cost allowing children to travel. It may also be affected by demands for children's work, including their transport role as porters (i.e. the requirement to help carry goods for family members etc. because of inadequate or costly transport facilities), on perceptual and cultural factors (for instance, attitudes to girls' mobility in Moslem families) and on the availability of peripatetic services. Young people's lives, as we will show, are substantially shaped by their access to services and associated mobility potential: improving access, whether through appropriate development of the transport system or other means, is crucial for raising the development potential of the continent.

Our findings emphasise the interconnectedness of mobility, transport and service access with cultural context, children's individual circumstances (age, gender, family socio-economic status and parental status) and livelihood trajectories. They suggest that solutions will be equally interconnected across transport, education, health and other sectors. There are important differences in children's spatial mobility related to urban or rural location, socio-cultural and economic context and physical environment. By in-depth studies in contrasting areas of three very different countries, we have been able to provide qualitative and quantitative evidence of the diversity of problems different African children face.

Following a review of our research approach in urban, peri-urban, rural and remote rural areas across the 24 study sites we consider some of the factors which emerged as significantly affecting young people's mobility and access, firstly with reference to education and secondly health. Vignettes of individual young people and their daily journeys in these two contexts support subsequent discussion of gendered mobility constraints, modes of surveillance, and inter-generational frictions and mobility resistances. The final section of the chapter considers some possible transport-related and non-transport interventions which could promote positive change.

Background to the Study

The research we conducted between 2006 and 2010 builds on a series of earlier studies in West Africa on gender, spatial mobility, transport and off-road access to services (Porter 2002, 2009; Porter and Blaufuss 2003). That work suggested that poor transport access (and high transport costs) to health facilities and schools, although a particularly major issue for remotely located communities, and with especially significant potential implications for young people, had been little explored. An action research on the livelihood impact of IMTs (intermediate

means of transport) in Ghana's off-road settlements focused on market women also highlighted children's roles in transporting produce as potentially a very substantial but largely unrecognised task, with possible impact on children's health and their educational opportunities (Porter, Blaufuss and Acheampong 2007 and 2011 in press).

This base of earlier research suggested some broad hypotheses which were tested first with reference to four villages in southern Ghana (Porter 2009) and then extended to the three-country study. These hypotheses are:

- lack of reliable low-cost transport may severely affect access to regular education, with subsequent impacts on livelihood opportunities (Universal Primary Education has substantially improved enrolment figures in Africa, but secondary education enrolment lags far behind, especially for girls);
- lack of reliable low-cost transport may impact severely on children's access to health services (including vaccination and other preventive health services) and to adequate safe water supplies (child mortality and morbidity rates remain high in many African countries);
- children's widespread (but often hidden) role as pedestrian headloaders may further substantially constrain their access to education, health and associated livelihood options since this reduces the time available to attend school or health centres etc. This is likely to apply particularly to girls, especially fostered girls;
- bicycles may have an important potential role in improving access to school and other services, but cultural and other factors are likely to impede their adoption, particularly among girls;
- mobility constraints may impede children's subsequent livelihood opportunities through impacts on both education and health and thus reduce overall long-term potential for poverty eradication. The constraints are likely to be even greater for girls than for boys;
- mobility constraints on children are likely to be higher in rural than urban and peri-urban areas, but even in an urban context there may be substantial constraints imposed by transport factors or fear of mobility due to violence, witchcraft, trafficking etc., particularly for girls;
- mobility needs and constraints are likely to vary not only according to age and gender of the child and socio-economic status of the child's family but also according to the broader local context (agro-ecological zone and associated economic production patterns, culture, density of school and clinic provision, access to radio and TV information services).

In addition to the more conventional academic research leading up to the current study, we conducted a pilot study on child mobility issues, testing a very different approach. This involved working with young people as researchers in India, Ghana and South Africa, guided by an Indian NGO with experience in this field (Lolichen 2002; Porter and Abane 2008). The pilot indicated the specific insights which child

researchers could bring to researching child mobility through the investigations they conducted with their peers: their clear view of children's perspectives, their ability to pick up issues that children were too embarrassed to draw to adult attention, or which children would think adults would not understand or would think unimportant. However, work in the pilot also led us to the conclusion that an extensive research programme, focused on production of a large comparative dataset for different regions, sufficient to convince policymakers, would need to incorporate substantial adult input, not least for logistical reasons. We consequently developed the two-strand methodology, described in the next section.

Methodology

Developing a two-strand methodology has been critical to obtaining the depth and breadth of understanding we required for this study. Thus, a more conventional adult academic research study draws from and is complemented by the young researcher strand.

For the young researcher[2] strand, 70 young people were recruited by country collaborators in Ghana, Malawi and South Africa early in the project. The recruitment was through local schools in the regions selected for the adult researcher studies (Cape Coast area and the Sunyani region in Ghana, Blantyre and Lilongwe districts in Malawi, Eastern Cape and Gauteng/NorthWest Province in South Africa). In each region, attempts were made to recruit around 12 children of diverse ages between 10 and 18 years from schools in a mix of settlement types: urban, peri-urban and rural. Where schools agreed, the collaborators usually visited to present the project to the pupils, who were asked to volunteer to participate, though in some cases the young participants were chosen by teachers, on the basis of essays their pupils had written on a relevant topic. Final numbers of young researchers varied according to the numbers individual country teams felt they could support and numbers of children coming forward to participate.

Those recruited were mostly secondary school pupils aged between 11 and 19 years when they started the project. In each country they attended a basic, one-week training workshop[3] in their home region where they were introduced to and tried out a variety of research methods. Each group selected the research tools they preferred at the workshop and decided on the time they could commit to the study. Methods selected included personal daily mobility diaries, photographic journals of the journey to school and journeys around home, interviews about mobility

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2   At the inception workshop, the young people involved said they were happy to be called child researchers, but when the project group reconvened in Ghana, two years later, the representatives of this group said they would now prefer to be referred to as 'young researchers'.

3   In Malawi where some of the young researchers also attended the inception workshop, the actual training workshops were for just three to four days.

including on accompanied walks, group interviews, ranking of travel modes and obstacles by school class groups, and counting and observations of children as load-carriers at key loading points. The young researchers subsequently conducted their own studies with their peers at sites convenient to them. The work they produced has not only fed into the themes and questions pursued by the adult researchers but also into their own booklet (Child Mobility Project Young Researchers' Group 2009) which describes their findings and methods.

The adult researcher strand has both qualitative and survey components. Intensive qualitative research (in-depth interviews, life histories, focus group discussions, ethnographic diaries, accompanied walks[4]) was conducted with children, their parents and key informants. The adult researcher qualitative work pursued questions and themes in part derived from the young researchers' findings. A questionnaire survey among child respondents aged 9–18 years (approximately 125 per site) which was designed subsequent to, and with reference to, the preliminary qualitative research by adult and young researchers was then conducted. The qualitative and quantitative adult researcher studies took place in eight specific sites in each country; two classified as urban, two as peri-urban, two as rural with services (usually a primary school, sometimes a clinic) and two classified as remote rural with no services (i.e. four sites per agro-ecological zone).

The project commenced with an inception workshop in Blantyre, Malawi in September/October 2006, enabling key country researchers to meet and review their research plans with each other, with the UK team and with Professor Michael Bourdillon who advised on the research component with children. The inception workshop also included young people who had been involved as researchers in the previous pilot project in South Africa and Ghana and could talk about their experiences, together with Malawian children who wished to participate in the new study. Teachers from Ghana, South Africa and Malawi were present to act as chaperones and to provide translation where necessary.

Young researcher studies and pilot studies for the adult researcher strand (involving country-based and UK researchers) were completed in each of the three countries in subsequent months. Subsequently, work moved to our focus areas for the main phase of the adult research strand, during which monitoring reviews with UK researcher input were conducted in each country. A review workshop was held in Ghana in October 2008. This was attended by 19 young researchers, including four from Malawi and three from South Africa, in addition to the adult academic researchers. During this meeting the young researchers developed a book concept and produced their first draft, with particular support from our NGO project collaborator, the International Forum for Rural Transport and Development, together with staff at the University of Cape Coast, Ghana.

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4   Mobile ethnographies, conducted through accompanied walks, have been a key tool in both adult and young researcher strands of the study and are discussed in detail elsewhere (Porter et al. 2010a).

Given the emphasis we place on sensitising policy makers to the transport, spatial mobility and accessibility needs of children, we needed to engage policy makers from the commencement of the study. We did this by establishing Country Consultative Groups (CCGs) in each of the three study countries: these consisted of around 20 people representing relevant ministries (including education, transport, health, women and children's affairs), local and international child-focused NGOs, transport unions, and other interested groups. They met at approximately six-monthly intervals through the project and provided advice in shaping the study, helped ongoing dissemination of our findings and encouraged commitment to implementation. Earlier experience using this approach had suggested that CCGs would be an important mechanism for helping to shape ongoing work. In the early stages of the project, working with the CCGs helped avoid duplication of effort (by alerting researchers to existing information and grey literature) and ensured the country project team was informed of relevant local policy and practice. It enabled informed round-table debate, analysis and interpretation of country project findings from diverse perspectives as they emerged, ensured ongoing dissemination of project information (aims, findings etc.) and helped to avoid the sort of misinformation and political manoeuvring which can be so damaging to project aims, operation and outcomes. CCGs also helped build contacts and extend networks for further project support.

The CCGs were particularly effective in Ghana and Malawi, perhaps in part because these are relatively small countries, each with a strongly networked professional middle class engaged in developmental activities. Here the young researchers in our project were able to make presentations and thus engage directly with policy makers: these engagements were very positive in terms of the seriousness with which young researcher presentations and findings were received and the very strong impact of the findings when presented by those directly affected. In Malawi, the local CCG support for the project led to funding from the former National Research Council[5] for an extension of the survey component of the study to Malawi's northern region. Our South African collaborators found it more difficult to engage national-level stakeholders, despite their location in a major national research institute, though they were able to put in place local stakeholder consultative groups in the two study regions.

Work with children and young people, especially where they are themselves involved actively in the research process requires particular attention to ethical issues (Save the Children 2000). Our aim from the outset of the study was to ensure that our young researchers were partners, not simply cheap labour, that they found their involvement a positive, empowering experience, and that we avoided tokenism. We benefited from our earlier pilot study and the very considerable experience of Michael Bourdillon in this work. In the context of promoting partnership, empowerment and avoidance of tokenism, we aimed from the outset to enable the young representatives of those children who chose to participate in

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5   Now known as the National Commission for Science and Technology.

the study to have the opportunity to present and discuss their findings and views with policy makers at the Country Consultative Group meetings and project dissemination events.

An ethical code was developed with the children present at the project inception workshop and agreed at each subsequent child researcher training workshop. It was thus in place prior to the commencement of the field component. This included such elements as training the child researchers themselves in ethical principles, particularly the freedom of others to respond or withdraw, and respect for all persons; the importance of negotiation between children and adult researchers regarding the data to be collected, and the appropriate methods; that the amount of time expected of child researchers should be negotiated at the training workshops and that child researchers would be acknowledged in all major project outputs. A full discussion of the issues involved in working with the young researchers across the three project countries can be found in Porter et al. (2010b) and in Robson et al. (2009) regarding Malawi.

Having set out our research approach we now consider some of the factors which emerged as significantly affecting young people's mobility and access, firstly with reference to education and secondly health.

Accessing Education: The Journey to School

The journey to/from school is a central theme of many of the interviews conducted with children in both the adult and young researcher strands and the focus of a substantial element of the survey. Walking is the dominant mode of travel to school for both genders, throughout all regions, in all types of settlement. In Ghana and Malawi it is almost the exclusive mode of transport on journeys to school: 98.6 per cent of girls and 97.4 per cent of boys in Ghana had walked to school the previous school day, and 99.3 per cent of girls and 99.1 per cent of boys in Malawi. Walking also dominates among both genders in South Africa (86 per cent of girls, 86 per cent of boys) but in remoter rural areas of South Africa, dedicated bus services are sometimes available to take children to school. Cycle use on the journey to school is remarkably low in all three countries (Porter et al. 2010c).

In remote rural settlements (which in our definition specifically did not include a primary school), the long journey to school is particularly taxing for small children, such that many start their education late (in some cases not until they are about 8 years old or even later). Parents across all three countries and in all settlement types tend to stress the potential dangers of travel for children living at a distance from their school and the safety provided by travel in groups, especially for girls. Children themselves are by no means sanguine about the journey they have to make on a daily basis. The following vignettes – one from a boy, one from a girl in each of two villages, one in coastal Ghana and the other in Eastern Cape, South Africa – effectively illustrate many of the prevailing themes in these discussions.

Charles, 11 years old, lives in a settlement without a primary school in coastal Ghana. He attends a private primary school in the nearest town, about 5 km distant from his house:

> I wish I could board a vehicle to school but … my parents cannot afford to pay any transport fare … I leave the house at 6 am each day but sometimes I don't get to school until about 8 because the distance is too far from the house … apart from the distance we struggle with each day, sometimes we see snakes on the route we use. At other times especially when it rains the road becomes slippery. The worst part of it is when we have to go to school when it is raining. There is no place to hide or to take shelter from the rain. We get to school all wet and cold. The most frightening problem is when we walk and meet vehicles that are unfamiliar to us plying this route. We usually run into the bush because we are afraid such vehicle may be used by serial killers who behead children. [prompt] sometimes we are told to go to the farm before we report to school ... this also contributes to my arriving late for school. [prompt – what happens if you are late?] I am caned.
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> … Things are a little bit different when we are returning home. We play and chat and enjoy the journey well … [he walks with his siblings]. On days that my siblings refuse to come to school, I also relax at home [but that is not often]. We attend school regularly except on days we have to go and help out on the farm. … [we] carry cassava home during the main harvest season. During that time, we seldom come to school. [prompt – what are the impacts?] It affects me because my colleagues are taught a lot of things by the time I return and I find it difficult to catch up with them.

Mercy, from the same village is 14 years old and is in primary 6 at another private school in town:

> I like walking in groups to school. We converse on the way to school. The journey back is more relaxed than the journey to school. Sometimes, when going home we stop in the way and play especially when we are tired … sometimes some of us quarrel on the way to school or from school. It is we the girls who usually quarrel on the way … the younger ones are entrusted in the care of their older siblings. … Because of [siblings, aged 7 and 5] I am sometimes late to school because they cannot walk faster. So I use to leave home early so that I can reach school early otherwise you are lashed for being late to school … our attendance is poor during the rainy season. Sometimes you prepare to come to school and you realise that it is about to rain … Generally attendance and punctuality are poor during the rainy season. Children from settlements far away do not come to school. We have a stream that we cross to school. During the rainy season sometimes you have to wait at the banks of the stream to get an adult to carry

you across the stream. When the stream is full to the banks we have to stay in the house till the water subsides …

Charles and Mercy both stress the difficulties and dangers of travel in the rainy season, the requirement to accompany siblings (because parents are usually too busy at the farm and do not perceive accompanying children to school as a necessary task for adults, especially when there are a number of siblings who can travel together). They also point out that corporal punishment – being lashed or caned – results from late arrival, but suggest that late arrival is associated with family-imposed tasks, whether looking after siblings, other domestic tasks, or going to work on the farm before school.

Similar themes to those in Ghana emerged in the South African Eastern Cape interviews – work before school, problems of travel in inhospitable weather without adequate clothing, corporal punishment following late arrival at school, the need to accompany siblings, companionship associated with walking with friends – though here there is a much stronger emphasis on the dangers associated with meeting dogs. Nicholas, aged 16, is in grade 9 and attends the Junior Secondary school (JSS) in his village in Eastern Cape. However, he is living with a foster family in one of the dispersed homesteads and must work before and after school and at weekends, dipping cattle and helping as a conductor on one of the vans which links the village to the nearest major urban centre at Port St John:

> There is a short way to get to school but we have to pass through people's yards. The dogs chase us. One of my friends got bitten by a dog … we always walk this way but the owner of the house doesn't want us to pass through his yard … one day he allowed his dogs to chase after us. We all ran but the dogs caught one of my friends and bit him. We shouted but no one helped … his parents reported the matter to the headman but nothing was done. I am now scared to walk through that homestead … I only enjoy the journey when I am with my friends as we get to chat to girls. When I am alone I don't enjoy. The journey is long. When it is very hot … I sweat and I have to wash my shirt when I get home because my armpits smell. I get a headache because I am hungry and tired by the time I get home. We don't play on the way.

> I travel to school with my friends. If my friends are not there I walk with other children from the neighbourhood … in summer it gets very muddy. Our uniforms get dirty from the mud. Our shoes also get muddy. When it is raining I don't have a raincoat, I use plastic packets to cover myself. In winter it is very cold in the morning. We wear short pants, our legs get very cold … we use two routes … the other route is long. It is clear, there are no dogs. We usually use the longer route when we are coming back from school. [If Nicholas is late, he is caned, and not allowed in until the second class].

Zodwa, 13 years, is in grade seven at the same school as Nicholas. It takes her about one hour to reach school and she is sometimes late because she has to prepare breakfast for all the family before she starts her journey. Like Nicholas she is afraid of the dogs she encounters, but her strongest fears concern attack from people she knows:

> there are older boys who ask us for money on the way back from school. They propose love to me and my friends and they speak foul language at us – they threaten us that they are going to catch us and sleep with us. I get so terrified that I am scared to walk alone … they sit on the way and smoke dagga. There is also a mad man who chases us. The small boys from school like starting fights on the way from school and they bully my smaller brother. [dogs are a problem too] … My younger sibling [11 years] walks with his friends but I keep a watchful eye on him as mother always says I should do because the older boys can pick on him and steal his money and stationery.

In South Africa, fear of rape on the journey to or from school is far more common than it is in Ghana and Malawi, and is at its highest in remote rural locations. Moreover, our survey data indicates that it is not only girls, but also boys, who fear rape there. Whereas no children in our Ghanaian remote rural settlements and only 2 per cent of girls and no boys in Malawi said they feared rape on the school journey, in South Africa 10 per cent of girls and 1 per cent boys in remote rural settlements expressed this fear. In the context of the high incidence rate for rape and extremely high HIV/AIDs prevalence rates in South Africa this level of fear is unsurprising (Dunkle et al. 2007; Wood et al. 2007).

The issue of work and its impact on education and the journey to school is a more consistent theme across research sites in the three countries. Heavy household and other work demands, especially if coupled with residence at some distance from school, lead very frequently to late enrolment, poor attendance and early withdrawal from basic education. This is usually strongest in effect on girls' education since Africa's transport gap presents a particularly heavy burden for girl children: it is girls who are most commonly required to carry water and firewood for domestic use and farm produce to market, in addition to the other household work contributions such as cleaning, cooking and sibling care they are frequently expected to perform (Porter, Blaufuss and Acheampong 2007). In all the Malawi sites, for example, the burden of pre-school household activities and the strong implications for girls' school attendance was emphasised by teachers and children alike, particularly with reference to carrying the family's maize to the maize mill for grinding: 'girls often abscond classes to go to the maize mill since maize mills are very far from here … Other household chores such as fetching water make children, especially girls, late for school' [female teacher, rural southern Malawi]. As another rural primary teacher working in the region observed, 'it's generally girls who are late for school, not boys' (because of girls' workloads). A 17-year-old boy pointed to the impact of work on his sisters:

my sisters [aged 14 and 8 years] who do not go to school do not go to school because they were being asked to go to the maize mill whenever I was tired. They would come back with aching legs and they were eventually forced out of school.

In Malawi, as in all our study sites, boys beyond the age of about 15 years are rarely expected to head load for the family, unless there are no available girls:

boys start carrying loads later than girls … most boys when they are 15 years old refuse to carry things on their head when going to the maize mill. If you see a boy aged more than 15 years headloading then you know he is either a fostered child or a houseboy, but for the other ones you have to entice them with a bicycle. [Rural Malawi, men's group]

The impact on girls' education is inevitably substantial:

Child porterage is an issue here. It is an issue where children have to help their parents to the market by carrying foodstuffs in the morning. This activity delays children and they get to school tired. This is a peculiar problem with girls … this activity affects children's academic life significantly. For example, they come to school already late. They just join the day's lesson mid-way and they cannot catch up with their colleagues. [Young male teacher, rural coastal Ghana]

Over time, this also becomes apparent to pupils. A 14 year old girl in a remote rural forest Ghana site observed:

The journey to school is too far for us so by the time we reach school lessons have already started … this makes us score very low marks … Irrespective of the long distance we trek to and from school … we are asked to go to the farm and plant as soon as we arrive home … On other occasions they ask us not to go to school so that we can help on the farm.

In Eastern Cape, where many rural boys play an important role in livestock herding and their work burden may, in some cases, equal or exceed that of girls, work before school frequently leads to delays in arrival and subsequent punishment for both sexes. However, even in this region, the pre-school work burden of rural girls was still commonly regarded as particularly high: 'it is a norm among almost every household that a girl child has the responsibility of collecting water and firewood before she come to school … for girls it starts at the age of five. In winter when the nearby streams are dry they are compelled to travel some kilometres to the river …' [woman schoolteacher, rural Eastern Cape].

Girls are usually late because they have to do many things in the house when they wake up … Yes, they are punished for being late. They clean the school

> premises. [some have a walk of one hour to school so that] by the time they get
> to school they are already tired and can't concentrate in class. [Father of four,
> rural Eastern Cape]

Our data suggests that for many young people living in remoter rural locations, a long journey to school presents the tipping point in a context where school attendance is, in any case, mediated by work requirements and an associated constant process of inter-generational negotiation. For rural girls in particular, the high labour demands associated with transport constraints (carrying water, firewood etc.) and other labour demands at household level commonly have a particularly severe impact on school access and performance. Even completion of basic primary education is thus, for rural girls, a major achievement.

We have drawn attention above to the particular difficulties experienced on long journeys to school in rural environments. In urban areas the home to school journey is usually relatively short (for instance, 50 per cent of urban pupils estimated their school journey took 15 minutes or less in coastal Ghana, 29 per cent in southern Malawi and 40 per cent in Eastern Cape), but it may still entail a variety of hurdles, including the necessity to undertake work – including load carrying – before or en-route to school. In urban Malawi a mother described how her 12-year-old daughter and 9-year-old son work before school, 'by 6 am the maize mill is already open. That gives my children ample time to go … and get to school in good time'. Each child carries a 10 kg bag. After school (and at weekends) they dig sand from the riverbed and carry it to builders who use it for construction.

Traffic imposes additional hazards in urban sites: many children reported walking along routes shared by fast, aggressive and potentially dangerous drivers: children are showered with dust in the dry season and by muddy, dirty water in the rains. In the southern African urban sites, in particular, there were also strongly expressed fears of human attack. Both boys and girls walking to school in uniform may be subject to taunts and harassment: older girls are propositioned and boys experience theft. Michael, a Malawian 16-year-old, observed, 'we wait for each other so that we can walk in groups. This prevents attacks from bad people … sometimes they beat us and tell us not to let anybody know about it ...[or] they will skin us to death'. In South Africa, security problems and violence emerged as even more prominent themes in the urban interviews we conducted. As one 18-year-old girl, observed:

> when I walk to school with my friends there are some boys who follow us and
> ask us for money. They frighten us because they are high on drugs and I am
> scared that they will do some bad things to us – that is why I don't walk alone
> to and from school.

In this context girls and boys of all ages feel they are unsafe to walk long distances on foot and select routes to school which avoid the quieter places where potential

attackers – whether suspected thugs, thieves, drunkards, dagga [cannabis] smokers or witches – may lurk.

Accessing Health Services

Unlike going to school which, in theory at least, is a regular and predictable event, going to a health facility is infrequent and unpredictable. Most of the time, children (and others) do not need to seek healthcare. But when they do, being able to access appropriate healthcare quickly and efficiently is often essential; in an emergency, it can mean the difference between life and death.

Overall, rates of health service use by children are relatively low: fewer than half of the children in the survey had visited a health facility of any kind in the 12 months preceding the survey, and more than 10 per cent had never been. Girls are more likely to use health services than boys: 46.1 per cent in the preceding 12 months for girls, 37.5 per cent for boys – a statistically significant effect $(p(chi^2)<0.0005)$. But by far the biggest factor influencing use of health services is where the child lives, with very substantial rural-urban differences in Ghana and Malawi in particular: Table 4.1.

Table 4.1   **Proportions of children reporting having used health service in preceding 12 months by settlement type and by country**

Settlement type	Percentage of children using any health service within last 12 months			
	Ghana	**Malawi**	**South Africa**	**All countries**
Urban	42.8%	53.2%	52.6%	49.4%
Peri-urban	30.8%	60.6%	57.9%	47.9%
Rural with services	15.4%	36.2%	55.3%	35.2%
Remote rural	13.5%	35.7%	56.1%	36.6%
p(chi sq)	<0.0005	<0.0005	NS	<0.0005

Assuming that morbidity does not vary significantly between settlements[6], the differences in health service use reflect differences in access and/or perceived needs. Difficulties in accessing health services were a common theme in interviews. In the survey, over half of the children in Ghana and Malawi, and nearly a third of those in South Africa, reported problems in accessing healthcare services (Table 4.2). The barriers to health seeking for children are broadly similar to those

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6   Morbidity data were not collected in the survey, because self-reported morbidity is notoriously unreliable. However, children were asked to report recent illness episodes in the interviews, and no obvious differences between settlements emerged.

Mobilities: new perspectives on transport and society

Table 4.2   Reported difficulties experienced by children in accessing health facilities, by settlement type and country

Ghana

Specific difficulty	Settlement type					p(chi²)
	Urban	Peri-urban	Rural with services	Remote rural	ALL children	
Too difficult to travel there	4.0%	7.4%	27.2%	34.7%	16.8%	<0.0005
Too expensive to travel there	5.3%	12.0%	22.6%	32.9%	17.0%	<0.0005
No one to accompany	1.3%	1.8%	1.7%	0	1.3%	–
Fees too expensive	27.8%	35.3%	36.4%	45.1%	35.6%	<0.005
Services of poor quality	0	1.1%	0.4%	0.6%	0.5%	–
Too busy with work	1.8%	11.3%	4.2%	4.6%	5.9%	<0.0005
Any difficulty	34.8%	56.8%	66.5%	72.2%	56.6%	<0.0005

Malawi

Specific difficulty	Settlement type					p(chi²)
	Urban	Peri-urban	Rural with services	Remote rural	ALL children	
Too difficult to travel there	18.0%	31.3%	56.5%	57.3%	40.8%	<0.0005
Too expensive to travel there	18.4%	3.2%	4.8%	8.9%	8.8%	<0.0005
No one to accompany	11.4%	17.7%	20.2%	13.7%	15.8%	<0.05
Fees too expensive	8.2%	1.2%	2.4%	4.8%	4.1%	<0.001
Services of poor quality	17.6%	22.6%	21.4%	16.1%	19.4%	NS
Too busy with work	0.8%	7.3%	2.0%	1.6%	2.9%	<0.0005
Any difficulty	34.8%	56.8%	66.5%	72.2%	56.6%	<0.0005

South Africa

Specific difficulty	Settlement type					p(chi²)
	Urban	Peri-urban	Rural with services	Remote rural	ALL children	
Too difficult to travel there	6.6%	17.9%	13.7%	38.9%	19.8%	<0.0005
Too expensive to travel there	9.7%	17.9%	11.9%	16.2%	13.8%	NS
No one to accompany	3.1%	17.9%	11.9%	16.2%	13.8%	<0.005
Fees too expensive	4.8%	6.5%	5.0%	2.4%	4.6%	NS
Services of poor quality	4.8%	2.7%	10.0%	5.3%	5.8%	<0.05
Too busy with work	3.1%	3.3%	5.5%	4.1%	4.0%	NS
Any difficulty	22.5%	27.1%	32.5%	46.5%	32.7%	<0.0005

reported in other literature on Sub-Saharan Africa (e.g. Rutherford, Mulholland and Hill 2010). Physical access difficulties and constraints feature prominently. In all countries, high proportions of children report experiencing difficulties in travelling to health services (26.3 per cent of children overall) as well as high costs of travelling (13.1 per cent overall). Travel difficulties are particularly problematic for Malawian children, with two-fifths reporting these as an obstacle to health service access.

In all three countries, there are substantial urban-rural differences in barriers to health services use, with rural children bearing the brunt of travel difficulties and high travel costs (Table 4.2). It is not just distance per se, but travel conditions: road quality, and the frequency, reliability and cost of public transport, can make it very difficult to reach a health centre. In rural areas, particularly settlements not on or near tarmac roads, public transport is typically infrequent, irregular and often unreliable. Unless the child is 'lucky' enough to fall ill on a market day, when more vehicles are usually available, it can be a long and worrying wait to secure transport to the nearest town, and for night-time emergencies it usually proves impossible. Moreover, drivers tend to charge at least double the tarmac fare to drive on dirt roads to remote settlements, or even refuse to drive at all:

> The problem accessing [clinic] is that, when a sickness occurs at night we have to carry the patient, whether young or old, to [town]. Even if we walk to [village], the drivers will refuse on the pretext that it is late night and dark. [Father, rural coastal Ghana]

> A woman sells tablets at [the village], but she only comes on Tuesdays. But unfortunately sickness doesn't have any specific day of coming. Sometimes children die because they are not sent to hospital on time as a result of lack of transport. [Focus group, adult men, Ghana forest zone]

As a result, many children in rural areas have to resort to walking or (for those who are too young or too ill to walk) being carried by someone else, to reach a health service. Overall, more than half of children's journeys to health centres were on foot. In Malawi, over half of children living in rural settlements had walked on their most recent visit to a health centre, despite the fact that for all of these children the nearest health centre was more than 3km away and, for about half (42.9 per cent of those living in villages with services and 54.3 per cent of those in more remote settlements), the journey was more than 9 km. The only other option for most rural Malawian children is to use a bicycle – usually borrowed: nearly two-fifths had used a bicycle to reach a health service, either pedalling themselves or (again for those too young or unwell to cycle), being given a lift by someone else; a journey dreaded by many. Interestingly, rural children in Ghana and South Africa reportedly rarely or never cycle to health services: they either walk or wait for a vehicle.

As well as the long distances involved, walking or cycling to a town can be extremely difficult and even dangerous, particularly in the rainy season, when

roads may become flooded and completely impassable. Children in one remote rural village in South Africa [Eastern Cape] reported having to walk eight or nine kilometres over difficult terrain to reach the nearest clinic. The journey involves crossing a large river. The bridge collapsed some time ago, which means that emergency transport cannot reach the village: patients have to be transported on someone's back or, occasionally, by donkey or ox cart. But, during periods of heavy rain, the river cannot be crossed on foot, meaning no access to health facilities at all. Similar accounts came from other rural settlements:

> Our major challenge is when the river has overflooded. Then you can't cross the river and the best you can do is to pray to the Almighty, and you can imagine when you were carrying a pregnant woman … It happened last February – this lady we couldn't get across. We decided we should pray and asked assistance of the women and through chance she was able to deliver on this side of the river – otherwise she could have been swept away. If we had had a bridge, the main problem would just be the distances. [Chief's son, rural Malawi]

> Sometimes we do not travel for a week when there has been a lot of rain, because the bridges get filled with storm water. Sometimes during such times there are children who need to go to a clinic and they just stay sick at home. [Boy, 17 years, remote rural South Africa, North West province]

However, although the journey to health services is usually particularly difficult for rural children in all three countries, for those living in urban and peri-urban settlements, travelling to health services can still be difficult, time-consuming and expensive, as these Ghanaian children report. And negotiating busy roads can be particularly hazardous for children when they are unwell.

> Vehicles are not available sometimes to transport patients to the hospital. If the illness is very serious, the patient could be carried by one or two people to the main road [to get a vehicle]. [Boy, 16 years, focus group, peri-urban coastal Ghana]

> Some of the drivers do not care about children so if you are a child and walk slowly across a road because you are sick, a vehicle may knock you down. [Boy, 16 years, focus group, urban coastal Ghana]

> It is quite difficult to go to the regional hospital. You either charter a taxi or go by commercial taxi, which is expensive. [Girl, 14 years, urban coastal Ghana]

Similarly, in one of the South African peri-urban sites, although there are clinics within a few kilometres, people experience difficulties accessing emergency services, since the ambulances are located at a hospital some 30 km distant. Particularly at night, people complain that ambulances take too long to arrive at a

scene, and hiring private cars to reach an accident and emergency facility can be prohibitively expensive.

Clearly, physical access is not the only obstacle to children obtaining appropriate and timely healthcare. User fees were another major reported obstacle by more than a third of the children in Ghana. As one 15-year-old put it, '[There] is a lack of money to pay for [health] services. You see, I cannot just walk into a hospital or clinic for treatment without going there with cash. They will not pay attention to you'. And nearly a fifth of children in Malawi complained about the poor quality of services. Getting to the health centre is no guarantee of effective treatment, as this mother comments: 'Some children taken to the health centre die while on the queue' (focus group of mothers, urban Malawi). Health facility staff are also reportedly often reluctant to treat children who are not accompanied by an adult.

However, like access to schools, our interviews suggest that distance, travel costs and travel difficulties can act as the tipping point, preventing many children from getting access to appropriate and timely healthcare, particularly in emergency situations. Moreover, travel costs and difficulties can interact with other factors to compound the problem: user fees for consultations or medicines might be just about affordable on their own, but in combination with the high costs of transport to a health facility, they can prove prohibitive. And the time taken to travel to a clinic, plus the time spent waiting (a frequent complaint), can mean a whole day's loss of work for an accompanying adult, compounding the economic costs. For children, this time cost can also have implications for schooling: this young woman from South Africa reports how, as a child, she and her grandmother went to great lengths to avoid missing school when she had to go to a clinic:

> I often used to fall sick as a child … I used to have colds and flu … My grandmother used to take me to a clinic at [town]. We used to travel in the early hours of the morning. I think we arrived at 6 o'clock … The clinic used to open at 7.30 am, but she would want us to get there very early so that immediately when the clinic opens we would get help so that when the bus returns from other villages we could get back to [village] and I should not miss school. [23-year-old woman, rural South Africa, North-West Province]

In other ways too, the children in our study are remarkably resourceful and proactive in overcoming access difficulties and other constraints to healthcare. Despite the belief of most adults that children lack the capacity to understand illness, describe symptoms, or to reflect critically on appropriate courses of health-seeking, most children are extremely knowledgeable about common infectious diseases and the different health services available, and made active choices about how to obtain healthcare. Many walk long distances, over difficult and dangerous terrain. Others earn small amounts of cash which they use to pay for transport to clinics and to cover costs of consultations and medicines. And, while (unlike for school) most children travel to health services with an adult, a significant minority go alone

(20.7 per cent in their most recent visit) or accompanied only by another child (9.3 per cent). For most children who seek healthcare independently of adults, this involves self-medicating with painkillers and other medicines purchased from local traders:

> Earlier this year, I was suffering from malaria. I lost appetite, I felt pain in my body, so I was convinced it was malaria. I bought Quick Action tablet from a drug store. I was not cured so I went to buy Kafalgin – also a tablet, but more powerful. That was better. Next time I will take Kafalgin if I suspect I am suffering from malaria. [Boy, 18 years, focus group, remote rural coastal Ghana].

More rarely, children reported seeking treatment from hospitals and clinics by themselves, while it is also not uncommon for children to prepare their own herbal remedies, using locally available plants. And many other children act on others' behalf to seek treatment:

> Me I go alone to hospital when am sick, but my brother always has to go with somebody … because he is a little boy, the other time I took him myself to the health centre, my mother was going somewhere and I had to carry him on my back. [Girl, 11 years, focus group, peri-urban Malawi]

However, again, children are typically more constrained than adults in their ability to overcome barriers to healthcare access alone. Many readily admitted that they used medicines from informal traders or prepared plant remedies as a fallback option, because they were unable to reach formal health services. And they are all too aware that the single dose tablets that they could buy from traders were not very effective.

Discussion: Gender, Surveillance and Inter-generational Frictions

Control over mobility reflects and reinforces power (Sheller and Urry 2006: 211). Many observations of young people in this study have drawn our attention to the way power relations shape the precise patterning of their individual mobilities and immobilities: who can travel along which paths or streets, using what form of transport, interacting with whom, stopping where (Porter et al. 2010d). Strong efforts are made by parents and carers to socialise girls into mobility compliance from an early age. In all our rural research sites, for instance, it is clear that boys are allowed much more freedom to move around than girls, and that this is related to their lower work loads, less danger of rape, no fears of impregnation and, not least, an implicit acknowledgment that boys are less easily controlled. Girls' restricted mobility is reinforced by strong social norms regarding 'appropriate' behaviour for females. The following two quotations, both from fathers in rural Malawi,

exemplify the kind of distinctions which are regularly made both by fathers and mothers regarding acceptable mobility and broader behaviour patterns for the two genders:

> the boy I don't know[where he goes to play] – as you know boys they just go wherever they want … my girls just play and chat around the houses close to our home. [The children are not allowed to go to distant social events – especially the girls because] they can get raped. [Father of a boy 14 years, two girls 13 and 7 years]

> … boys have more freedom than girls [prompt – why?] they are just boys … girls work hard more than boys, hence boys have more time to move around … Girls ought to stay home and look after the house and cook … There is little for the boys to do [just] harvesting and cultivating. [Father of six children, four girls, two boys]

Such attitudes inevitably impact strongly on girls' spatial mobility patterns. Remoter routes in rural areas are usually frequented by girls and women only when they can travel together in groups: safety in numbers is a common theme in interviews. Girls in both rural and urban areas report a strong awareness of local sites of potential insecurity: cemeteries, shrines, public bars and video houses, areas of high grass in the wet season etc.

Young people's fears may be reinforced by parental concerns which are more strongly focused on girls (especially post-puberty) than boys, and are highest where night travel is concerned, whether in urban or rural areas. Our evidence suggests that young girls are often discursively constructed by their parents and guardians as weak and helpless – potential victims – in the context of daytime travel, but once darkness falls, as promiscuous sirens who may submit to all the temptations of bars, nightclubs, discos and dances.

Adults employ a range of strategies in their efforts to achieve control of the mobility of young people in their care. Care and control, the two faces of surveillance (Lyon 2001, 2003), take a variety of forms. We observed strong encouragement of group travel on the school journey, but other means of surveillance include eliciting reports from neighbours and siblings, denoting certain spaces (such as bars) out-of-bounds, warning of potential natural and supernatural threats, threatening punishments which will be imposed following late return, imposing extra household tasks following late return, such as denying food following late return and, in some cases, giving beatings and, finally, excluding the young person from home or (in urban areas) threatening to send them back to the village where the community will observe and report on any misdemeanours (Porter et al. 2010d). Inevitably, constant expressions of fear, especially when associated with careful surveillance and severe punishment for transgressions, can cause strong resentment among young people and an escalation of inter-generational tensions, as the following quotations from Malawi and Ghana illustrate. Under

cover of darkness, there is of course more space for (discreet) resistance, hence the particular reluctance of carers to allow their young female charges out after dark:

> you can't see girls in this village walking late in the evening … girls just don't walk anyhow … parents want to protect their lives [prompt] from getting pregnant or catching HIV/AIDS. Boys can go out late in the evening. [Out-of-school girls' focus group, rural Malawi]

> Boys can even come home very late at night but not us … Parents always doubt our movements. They fear we might get pregnant … [if we are late] parents shout at us, we are not allowed to enter the house, we are whipped by our guardians. [Out-of-school girls, 16–18 years, focus group, urban Malawi].

> In the nights my parents do not permit me to go out because according to them I can become a bad girl if I go out in the nights. Whenever I return home late in the daytime, my mother … insults me. [Girl, 13 years, rural Ghana].

> Nowadays it's a little scary walking round this neighbourhood in the evenings because there are ritual murderers around … I told my mum that I was going for choir practice in the evening and my mum told me not to go since there was a wake-keeping in the area … when I got home [she] was very angry. [Girl, 18 years, urban Ghana]

Such high surveillance and mobility restrictions may be imposed in a context of care and concern but they have substantial implications, not least in terms of girls' opportunities to build social networks, so often essential in an African context for the development of more lucrative livelihood opportunities.

Conclusion: Review and Prospect

This chapter has focused on young people's mobilities in sub-Saharan African contexts where there has been little research to date. Work across 24 sites has enabled us to build a comparative perspective which is particularly valuable in building a larger picture of mobility patterns across the continent.

In terms of the material presented in this chapter, a key theme which emerges from an exploration of the journey to school is the gendered nature of mobility, which is strongly related not only to girls' perceived vulnerability and potential promiscuity but also to cultural conventions regarding female work. The interconnectedness of mobility constraints associated with perceived vulnerability, workloads and time poverty has a remarkably pervasive impact on girls' access to education, especially – but not only – in remoter rural areas.

Our findings suggest that there are a number of ways in which young people's access to services could be substantially improved. These may involve both

transport and non-transport interventions with mobility implications. In terms of possible *transport interventions*, we would suggest that the walking bus concept may have specific value in contexts where children are threatened by traffic dangers or vulnerable to human attack en route to school (as at one of our peri-urban sites in South Africa where both girls and boys face a real threat of physical violence, including rape en-route to school). The concept involves travel groups utilising a register, supervised by adults and with 'bus stops' where children join the group. We are not aware of any application of the walking bus concept outside Western urban contexts but suggest that it may have substantial potential in low-income countries, to improve safety from attack or traffic (as opposed to a common Western focus on improving health/obesity reduction).

Another potential intervention would be swimming lessons, particularly for rural girls. At many of our rural sites, children have to cross streams and rivers which sometimes rise extremely rapidly in the wet season (as described above by Mercy). Our research indicates that boys are far more likely to know how to swim than girls, and that it is far more common for girls than boys to be absent from school during such conditions.

Traffic accident rates in Africa are among the highest in the world and are set to rise as urbanisation and vehicle numbers increase. Trading along busy roadsides is one of the commonest causes of traffic injury and death among young people (Mock et al. 1999; Nantulya and Reich 2002; WHO 2004: 31). In our urban and peri-urban research sites we encountered many out-of-school children working around busy roads, often selling goods to drivers and passengers in passing vehicles. This can be extremely dangerous. In all three countries, in-school children generally receive some basic road safety training through their national curriculum requirements. Out-of-school children, however, receive no training yet appear most in need of guidance. A road safety training programme explicitly designed for application with illiterate young people would be extremely valuable. It would probably be best implemented by local NGOs specially focused on road-safety.

Children crossing dangerous roads and suffering accidents on the way to/from school, or attending schools other than that closest to home in order to avoid daily crossing of a dangerous road, also figured in the research data. More widespread adoption of scholar patrols for crossing busy roads at the start and end of the school day – possibly run by trained older children – plus road cones, stop/go batons and reflective vests could be beneficial in this context.

Cycling only rarely appears in our journey to school stories. In other contexts, boys report some access to cycles for the purpose of errands, carrying maize loads (Malawi) etc., but our data shows that cycling is essentially viewed as a male activity, by both genders and all age groups *(IFRTD Forum News* 2010). If perceptions changed and cycles were available, they could enable girls to access school more easily and reduce their common time poverty problem, as Rao (2002) has reported in an Indian context, where cycle hire centres have had extremely beneficial impact. Cycle hire centres based at schools, with subsidised hire and

cycling and maintenance lessons made available to girl pupils, could also support a broader change in terms of female cycling by encouraging development of critical mass (Starkey 2001).

There are other *non-transport interventions* which could improve access to services substantially, especially for girls. In terms of girls' domestic work loads and time poverty, which impact so severely on their access to education and educational performance, installation of improved water supplies, community woodlots, more and more efficient wood-burning stoves and crop-grinding mills could bring substantial benefits (Malmberg Calvo 1994; Doran 1996: 12) by reducing girls' labour inputs, including porterage. They could enable girl children not only to get to school but to arrive punctually and less exhausted.

We also found that many girls from rural areas have to travel long distances to school each day or must board. Boarding facilities are often limited at secondary schools and absent at primary/JSS. Consequently many girls have to stay with relatives in town, or rent a room (termed self-boarding) in order to attend school. Girls who are self-boarding are vulnerable to advances from predatory men, especially when they have insufficient funds for personal upkeep. Child respondents and parents in all three countries reported cases of girls who become involved with boyfriends to help support them in town, but as a consequence return home pregnant and drop out of school. Although schools now officially allow girls to return to class after their babies are born, there are often insufficient family funds/support for the mother and child to make this feasible and they face stigma. One low-cost scheme to support girl self-boarders could be to introduce a mentoring scheme whereby older women (preferably those who have themselves been self-boarders, such as university staff in university towns) provide advice and emotional support within an organised structure of regular meetings.

Many children in our study, as we saw in the journey to school vignettes above, face punishment for late arrival at classes, even when this is due to pre-school household work demands or travel distance constraints. Punishment by teachers – which is widespread and ranges from laborious and unpleasant work tasks such as lavatory cleaning and compound sweeping to beatings and being excluded from class – encourages pupil truancy. Children regularly decide it is preferable not to attend school on the days they are going to be late. Regular absences from school also encourage early drop-out, since it is difficult to keep up with the rest of the class. The teachers who provided support at our child researcher training workshops expressed considerable surprise about the extent of this problem for children and its repercussions and said this would change their own practices: with long periods of urban residence they had inadequate appreciation of the constraints children face and the impact of punishments. Teacher sensitisation programmes in conjunction with local Ministries of Education for teachers, in which schools are helped to design and implement contextualised lateness policies, could offer a low-cost intervention with considerable potential.

Improving access to health services requires a very different set of interventions. As noted above, unlike journeys to school, which are (relatively) regular and

predictable, children often need to go to health services quickly, unexpectedly, and at difficult times. The physical difficulties, combined often with high costs, of reaching an appropriate health facility quickly can be prohibitive, and there are too many tragic stories of children (mainly from rural areas) who did not manage to make the journey in time. High priority must be given to expanding high-quality health services in rural areas and improving referral services, in order to address the substantial rural-urban gap in children's access to health services. We have also shown that many children are capable and proactive health seekers, but are hindered in their quest by lack of money for transport and treatment, constrained mobility, and, sometimes, adults' dismissive attitudes. Serious consideration needs to be given to enabling children to seek treatment safely and effectively, including, for example, the development of guidelines with accompanying training for local pharmacists and grocery-store owners in providing appropriate advice or treatment for children.

These suggestions towards improved service access and related issues are based, above all, on compelling testimonies from the young people who are central to this study. The booklet which the young researchers themselves produced (Child Mobility Project Young Researchers' Group 2009) speaks directly to policy makers and others about the centrality of improved mobility and service access to young people's lives and life chances. Our task now is to ensure that the findings which have emerged are not only disseminated but also acted upon, so that real benefits are experienced in young people's lives.

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