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Youth Sector Engagement Group

The State of Youth Health in Ghana's Construction Industry

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Research Brief | Stakeholders

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Overview

This brief presents findings from a mixed-methods study of the stakeholders of young construction workers' (aged 18-35 years) health, their roles, and their stakeholder preferences. The study focused on workers in the three largest urban areas in Ghana (i.e., Accra/Tema, Kumasi, and Takoradi/Cape-Coast). Interviews and a focus group discussion with health experts, employers, and young workers revealed nine categories of stakeholders of young construction workers' health were identified, viz.: health group, occupational health and safety agencies, construction industry actors, government, academia, media, youth health activists and promoters, community, and construction employees. A survey of 445 young construction workers revealed the most preferred stakeholders to be the media, academia, and youth health activists and promoters. The least preferred stakeholders were government, and occupational health and safety agencies. The research emphasizes the need for a collaborative and coordinated stakeholder effort toward undertaking more research, developing policy frameworks, designing and implementing workplace wellbeing interventions, and increasing young workers' health and safety literacy.

Introduction and background

Young construction workers suffer significant rates of poor physical and mental health. Studies have shown, for example, that young construction workers have higher rates of suicide, substance abuse, and musculoskeletal disorders compared to others of a similar age in other industries and older workers[1]. To overcome this problem, all stakeholders must contribute to the management of young construction workers' health. Nonetheless, very little research is available on the stakeholders of young construction workers' health and their roles. Furthermore, the little research available focuses predominantly on the case of stakeholders in developed countries such as Australia, the UK, and the US. Very little is known about stakeholders in the Global South1 context.

It is important to give priority to any issues that affect the health of young people in the Global South because almost 90% of young people under the age of 24 years reside in that part of the world[2]. By giving attention to the health of such a significant group of people this study has the potential to provide insights that can help accelerate construction safety performance towards achieving the "zero harm" goal[3] and Sustainable Development Goal (SDG) number 3 (good health and well-being).

As is the case in many Global South countries, Ghana's construction industry is attracting an increasing number of young people[4]. Both young male and female workers below and above the legal working age are entering the construction industry at a faster rate than older workers[5]. This is being facilitated by industry conditions such as a high number of small construction firms; the project-based nature of construction work; extended procurement chains; multiemployer worksites; high worker turnover and the extensive use of casual and inexperienced workers[6]. Within the last decade, the construction industry in Ghana has received both foreign and local investment to tackle youth challenges such as unemployment, inadequate technical training, and poor health and safety[7]. Ghana's construction industry therefore presents an ideal case for exploring in-depth issues about the stakeholders of youth health in construction industries of the Global South.

Aim

The aim of this study was to identify the key stakeholders responsible for managing youth health and safety in Ghana's construction industry. This study addressed the following research questions:

- *Who are the stakeholders of young construction workers' health and what roles do they play?*
- *Which stakeholders are preferred by young construction workers to help address their health conditions?*

1 Also known as developing countries, lower-and-middle income countries (LMIC), or the third world.

Methodology

The research questions were addressed using a mixed-methods approach. The first phase began with a comprehensive review of both academic (e.g., research journal publications) and non-academic literature (e.g., industry reports and policy documents) to gain an understanding of existing research on youth health and safety in the construction industry. Subsequently, qualitative data was collected through in-depth interviews with different participants, followed by an expert focus group discussion[2]. The second phase involved a quantitative survey of 445 young people working in various trades and professions in different sectors of the construction industry. Questionnaires were administered face-to-face and online. After the quantitative survey, 459 questionnaires were retrieved for analysis. A total of 445 useful questionnaires were retained for use. Descriptive statistics were used to describe the study sample and the overall response pattern on study measures.

Key findings

Characteristics of the survey respondents

Respondents' age ranged from 18 to 35 years, with the mean age of 26.3 years (SD = 5). Typical of the construction industry's male-dominated workforce in many countries, majority of the survey respondents were male (94.4%). Almost a third of the respondents reported being in a partnered relationship, and under 1% reported their marital status as either separated or divorced. More than half of the respondents (61.8%) reported having dependents, and the average number of dependents reported was two. The majority of respondents (97%) reported having received some form of formal education.

Stakeholders and roles

Nine categories of active stakeholders of youth health were identified. Panel 1 presents the nine stakeholder categories, their respective components, and their roles.

2 In September 2020, semi-structured in-depth interviews were conducted with 21 purposefully selected participants (e.g., construction workers, construction professionals, employers, health experts, researchers, etc.). Following this, a focus group comprising eight experts in youth health and safety was conducted to validate interview results, develop a stakeholder classification, and to obtain further insights to augment interview findings. Data from the interviews and focus group was thematically analyzed and used to develop a survey questionnaire for collecting quantitative data.

Panel 1: Key stakeholders of youth health in Ghana's construction industry

Stakeholder category	Components	Roles
Health group	Orthodox (doctors; nurses; physician assistants; psychologists; pharmacists; chemical sellers; etc.) Public health agencies Traditional (spiritualists; herbalists) Religious (religious leaders; faith healers)	Regulation of OHS practice Provision of OHS education Development and implementation of wellbeing interventions
Occupational health and safety (OHS) agencies	Regulatory bodies Training institutions	Ensuring compliance with OHS legislation Training and certification of OHS professionals Public education on OHS issues
Construction industry actors	Project clients Employers/contractors/master craftsmen/trainers Professional associations and construction youth groups Workplace OHS practitioners	Direct oversight for employers' and workers' compliance Provision of workplace OHS resources Advocacy for reforms in OHS legislation Workplace OHS training
Government	Central government Local government (MMDAs) Law enforcement agencies (Police; Narcotics Control Commission; Food and Drugs Authority [FDA]) Courts and social welfare agencies	Provision of OHS legislation Funding Management of OHS resources and logistics at the national and local levels Enforcement of regulations
Academia	Educational institutions Teachers and lecturers Researchers	OHS research and development Training of workers
Media	Radio Information centers Television Newspapers and electronic books Social media	Provision of OHS education Public sensitization
Youth health activists and promoters	NGOs and other private organizations Social groups Youth influencers (celebrities/pace-setters/etc.)	Implementation of youth-based and youth-led OHS programs OHS research and innovation Advocacy for reforms and compliance
Community	Traditional leaders Community volunteers Families Friends	Provision of access to young people Caregiving
Construction employees	Individual workers Co-workers	Ensuring individual and group compliance Providing feedback and support to other stakeholders

Young construction workers' stakeholder preferences

The stakeholder preferences of young construction workers are shown in Panel 2.

Panel 2: Ranking of stakeholder categories in terms of young workers preferences

Stakeholder category	Mean Score	Rank
Media	395.5	1
Academia	395.0	2
Youth health activists and promoters	369.3	3
Construction employees	355.0	4
Construction industry actors	350.3	5
Community	332.3	6
Health group	268.0	7
Government	186.0	8
Occupational health and safety (OHS) agencies	158.0	9

Note: Mean scores are determined by summing up the total frequencies for the different components in each category and dividing the total by the number of components in the category.

Discussion and implications

The poor rate of health literacy among respondents makes it imperative for stakeholders, especially the health group, the media, academia, and youth health activists and promoters to develop and implement programs aimed at boosting the OHS literacy among young workers. A key focal point should be on the preferences of young people and how to encourage them to use available support based on their preferences.

The media, academia, and youth health activists and promoters can get leverage through the use of non-print media such as social media platforms and other online sources since these resources are rapidly emerging as the main help-seeking avenues preferred by young people[8].

Despite the issues of low job autonomy and their poor rates of OHS literacy, the inclusion of young workers[3] as stakeholders is plausible because past research has shown that they have a higher capacity than older workers to respond positively to workplace health interventions (e.g., suicide prevention programs)[9]. Young workers for instance seriously consider mental health to be a workplace health issue and therefore have a better potential for supporting themselves and others to achieve greater "intervention-associated change"[10]. This is an indication that for interventions to be successful, they ought to be developed and implemented such that they are largely driven by young people themselves.

Young construction workers' perception that the government is not serious and the consequent low preference for the government is a matter of serious concern since the government is invariably the overarching stakeholder of youth health. Respondents' low preference for the government could be because stakeholder activity in many Global South countries is constrained by governments' inadequate fulfillment of their responsibility toward youth health and safety[11]. The government needs to take practical steps to shore up its image as far the management of youth health in the construction industry is concerned.

3 Young construction workers are classified under construction employees.

Conclusion and recommendations

Construction work is an important source of livelihood for many young people. Nonetheless, engaging in construction adversely affects the health of young people. To provide young construction workers with the guidance and support they need throughout their training and working years, the following recommendations are outlined for stakeholders:

Considering that industry actors have a high level of preference among young workers it is imperative for the Ghana Chamber of Construction Industry to set up a special committee to provide the co-ordination and monitoring required for all stakeholders to play their roles effectively.

All stakeholders should develop and implement a common policy framework for managing youth health and safety in the construction industry. The framework should seek to achieve a coordinated stakeholder effort through the promotion of multi-stakeholder collaboration. The framework should also seek to bolster young construction workers' involvement in the management of their health by recognizing them as key stakeholders and addressing any ethical and logistical challenges to research involving young people.

Academic institutions and OHS agencies should collaborate with construction employers to redesign working processes and improve the workplace environment to be responsive to the critical issues (i.e., stage of physical development, limited job skills and work experience, discrimination, stigma, lack of supervision, and poor understanding of safety issues) affecting young people's health and safety.

Lawmakers should review current OHS legislation to address the specific case of young workers' health and safety in the construction industry and strengthen mechanisms for ensuring compliance with OHS regulations.

The health group, community, and construction employees should collaborate to develop community-based approaches for promoting good youth health and safety practices. The target should be to develop the skills of parents, young people, community leaders, volunteers, and others in the development of confidence for interacting with health professionals. Community and construction employees should be helped to develop confidence for engaging other stakeholders. They should also be taught skills related to the provision of emotional support, early identification of poor health symptoms, and how to encourage young people to seek professional help.

Youth influencers, youth-focused NGOs, and other private organizations (e.g., Participatory Development Associates, Global Communities, the Youth Sector Engagement Group) must collaborate with construction industry actors (especially youth groups among the construction workers associations) to spearhead the formation of a special interest group for encouraging networking and health communication among young people.

Youth influencers and the media should develop and use non-print digital media platforms (e.g., social media, mobile apps, radio, etc.) to disseminate vital information required to improve health and safety literacy, especially mental health, among employers, young workers, and any other relevant groups.

Additional information

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Ethics approval (No.: 002/20) for this research was granted by the Ethical Review Committee (ERC) of Participatory Development Associates (PDA).

The full report is available at www.pdaghana.com. All data used in the study and any additional information from this study may be obtained by contacting Samuel Frimpong at s.frimpong@unsw.edu.au.

to link to the original resource on the PDA website. All perspectives and opinions articulated in this paper are those of the authors, who took the final decisions on content, and do not necessarily represent the views or policy of YSEG or its partners.

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