ETHNOGRAPHIC PERSPECTIVES ON RURAL WOMEN'S REPRODUCTIVE HEALTH
DECISIONS IN GHANA: THE CULTURAL INFLUENCES OF GENDER RELATIONS,
KINSHIP AND BELIEF SYSTEM

by

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Abstract

Ghana, one of the challenging contexts settings in sub-Saharan Africa, is a strong democratic nation and one of the area's emerging economies, yet the country still faces poor maternal health with maternal mortality ratios at 350/100,000 live births. This statistic means that the country's efforts to achieve Millennium Development Goal-5—the reduction of maternal mortality by 75 per cent by 2015—remains a mere dream. In this dissertation, I explore rural Ghanaian women's perspectives on the influence of social structures—especially, kinship and gender relations, individual maternal practices, the social meaning of motherhood and cultural beliefs—on their reproductive health decisions and maternal health service utilization. Secondly, I explore rural midwives' perspectives on providing services to women in Talensi-Nabdam district of the Upper East Region. Using ethnographic methods— participant observation, face-to- face interviews, focus groups, "deep hanging out"—I gathered data in six villages and four health clinics. Participants included 27 women of childbearing age as well as older women who provide traditional maternal health services to rural women and four midwives. My findings suggest that a complexity of socio-cultural structures and concepts, sustained gender-based violence and, an increased disproportionate gendered division of labour, affect women's reproductive health decisions at the household level. At the level of the health care system and government, poor health care provider attitudes, over medicalization of reproduction, application of unrealistic, unsustainable and culturally inappropriate local and foreign policies, poor infrastructural development and weak social protection policies all impact women's reproductive health decisions and access to care with profound negative implications for maternal wellbeing. I highlight not only typical issues, often taken-for-granted by many scientists, but also how these

issues have extreme negative impacts on women's wellbeing. This diverse perspective offers a better understanding of maternal health services provision and utilization that will challenge the status quo and prompt improvements in maternal health in Ghana and other Sub-Saharan African nations. I offer recommendations, as well as future research, for health care providers, policymakers, medical and nursing education and government in an effort to promote a better understanding of rural women's reproductive health and general wellbeing.

[Key words: Ghana, rural women, reproductive health care, challenging contexts, MDG 5]

Preface

Ethics approval for this research was granted by the University of British Columbia Okanagan Behavioural Research Ethics Board with certificate number H11-01443. Non-formal Ethics approval was also granted by the community leaders of the study area in Ghana.

Table of Contents

List of Tables

List of Figures

List of Illustrations

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Dedication

I dedicate this dissertation to my daughter Vi-diba Claire Akaribo Yakong for bringing more joy and meaning into my life and in loving memory of my nephew Kennedy Yemini Anaba who died in 2012, before this PhD was completed. Kennedy worked tirelessly to support me in diverse ways during my fieldwork in Ghana for this research and wanted to see his aunt become Dr. Yakong. Unfortunately, he died prematurely in a road traffic accident, while on his way to his university graduation ceremony to receive his degree, for which he worked very hard but never had the chance to hold his certificate. Even though he is gone, I can still feel his support, love and pride for my degree. This is for you Ken.

Chapter 1. Introduction

Background of study

This ethnographic study is a further exploration of my previous research (Yakong 2008), which focused on rural Ghanaian women's experiences of seeking reproductive health care. In this current research, I explored how social structures—especially kinship and gender relations, individual maternal practices, the social meaning of motherhood and cultural beliefs—influence women's reproductive health decisions and service utilization, and how these might impact on women's reproductive health choices. Cross-culturally, gendered relations, kinship and beliefs play a major role in peoples' reproductive health choices at both macro and micro levels, decisions that can have critical implications for maternal and child health. The overarching idea that has guided this enquiry is that, in the patriarchal society of northern Ghana, the construction of gender relations, the cultural belief system, the cultural meanings of motherhood and kinship create a context for utilization and/or non-utilization of maternal health services in rural areas of this region. These cultural considerations are not only contributing factors to women's uptake of reproductive health services, to high fertility rates and poor maternal health, they are also implicated in high maternal and infant mortality rates. In order to guide readers of this study, I take reproductive health to be:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (International Conference on Population and Development [ICPD] 1994).

> Globally, maternal health is a priority area and thus, one of the main targets of the

Millennium Development Goals ([MDG]; United Nations Millennium Declaration 2000).

Worldwide, on a daily basis, at least 1,600 women die from childbearing complications. The greater number (99 per cent) of these deaths occurs in countries with limited resources, with Asia and Sub-Saharan Africa accounting for the highest numbers of overall (Biritwum 2006; Guttlieb and Lindmark 2002; Mauldin 1994; UN MDGs Report 2012; WHO 2004, 2010). As of 2008, the World Health Organization (WHO) reported that sub-Saharan Africa records the highest "adult lifetime risk of maternal death (the probability that a 15-year-old female will die eventually from a maternal cause)" (2008:1). Currently, the UN MDGs 2012 Report on progress on maternal health is an indication that, in sub-Saharan African, the achievement of MDG 5, to improve maternal health, remains a mere dream. The World Bank and the International Monetary Fund global progress report on MDGs (2013) also clearly indicates that Sub-Saharan Africa is lagging behind other regions on most MDGs, including goal 5. This lack of progress is because nearly all aspects of maternal health still face several challenges based on the over medicalization of reproduction and the application of unrealistic, unsustainable and culturally inappropriate local and foreign policies.

In most resource poor nations, including Ghana, maternal health has been compromised due to several factors that hinder women's access to maternal health care services; yet, these factors often remain either unexplored or ignored. Ghana's maternal mortality ratio is still on the increase and remains as high as 350/100,000 live births (UN MDGs report 2012; Ghana Health Service [hereafter GHS] 2011 Report) despite integrated efforts to improve maternal health; this is particularly true in rural settings. According to the GHS 2011 Annual Report, the national institutional maternal mortality ratio has increased. In 2009, 169.9/100,000 women died; in 2010, 163.2/100,000 deaths occurred, a very slight decrease from the previous year, while in 2011, the numbers increased to 173.8/100,000, thus raising a number of questions that need to be explored.

On a yearly basis, an average of 4,000 Ghanaian women die from childbirth related conditions and over 200,000 end up with various kinds of disabilities as a result of pregnancy-related complications (Owusu 2013). On a regional basis, the Upper East Region—where much of this research was conducted—reported 124 actual institutional maternal deaths from 2007 to 2010; the Ashanti region in the same period recorded 466 deaths, while the Western region recorded 182 deaths. From 2008 to 2010 the Upper West region also recorded 47 deaths and from 2009 to 2011, the Volta region reported 224.(n1)These figures are among the highest in the world and the trend serves as a setback for the achievement of UN Millennium Goal 5 which aims at reducing maternal mortality ratios by 75 per cent by 2015. Further, these statistics exclude deaths that have occurred outside of health care institutions. As in other poor countries, the exclusion of maternal deaths occurring in the communities means that the maternal mortality ratio recorded in the country is underestimated. This omission strongly suggests that the figure is probably much higher; if all deaths related to maternal issues were properly documented, this would present an inclusive picture of the actual situation within countries having clear implications for maternal health. The vast majority of maternal deaths could be prevented if women's cultural views regarding their reproductive health decisions and options were respected and supported by health care systems at the macro level. Furthermore, there could also be much improved maternal health if national health care systems were to demonstrate a stronger commitment to service provision with a positive attitude towards women seeking health care, and to develop a collaborative or coordinated system of health services delivery inclusive of all stakeholders.

Although a multitude of factors influence women's reproductive care access, current research and policy discourse generally perceive the constrained autonomy of women in

challenging contexts nations as a major obstacle to utilization of reproductive health services, thus hindering improvements in women's reproductive health (Guang-zhen and Vijayan 2001; Mumtaz and Salway 2009). Challenging context is (n2) a term coined by Crichton (2013) to replace terms previously used to describe countries other than the west, which seemed to share similar perspectives on the status of women and the implications for women's general well-being. Crichton's "challenging context" also supports theoretical discussion related to the language used in describing "developing nations" and the way that many have problematized that language, as well as challenged the colonial views that shaped these parts of the world and its contemporary peoples. There is often an overemphasis on empowering women with decision-making skills directed towards making the necessary decisions to access reproductive health care (Hou and Ma 2012), while the cultural constraints that disempower women are overlooked. It is common for policy makers to pay attention to the provision of health facilities and/or strengthening the health care systems in limited resource countries (Archibong and Agan 2010; Hardee et al. 1999; Mutihir and Golit 2010). Cross-culturally, these concepts play a pivotal role in constructing and shaping women's social ways of being and their reproductive health choices and experiences.

Despite the fact that the above concepts directly and indirectly impact women's reproductive health, we know little about women's own perspectives and the ways in which they understand and make decisions about their reproductive health. For example, we need to ask women about the influences on their decision making; how they cope with the repercussions of their decisions, if any; what changes they think would help improve their reproductive and maternal health situation. Information regarding women's reproductive health, particularly in resource-poor nations, is interpreted through a western biomedical model and presented by

academics, health care experts, non-governmental organizations and policy makers. To what extent this information captures women's views about their reproductive choices; why, how and when they make the choices they make and their understandings, which guide their decisions, remain unexplored and, more significantly, neglected.

Interpretations of women's reproductive health in resource-poor nations are often guided by the dominant biomedical ideology that surrounds reproduction and by patriarchal policies, both of which neglect the sociocultural explanations determining women's reproductive choices. Very few ethnographic accounts exist of women's experiences from their perspective (Avotri and Walters 1999; Bawah et al. 1999; McPherson 1994). Rather, the focus has been to determine why women do not use maternal health care services; a point of view that blames women for personal neglect and irresponsibility. This is especially the case in birth control programs focused on limiting births to control population growth in countries with developing economies. The overall goal of my study is to stimulate further discourse, further research and the development of realistic new programs concerning reproductive health in resource poor countries. My findings can inform programs and policies that are more focused and, ultimately, more effective in improving the overall conditions that negatively affect maternal health in resource-poor nations. Furthermore, consideration of the findings of this study will also result in a reorientation of health care delivery approaches and of the education of health care providers to consider the implications of culture in maternal health. This consideration will serve as a call for a paradigm shift in national and international government, as well as sponsor approaches to improve services that support women's reproductive health care needs through the lens of culture and gender issues.

Another complication for maternal health care that is emerging in sub-Saharan Africa in general, and Ghana in particular, is the increase in cases of infertility, described by many researchers as a maternal and public health issue that affects millions of women (Donkor and Sandall 2009) (n3) thus, demands both medical and policy attention. Yet, this issue is notably missing in the reproductive health service reports in Ghana and other limited resource countries, and it is absent in the UN MDGs to address global maternal health, thus making it a neglected maternal health issue. Infertility issues seem to be highly politicised and as a result, all governments and health systems in developing economy countries appear determined to overlook its relevance. Though not an intended focus of this study, the issue of infertility emerged in the findings and is included in the discussion in subsequent chapters.

Factors influencing women's reproductive health decisions

Cross-culturally, researchers have examined a range of factors perceived to be influencing women's reproductive experiences and decisions. These factors include: (a) access to services, (b) socio-cultural factors, (c) kinship, (d) gender relations, (e) women's education, (f) quality of health services and poor health care financing strategies, and (g) poor implementation of health care policies (n4). For the purpose of this research, I explored how gender relations, kinship and belief systems influence women's reproductive experiences and decisions. These concepts are examined below in separate sections. In the first section, I provide a brief overview of the general health status of Ghanaians and the health care delivery system in Ghana.

The context of health status of Ghanaians: Health care delivery systems and access

Ghana is located in West Africa with a total land mass of 238,500 square kilometres. Currently, the total population is approximately 24.5 million people (Ghana 2010 Population and Housing Census). Ghana is divided into 10 administrative regions with a total of 216 district assemblies and municipalities (GhanaDistricts.com 2013). Accra serves as the capital of the nation. There are over 90 ethnic groups with a variety of distinct cultural identities, belief systems, customs, values and practices which impact various aspects of the lives of the people, including types of marriages systems, reproduction and family structure, construction of health, illness and healing practices, social interaction and gender construction attitudes (MOH, 1999). The country is governed by a democratically elected government and currently perceived by the international community as one of the best examples of countries in the continent of Africa that has embraced political democracy and respect for human rights and the rule of law. Also, Ghana is noted as an African country that uses AID dollars the best.

Health status of Ghanaians
Generally, the health status of Ghanaians is believed to be improving since the attainment of independence from the British in 1957 (MOH 1999). Although this perceived improvement in Ghanaians' health status places the country in an above average position in Africa, there are indications that Ghana is not performing as well as other African countries with similar development levels (MOH 1999). With regard to the maternal and reproductive health status of women, Ghana's maternal mortality rates are still among the highest in sub-Saharan Africa (UN MDGs Report 2012; WHO 2004, 2010), making it a challenge for the achievement of MDG-5. The slow improvement in the health of Ghanaians is attributed to poverty, low female literacy

rate, gender disparity and inequity, high population growth rate, poor nutrition, limited access to health care (especially among rural dwellers), poor attitudes of health care providers towards patients, cultural beliefs and practices, limited access to potable water and poor sanitation (MOH 1999; Heyen-Perschon 2005; Yakong 2008).

Organization of the Ghana health care system

The organization of the health care system in Ghana is based on a range of levels— national, regional, district, sub-district, and community (MOH 1999, 2003, 2006; Ghana Health Service 2002; 2003; Heyen-Perschon 2005). Health care service provision rests with both public and private sectors. The private sector contributes about 35% of health services delivery in Ghana, including the mission health services; yet, this sector receives very little to no support in terms of material, budgetary allocation and human resources from government to enhance effective service delivery (Ministry of Health 2003; Ghana News Agency 2013). The private sector is grouped into private allopathic and traditional health service providers (MOH 1999). The private allopathic service includes the private-for-profit and the private-not-for-profit providers. The private-for-profit providers may include doctors, nurses, midwives, medical assistants, pharmacists and laboratory technologists who operate health facilities on a private basis and provide a range of health services (mostly based in urban areas) that are quite expensive for the average citizen, especially women and children (MOH 1999, 2003). Other private-for-profit providers include chemical sellers, who sell basic drugs in privately owned smaller shops located in towns and rural areas, shops often staffed by untrained individuals (MOH 2003).

The private-not-for-profit providers are clinics and hospitals usually based in rural areas and operated by a variety of religious bodies under an organization known as Christian Health Association of Ghana (CHAG). The main focus of their work is directed toward the poorest of

8

the poor and with vulnerable groups, such as children, women, the elderly and those with HIV

and AIDS (Heyen-Perschon 2005). CHAG often provides outreach health care services, going

out to "far to reach areas," to work with the underserved population and covers about 20% of

antenatal services (MOH 2003). CHAG partly relies on the government sector for support for

both human resources and finances. More often than not, the competition for resources—

financial and human—can cause conflict between the Ghana Health Services system and CHAG,

which in turn makes it even more difficult for the mission health service system to achieve its set

goals of reaching out to those with limited access to services. Beyond limited resources as the

source of conflict is the perception held by the majority of Ghanaians that CHAG provides

quality services to their clients compared with the public sector. This anecdotal evidence creates

rivalry within the two systems, the consequences of which can affect Ghanaian recipients. Other

private health care providers include nongovernmental organizations (NGOs), professional

associations and various advocacy groups. The health care services of NGOs are mainly

preventive and health promoting services.

Traditional health providers/healers, such as traditional birth attendants (TBAs),

traditional male circumcisers (Wanzam), bonesetters, soothsayers and herbalists, are practitioners

of all kinds of traditional medicine (MOH 1999, 2006). In the rural areas of Ghana, similar to

other rural locations in Pakistan, India and Nigeria, most childbirths are attended by untrained, or

perceived to be untrained health care professionals, including TBAs (Abodunrin et. 2010;

Amoako, et al. 2009; Campana 2003; Shaikh and Hatcher 2005). Other traditional medicine

practitioners include spiritualists. Although TBAs offer important services to their communities,

they have been severely criticized by the biomedical health care system as bearing responsibility

for the high maternal mortality rates in the country and are often asked to stop their practice

(Kruske and Barclay 2004; see Yakong 2008). This traditional sector of the health care system has been neglected by government with regard to technical support and training that would upgrade their skills and allow them to meet the needs of the populace.

Access to basic health care

With regard to health care access, there is continual disparity between urban and rural areas, and especially within the three northern regions, the Volta, the Western and the southern part of Ghana. Despite the fact that the majority of Ghana's population lives in the rural areas (about 70 per cent), health care facilities, as well as qualified health care personnel such as doctors and nurses and other medical specialists, remain concentrated in urban areas (Adams et al. 2004; MOH 1999; 2006; Heyen-Perschon 2005; Kwansah et al. 2012). Although in Ghana, the human resource division of the Ghana health service is responsible for determining and distributing health care professionals to places where their services are most needed in the country, and who by requirement of their training which is partly sponsored by the taxpayers money, are required to honour such postings, in many cases, those professionals posted to work in the rural regions, refuse to honour their postings (Ghana News Agency 2013). This refusal to honour postings creates human resource gap between urban and rural settings and thus, contributes to the poor quality health care delivery to the rural population. Although lack of health care personnel is a factor that limits access, evidence also shows that even where such personnel is available, the sustained poor attitudes of health care providers towards patients, especially in rural settings, can play a crucial role in limiting access to the needed services (Alliance for Reproductive Health Rights 2013; Yakong et al. 2010). However, evidence also reveals that poor working conditions, heavy workloads, lack of technology, lack of a well-defined system of mentoring and limited

opportunities for professional advancement are just some of the reasons that lead to health care professionals' reluctance to work in rural settings (Kwansah et al. 2012). For those who work in rural settings, these limitations can also contribute to providers' poor attitudes towards patients. Similar evidence has been recorded in a study which sought urgent attention to improve the health of vulnerable populations, such as those living with HIV and AIDS in South Africa (Rawat 2012). Emerging as a global issue but mostly affecting resource-poor countries, the World Health Organization reported that 57 countries, mostly in Africa and Asia, are currently experiencing a serious health workforce crisis. This crisis presents severe negative implications for health indicators, particularly for the rural populace (WHO 2009). To ensure improvements in quality of life for citizens of affected countries, it is critical that governments show a sense of commitment and the political will to make the necessary pro-active decisions and changes to scale up the required human resources needed to provide quality care.

In Ghana, despite the fact that the majority of the rural population has more access to traditional health services, and often prefers traditional health care providers to the modern health care, TBAs are particularly reluctant to provide maternal health services (MOH 1999; Yakong 2008). Several reasons are attributed to this reluctance. First, there is a lack of recognition and respect for their work by the dominant health care system, which blames them for inappropriate referral of patients and holds them responsible for high maternal mortality rates. Second, they lack specific remuneration for their services and resources to support them in their work. And, finally, their work is restricted as they are given unrealistic directives and are used as mere messengers by the dominant health care system (Izugbara et al. 2009; Roost et al. 2004; Yakong 2008). Studies on the impact of TBAs' work on maternal health in challenging contexts such as the Upper East region suggest that their services contributed insignificantly

towards the achievement of MDG-5 despite training offered them (Roost 2004; Smith et al. 2000). Although this finding is contested (Izugbara 2009), the conclusion is that investing in training programs to increase TBAs knowledge in reproductive health services is a mere waste of financial resources (Smith et al. 2000; Roost 2004). However, over the past years this TBA training program has been criticised for its use of culturally inappropriate and complicated teaching materials, mostly western, urban-based style of teaching and learning; rural, non-literate older women may find it difficult to comprehend what is being taught. Research has also claimed that the training failed to incorporate aspects of TBAs' traditional knowledge but rather, focused on biomedical authoritative knowledge that was inappropriate for this group of healers (Mathole et al. 2005). These reasons, and the continuous unrealistic critique of TBAs' practice decreases their morale to offer continued services to women in need, and suggests why this sector within the health care system is still underdeveloped and its practice is somewhat restricted, as well as undermined, by the dominant biomedical health care system (Heyen-Perschon 2005; Yakong 2008).

As a result of the disparity in the health care system distribution discussed above, there is a gap in general health outcomes of Ghanaians, and most significantly, the health outcomes of women and children (MOH 1999; 2006; Heyen-Perschon 2005). Maternal and infant mortality rates continue to increase, especially in rural areas, and childhood malnutrition continues to manifest in the three northern regions, thus contributing to the high infant and child mortality rates. Heyen-Perschon (2005) claim that boys are much more likely to suffer from malnutrition than girls, due to food insecurity common in the northern part of Ghana, contrary to other findings in Ethiopia, which suggest girls are much more likely to be affected than boys (Hadley et al. 2008); and, approximately, 40 children in 100 are malnourished (Ashong and Smith 2001;

Campana 2003; GMOH 1999; 2006; Heyen-Perschon 2005). However, this finding that boys are more prone than girls to malnutrition in Ghana appears inconclusive because the data was not explanatory of the factors contributing to such a finding.

Another health concern in this region is the ongoing challenge of malaria. Despite a concerted effort for its elimination, malaria continues to be a major public health problem in Africa. Globally, 250 million people become infected with the malaria parasite annually and approximately one million die, with 91 per cent of deaths occurring in Africa; Ghana is no exception (Agusto et al. 2013; WHO 2011). Malaria is among the top 10 diseases in Ghana that account for the greater percentage of causes of morbidity and mortality affecting all age groups, but it is most fatal among children less than 5 years of age and pregnant women (Ghana Health Service annual report 2011; Heyen-Perschon 2005; MOH 2006). Currently, the use of mosquito nets is the most effective and recommended strategy in malaria prevention and control in most limited resource nations (WHO 2011). A recent study suggests that the proper use of insecticide mosquito nets could reduce malaria incidence by 50 per cent and it could even be eliminated if 75 per cent of the population were to use treated bed-nets (Agusto et al. 2013:58). However, the majority of the population does not have access to mosquito nets or the insecticide for re-dipping the nets, due to the cost. Another factor affecting the continued presence of malaria is a lack of understanding of the proper usage of the bed nets (see figure 1. below). For its desired outcome, a clear understanding of the use and maintenance of the net is crucial; hot weather conditions also makes it uncomfortable for users and can reduce the effectiveness of nets as a result.

Figure 1. Two babies sleeping in a mosquito net in a rural Ghanaian home.

According to the WHO (2013:viii), approximately 1.24 million deaths occur annually worldwide due to road traffic accidents. Injuries from road traffic accidents are the leading cause of death among young people aged 15-29 years and the eighth leading cause of death globally. The African region accounts for the majority of these deaths and Ghana, again, is no exception. The above reports show that the highest road traffic fatality rates were in middle-income countries, particularly the African Region; these calamities can be prevented if road safety laws were properly implemented. On a daily basis, apart from the disease burden, the majority of Ghanaians, particularly ordinary Ghanaians, lose their lives to equally preventable road traffic accidents, resulting from a lack of road and public safety laws and weakened public systems responsible for implementing such laws. This lack of implementation is often due to corruption in the public sector, most especially among politicians, the judicial services and the police force. Corruption in Ghana has become entrenched over the past decades as it has in other developing

nations (Spangler 2011). Apart from road traffic issues, corruption in general is a cultural, as well as a gender issue, because it tends to overlook crucial factors, especially those issues affecting women and children in diverse ways, the consequences of which have serious negative implications for families and the future development of the country. For example, health care programs aimed at improving maternal health care access—such as user fee exemptions for women accessing labour and delivery services at health care facilities—failed to achieve its purpose as a result of corruptive practices at both the macro and micro levels of government and health care provider level (Witter et al. 2009). The result of this practice affects women compared to men and the consequences are irreversible.

The economy

Although Ghana is well-endowed with natural and economic resources, these resources are unevenly distributed, with the three northern regions being the most disadvantaged. Evidence reveals that poverty is on the increase in these northern areas when compared with most parts of the southern sector of the country (Ashong and Smith 2001; Heyen-Perschon 2005; Whitehead 2006). This increase in the poverty gap is compounded by the nature of harsh weather conditions that impact agricultural activities and contribute to recurrent outbreaks of communicable diseases, such as cerebrospinal meningitis, which periodically occurs in this part of the country, in a severe form (Upper East Regional Health Directorate 2010 Annual Report), the lack of access to quality health care and sustained sociocultural structures that foster gender inequalities. Whitehead (2006) argues that this economic disparity between the north and south has a history going back to both the pre-colonial and colonial eras, as well as post-colonial history and remains a current political debate.

Gender relations: The influence on women's reproductive decisions

According to Blanc (2001:190) the concept of gender refers to "the expectations and norms shared within a society about appropriate male and female behaviour, characteristics, and roles" (also see Gupta 2000). In this study, I draw upon this definition. The structure of gendered relations or, to put it more bluntly, power relations between and men and women, is often determined by societies in their capacity as custodians of culture. Although the nature of the expectations and roles are shaped by place, time and belief system, including religion, in resource poor countries such structures can have both positive and negative influences on women's reproductive health experiences and decisions (Bawah et al. 1999; Mumtaz and Salway 2009; Speizer et al. 2005). Social research on the use of maternal health services, particularly birth control, demonstrates that the extreme gender disparity characteristic of African cultures has a negative influence on women's reproductive health decisions (Adongo et al. 1997; Bank 1994; Bawah et al. 1999; Orisaremi and Alubo 2012). In sub-Saharan Africa, studies show that men tend to have a higher desire for large families than do women (Bawah et al. 1999; Blanc 2001; Phillips et al. 2012). In Ghana, for example, more women want to adopt modern birth control methods than do their husbands, but these women are constrained by the reluctance of their husbands and their kin to accept this method of family planning (Bawah et al. 1999; Yakong et al. 2010). In some remote northern Ghana communities, compelling evidence reveals that rural women's reproductive roles and responsibilities are not only determined by their husbands, but also by extended family members, leaving women with limited decision-making authority and less control over their reproductive rights (Phillips et al. 2012). This lack of autonomy can be attributed to the traditional customs of bride price (n5) (Tertilt 2002:5), whereby a woman is usually viewed as property of her husband's family, acquired for the

16

purposes of reproducing the lineage to sustain the family name (see Oriaremi and Alubo 2012; Phillips et al. 2012; Yakong 2008). Bride price is a form of marriage rite, whereby the family of the groom pays the family of the bride with culturally appropriate items—usually animals or money—as compensation for marrying a daughter (Tertilt 2002). In such situations, a woman's ability to make independent decisions regarding her reproductive choices is limited and not without sanctions by her affines if suspected that she is using birth control.

As well, poor socio-economic conditions prevailing in most parts of Africa coupled with traditional practices where women have limited opportunities to own property and wealth can complicate women's autonomy and ability to make decisions on their reproductive health choices. Most decisions around reproductive health in resource-poor countries involve financial constraints dues to a lack of viable health insurance systems. For example, in Ghana the only existing health insurance system is over-politicized and near collapse and most poor families are unable to register due to relatively high premiums (Dixon 2011). User fee systems, common in most challenging contexts, like Ghana, where patients pay out of pocket for medical care, negatively affect most women's ability to pay for reproductive health care (Dzakpasu et al. 2013; Hercot et al. 2011; Nanda 2002; Russell 1996; Witter et. al. 2007). A national policy established a few years ago to exempt women from paying for prenatal, labour and delivery services in health care institutions, has currently been replaced by a national health insurance scheme (Witter et al. 2009). These health care financing policies have been systematically influenced by corruptive practices at both macro and micro levels. At the micro level health care providers illegally charge a fee for services covered by exemptions and this, in turn, impedes women's ability to access care. Women who rely on their husbands for financial support are unable to make decisions around their reproductive health based on their personal choices. As a result,

financial dependencies further buttress the already existing gender stratification that constrains women's power to make informed decisions. Dependency on affines, combined with the payment of bride price, since lineages pull all their resources together to make the payment, is often viewed as economic gain for the bride's family—most especially her patriline, because mothers have limited voice in such decisions—and turns a woman into a purchased property that exists to fulfil affinal procreation goals (Phillips 2012; also see Yakong 2008). In societies where dominance of patriarchal and unequal gender relations exists, women's ability to take control over their reproductive rights continues to be a major challenge and impediment to the achievement of equal rights and the attainment of the MDG-5.

The relationship between kinship and reproduction

According to Linda Stone (2006:5), kinship is "defined as relationships between persons based on descent or marriage," while patriarchy refers to the "system of gender inequalities, which empowers men and oppresses women" (Boakye 2009:1635). Similarly, Hunnicutt (2009) states that patriarchy "means social arrangements that privilege males, where men as a group dominate women as a group, both structurally and ideologically" (557). These concepts play a major role in determining women's sexuality and fertility decisions cross-culturally. (n6)

Kinship informs social organization and varies from one society to another (Maynes et al. 1996; Nukunya 2004; Stone 2006). There are stratified social expectations, obligations and roles for members of every kin group. In this context, a major expectation for men and women includes marriage and childbearing (Gipson and Hindin 2007). In most challenging contexts, the influence of kinship cannot be ignored because of its role in reproductive issues; for example, kinship relations can have negative implications for both fertile and infertile couples. (n7) In societies such as those in northern Ghana, where kinship is traced through the patriline—

societies in which descent, hence group membership and rights to group resources is traced through the male line—childbearing is an obligation of the couple and a primary reason for initiating marriage in the first place. For example, Hollos et al. (2009) demonstrated that, in two rural communities in Nigeria, infertile women faced severe social consequences in communities where kinship is patrilineal. In Amakiri, a patrilineal community in Nigeria, infertile women are unable to achieve social womanhood and, consequently, would have to relocate to different environments or return to their natal homes where they might be accepted or not. Globally, about 44 per cent of cultures in the world are patrilineal, with the majority found in China, India, the Middle East and Africa, including Ghana (Stone 2006).

Kinship plays an important role in women's reproductive health decisions in many different ways. In some patriarchal societies, an infertile man reserves the cultural right to relinquish his sexual rights to his wife to another man, with whom she bears children to represent her husband's lineage/name. Ghana falls within such societies (Yebei 2000). The woman, in this case, does not form part of the decision making and loses the right to control her own sexuality should her husband and his kinsmen decide to give her out to bear children for the family/lineage. In some African countries, for example, a woman's access to a husband's wealth is also through her ability to bear children, especially a male child (Feldman-Savelsberg 1999). Similar to Ghana, in patrilineal communities in Nigeria, a woman loses her right to her husband's residence unless she has a son (Hollos et al. 2009), thus signifying a male-centred dimension to women's reproductive health decisions. It is evident from all dimensions of social life in these locations that kinship and patriarchy influence women's fertility decisions and must be critically examined and factored into social and health policy to promote women's rights and well-being.

Belief and cultural values: Personal and imposed

Cultural beliefs, values and practices and knowledge of disease also shape health care seeking behaviours and service utilization, irrespective of sex, age, gender, socioeconomic status and educational level (Adongo et al.1998; MOH 1999; Shaikh and Hatcher 2005; Shoveller et al. 2007; Yakong 2008). In rural Ghana, for example, less than 20 per cent of women associate the cause of malaria with the mosquito. During ill health, approximately 70 per cent of the population consult diviners to identify the cause and to suggest treatment; some particular illnesses are believed to be restricted to traditional healing practices alone or caused by particular spirits and ancestors for wrong doing (Atindanbila and Thompson 2011; MOH 1999). Studies in other cultures, such as in Cameroon, reveal that causes of infertility, for example, are associated with ancestral spirits and witchcraft and, therefore, healing/treatment is determined by traditional methods (Feldman-Savelsberg 2002).

In most challenging contexts, it is culturally appropriate that family plays a major role in an individual's health care decision making and seeking, which has a significant impact on health care service utilization (Grewel et al. 2005; Jansen 2006; Shaikh and Hatcher 2005; Yakong 2008). Thus, the choice of health care provider is based on an individual's beliefs and values around what contributes to ill health and healing, whilst at the same time, choice of provider and service utilization is not decided singlehandedly, but influenced by a complex multitude of factors.

In Sub-Saharan Africa, traditional religious beliefs and practices are embedded in lineage systems that impact the structure of society, which in turn influences health decisions (Adongo et al. 1998; Stone 2006). Marriage customs, the societal value of having large families and strong extended family ties regulate reproduction (Feldman-Savelsberg 2002; Gipson and Hindin 2007;

Nazzar et al. 1995). These beliefs and values consequently influence the level of acceptance of

contraception in most African cultures, including Ghana, creating higher fertility rates (Campana

2003; Dodoo and Landewijk 1996; MOH 1999; 2006; Talensi-Nabdam District Health

Administration 2007) and negative health implications for women. In large part, the low

acceptance of contraception can be attributed to women's lack of autonomy over their fertility

regulation as a result of traditional beliefs, values and practices around childbearing. The

sociocultural demand for bearing many children endangers women's health in general and

reproductive health in particular (Shaikh and Hatcher 2005). Similar to Ghana, in Ethiopia, the

cultural expectation that sexual issues should not be discussed publicly among women,

contributes to preventing women from participating in health programs such as HIV prevention,

thereby limiting their knowledge of such health issues and influencing their reproductive health

care seeking behaviours (Cummings et al. 2006).

The social values and beliefs that place emphasis on having large families influence

health service utilization for both men and women irrespective of the socioeconomic

implications of large families (Gyimah 2009). In rural Ghana, birth control use by women is

viewed as a violation of the woman's cultural obligation to bear many children for her husband's

lineage and creates disharmony in marriage relationships between husbands and their kin (Bawah

et al. 1999). However, in most West African countries, births are spaced by women's observance

of prolonged rules of postpartum sexual abstinence and the utilization of modern contraception is

considered either culturally irrelevant or inappropriate (Bledsoe et al. 1994; Lesthaeghe 1989;

Pearce 1995). Within this context, women who nurse their babies are expected to stay with their

mothers-in-law and have no sexual contact with their husbands until their child is about two to

three years old. Men in this case, are allowed to have extra marital sexual relationships, while their wives must abstain to prevent an unplanned pregnancy.

Cross-cultural studies in most challenging contexts reveal the high value placed on the male child, which contributes to a lack of support for the use of health care services for birth control (Adongo et al. 1997; Liamputtong 2007; Pearce 1995). Gyimah (2009) argues that polygynous marriage, wherein a husband has more than one wife at the same time (Zeitzen 2008), which characterizes most marriage structures in sub-Saharan Africa, also influences health care service utilization and health seeking behaviour. This is due, in part, to the economic challenges facing such families, challenges that consequently impact child survival, particularly in Ghana. Thus, cultural beliefs and values, social practice and family structure shape people's choice of service provider, service utilization and health care seeking behaviours.

Religious practices, personal and imposed, traditional and contemporary, also influence women's reproductive health decisions and thus play a pivotal role in their access to some reproductive health services, including birth control. In Ghana, as in other sub-Saharan African countries such as Kenya, some health care providers act as gate keepers to restrict women's access to birth control by imposing their own religious beliefs on the women (Lema 2012; Stanback and Twum-Baah 2001). In studies in both Ghana and Kenya respectively, women accessing reproductive health care, particularly for birth control and other related services, are denied such services based on the beliefs of the health care providers who view such requests as immoral. In the case of birth control, providers' consider women's age and marital status and base decisions on such identifiers to provide service. Though some health care providers view this practice as an ethical dilemma and a violation of their code of ethics, what holds is the negative implications such decisions have on the reproductive health outcome of women seeking

such care. Some institutions, such as the mission health care institutions, do not offer birth

control to women who request it, since to do so is against their church's particular doctrine on

birth control. For example, during my interview with Christiana, a midwife who worked for a

mission health facility in northern Ghana, she revealed that even though her work as a midwife

includes provision of birth control methods and she is required by the Ghana Health Services

policy to do so, she is currently working for the mission health service and has to abide by their

rules. As a result, she is not able to provide for women who request for birth control. This

midwife felt uncomfortable about her inability to provide services that she felt could help women

realize their reproductive health goals. She lamented, "I need my job to earn income; so, I have

to do what they say or else lose my job. But what I do is, I try to redirect women to other places

where they can find what they want." Although the women may not be part of the particular

church's faith, or the faith of the individual care providers, they are obliged to comply with the

service providers' religious beliefs that reject the use of birth control. In this way, the religious

values of the care providers can also contribute to the unmet need of women's reproductive

health decisions. However, whatever the case may be, the end result is that women suffer the

consequences of unmet reproductive health care needs while, at the same time, receive blame for

non-use of such services, an issue they have no absolute control over. As revealed in the

background to this study, there are many factors that can impact the maternal health choices for

women in rural settings. These factors have become a concern and must be investigated if Ghana

and similar countries with similar challenges are to meet the MDG goals of improving maternal

health. In the next section I present an outline of my dissertation.

Dissertation outline

My dissertation is divided into seven chapters. In this, chapter one, I have drawn from existing literature to present a background for my study, the context of the organization of the Ghana Health Care System and a brief overview of the current health status of Ghanaians. In chapter two, I present my research journey—the study setting, theoretical framework, research methodology and description of the research participants. In chapter three, I discuss the cultural and social context of female roles and the implications of these roles for women's health and well-being. Chapter four focuses on the invisible role of rural women as mothers, wives and producers within the context of gender and labour and the consequences of these invisibilities on women's reproductive and social lives. In chapter five, I analyze data on factors influencing maternal health care access and service delivery from the perspectives of rural women and midwives. In chapter six, I explore infertility as a woman's health and gender issue and its invisibility within the health care system in Ghana and around sub-Saharan Africa. Finally, chapter seven draws conclusions and reflects on the study and makes recommendations for stakeholders in reproductive health care in Ghana and around the globe.

Chapter 2: The study in context: the study setting, research methodology and participants

My motivation for this research

Before I began graduate studies, I worked as a nurse for a number of years primarily with women and children in rural settings in northern Ghana. During my years of work, I became bothered by the precarious nature of women and children's well-being. I was often troubled by the extremely challenging contexts within which women lived their lives, especially the numerous frustrations they faced while accessing care, usually from their husbands. It did not matter whether these women were accessing maternal health care for themselves or general medical care for their children, they faced challenges. I am familiar with the nature of patriarchal society and the interplay of gender dynamics in the local communities and families in Ghana, specifically in northern Ghana, where the male dominant culture frequently plays out with extremely negative consequences for women and children. I am also quite aware of the gender relational debates and how these debates might impact or challenge women's decisions on a daily basis on a number of issues. These challenges ranged from the lack of freedom to make decisions around choosing life partners, to decisions to access health care, to lack of resources to pay for medical bills as well as provide food for nourishment. Each day, I finished my daily shift at the hospital with more questions than answers and worried about what I could do to help women gain a better understanding of their experiences in their day-to-day lives and in their role as mothers, wives, sisters and providers for their families. On a daily basis, some of the health care providers, who were in a much better social position compared to these women, either ignored or found it difficult to understand women's situations and, consequently, tended to conclude that their clients were being irresponsible in their family life.

Ghana's social welfare system is intended to protect the vulnerable in society, such as women and children. In Ghana, as elsewhere, this social welfare system is managed by males and their masculine and cultural interpretation of women's lives and place. In Ghana, these attitudes, combined with endemic corruption, mean that the social welfare system in place offers little help for women. Through my role as a nurse, I reached out a few times to the social welfare system to find help for women and their children who were in trouble. Surprisingly, however, in most cases women resisted such help because it was perceived to be culturally inappropriate for women to challenge their husbands' views on any grounds. This personal narrative from my observation and experience as a nurse had negative implications for women's physical, emotional and social well-being and needed to be explored at a much deeper level from women's perspectives. Thus, when I had the opportunity to participate in interdisciplinary graduate studies, my interest in these issues grew and turned to engaging in research that focuses on the intersections of gender relations, kinship and cultural beliefs and women's reproductive health. During this time, I acquainted myself with the cross-cultural literature on issues of gender and reproductive health, with a focus on nations located within challenging contexts nations. As I became more aware of the gender-based issues mostly affecting women, simply because of their gender, I felt challenged to explore Ghanaian women's perspectives on a number of issues including their reproductive health decisions and choices. The above personal narrative has been the motivation for this research project.

Study setting: The Talensi-Nabdam District of Ghana

The Talensi-Nabdam District (hereafter TND) is located in the Upper East Region of Northern Ghana in West Africa with a District capital in Tongo (see Illustration 1. below: Sketch map of the Upper East Region, also shows the study area). This fairly new District is entirely rural and

26

was carved from the Bolgatanga District Assembly in 2004. The District is bordered to the north by the Bolgatanga District, south by the West and East Mamprusi Districts, Kassena-Nanakana District to the west and the Bawku West District to the east. The TND has a total land area of 912 square kilometers (TND Assembly Annual Action Plan, 2010). The physical environment is Savannah grassland. The majority of houses in the rural areas are made from mud and thatch, with poor water and sanitation systems. A large proportion of the total population have no access to toilet facilities and, thus, indiscriminate defecation in the landfills is common and can be a public health hazard. The main sources of water include boreholes, hand-dug wells and man-made dams. The District's population is comprised of two distinct ethno-linguistic groups, of which slightly more than half are Talene speakers and the remaining are mainly Nabit speakers. Although similar, the dialects do differ slightly from one another. Despite their dual-linguistic identity, the Talensi-Nabdams are, in most respects, a homogenous group with a unique cultural heritage entirely different from the rest of the country (Yakong 2008). This District is inhabited by approximately 100,879 people with females out numbering males, resulting in a gender ratio of 50.4 per cent: 49.6 per cent. Historically, gendered roles and relations in this District are visibly segregated and kinship is based on patrilineality (n8). Although the practice is currently diminishing, marriages can often be polygynous with a strong emphasis on childbearing and preference for male children. Child marriages are also common, with poor families often lured into marrying off their young daughters for economic gains. Indigenous African religious practice dominates in this District, followed by Christianity and Islam, as well as a few inhabitants who call themselves "free thinkers." Although there are several poorly equipped educational facilities with limited numbers of qualified teachers in the District, in general, literacy rates are very low, especially among women and girls. In the three northern regions,

including this study area, 71 per cent of women compared to 59 per cent of men have no primary education and, in addition, literacy rates in this part of the country are below the national average, with women as the most affected (Food and Agricultural Organization 2012; Ghana demographic and health survey 2008).
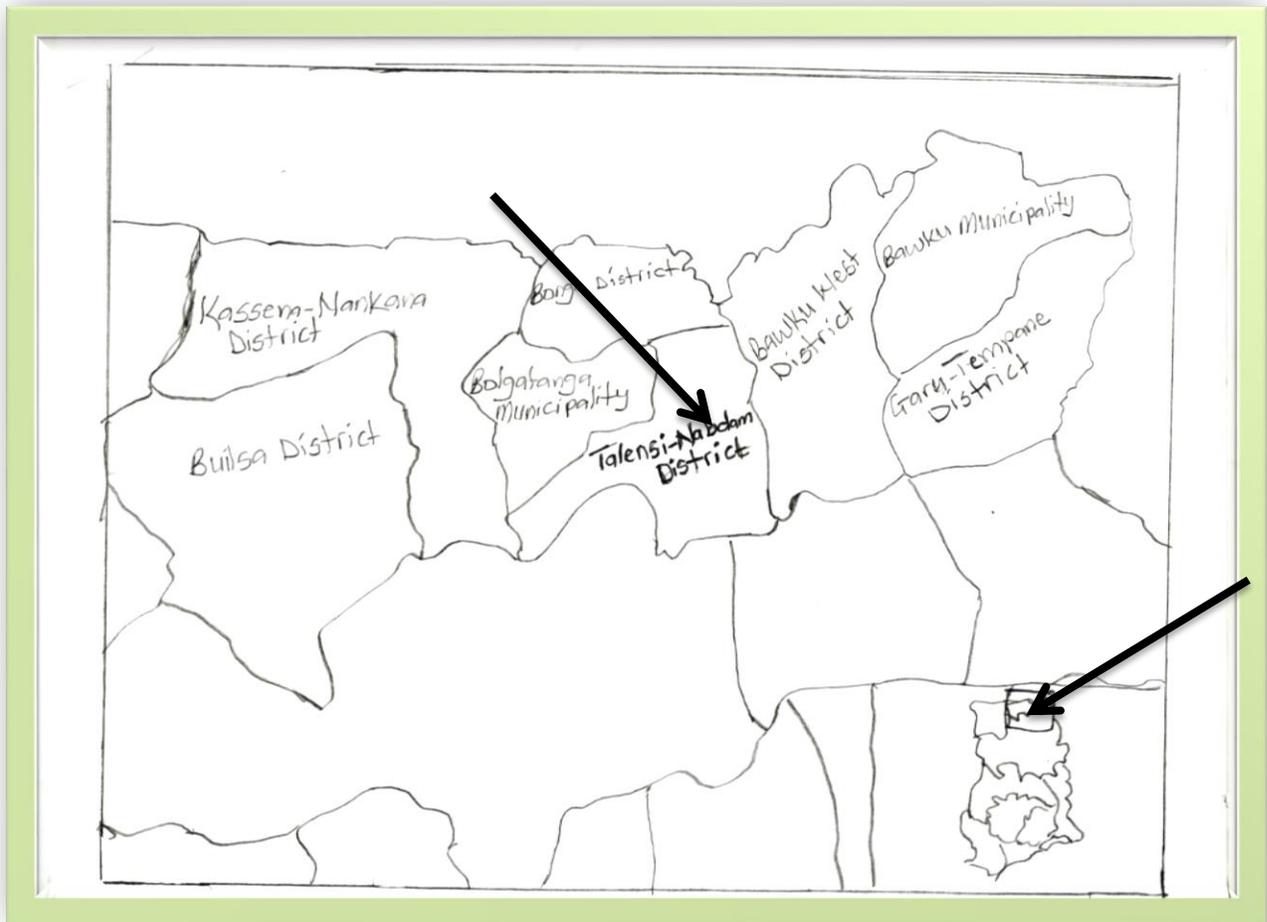
Illustration 1. Sketch map of Upper East Region of Ghana. Arrow 1 below shows the location of the Upper East Region within the Map of Ghana. Arrow 2 above indicates the Talensi-Nabdam District and study area. © Vida Nyagre Yakong, 2013.

Earning a living

Subsistence agriculture represents the main source of nutrition of the people in the District. Approximately 90 per cent of the District's population relies on rainfall to grow their food crops (TND Assembly Annual Action Plan 2010). Main food crops cultivated in this area include rice, maize, cowpea, sorghum, millet, groundnuts and beans. Vegetables of various kinds, including tomatoes, are also grown, mostly in smaller quantities for household consumption. The erratic rainfall, limited to the June to October period, combined with a lack of access to a reliable irrigation system for dry season farming, restricts farming to a single growing season. The inadequate rainfall and frequent drought leads to poor harvests and, subsequently, food crises and severe poverty, which can impact people's health, most especially, women and children who have limited access to resources. Animal husbandry, including cattle, goats, sheep, donkeys, pigs and poultry is a common practice; however, limited sources of water due to poor rains also makes it difficult for animal rearing in the dry season. Many farmers also lose their animals to diseases due to the limited, ineffective and high cost of veterinary health services in the area.

Although basic agriculture is the main source of subsistence for the people, women have limited access to farmlands. Culturally, only men own real property (Runger 2006); land and its uses are passed down the patriline. Because women marry out, they have no access to paternal farmland which is passed to their brothers; in-marrying women have no access to their husband's land for similar reasons and merely hold paternal land in trust for their male children to inherit. It is a necessity for women to place more value on bearing a male child, since her male children will be her connection to her husband's land; thus her sons provide her security in her later years. The socio-cultural structures defined by customary law with regard to women's participation in acquisition of property, including farmland after marriage (Duncan and Brants 2004), further

complicate women's full participation in agricultural activities and, consequently, their free access to and control of the food produced from their husband's farms. The consequences of the above factors are gender-based, as well as childhood poverty, which have serious implications for maternal and child health. Thus, kinship rules and gender concepts contribute to both child and maternal morbidity and mortality rates in this part of the region.

Inadequate road networks contribute to poor access to health care and socio-economic improvements in the District. Currently, the District is linked to the rest of the region by one unsurfaced gravel road. A privately owned commercial transportation system operates infrequently in the District, mostly on market days (usually 3 days per week). The road is frequently flooded during the rainy season, often cutting off some villages from linking up to the entire District (see figure 2. below). The most reliable means of transport for most inhabitants are motorbikes, bicycles and donkey carts. There is only one ambulance available for use by all the District public health facilities, covering a total area of 912 square kilometers with over 100,000 people. However, this ambulance is not easily accessible by patients because of high cost and physical access due to the poor road network. The lack of a reliable transport system makes it difficult for patients who live far from clinics to access services in times of need, an especially serious concern for women in labour. Furthermore, the poor road network can also affect those who engage in small scale business ventures by making it difficult to properly transact their businesses, particularly during the rainy season, which in turn, complicates their opportunity to improve their economic conditions.

Figure 2. Vida Yakong on motorbike during fieldwork near Tongo, the district capital of Talensi-Nabdam. Photo depicts nature of roads linking communities within the district Photo credit: Cynthia Anaba, Research Assistant, August 2007.

The health sector

The health sector in the Talensi-Nabdam District is operated by both public and private sectors, which include non-governmental organizations, missions and traditional practitioners. Officially, there are eighteen health facilities in total, comprised of three health centers, six clinics and nine Community Based Planning and Services [CHPS] zones (Upper East Regional Health Directorate 2010 Annual Report). All of these health facilities provide general and reproductive health services to women, which include prenatal, labour and delivery, postnatal and birth control methods, with the exception of the mission clinic which does not provide birth control services due to their doctrine around modern birth control technology. Trained midwives and

community health nurses are responsible for providing reproductive health services, but are constrained by a lack of adequate medical supplies and equipment required to provide quality care. Health conditions beyond the management of District level staff are referred to the regional hospital in Bolgatanga, the capital of the upper east region. All clinics, in principle, provide 24-hour medical services. However, most of the health facilities are inadequately staffed, which impacts clinic hours of operation and provision of specific services.

In addition to the formal sector, traditional practitioners include 60 traditional birth attendants (TBAs) and 55 traditional healers at various locations throughout the District. Although, in principle, TBAs are not permitted by the Ghana Health Service to attend women in labour because they are considered non-skilled service providers, for various reasons they still remain labouring women's first choice for delivering their babies (Yakong et al. 2010). A TBA is defined by World Health Organization [WHO] as "a person who assists the mother during childbirth and who initially acquired her skills through delivering babies herself or through apprenticeship to other TBAs" (WHO 1992:4). The role of the TBA goes beyond conducting deliveries. According to the African medical and research foundation [AMREF] the TBA also:

> Helps with initiating breastfeeding; providing health education on sexually transmitted illnesses (STIs), reproductive health and nutrition; visiting mothers during and shortly following delivery to check for and educate them on the associated danger signs; and accompanying referrals to the health facilities for complicated deliveries (n.d.:1).

Similar to other challenging contexts (Islam and Malik 2001), TBAs account for about 50 per cent of total deliveries in this District. In addition, TBAs provide counselling for couples facing marital problems. Women TBAs, and sometimes men too, are usually in their middle age (Twumasi 1988). Twumasi claims that TBAs can also acquire their skills through spirit

possession. The above claim complicates how the biomedical system and, for that matter, science based-practitioners view this group of practitioners, often labelling them as superstitious.

Traditional healers, who may include herbalists, spiritualists, diviners and faith healers acquire their skills and powers through training from kinsmen, ancestors, lesser gods, the Supernatural Being and oral tradition (Atindanbila and Thompson 2011; Twumasi 1988). These healers and the TBAs, who sometimes fall into this traditional category, are the frontline health service providers in rural areas and the most utilized due to proximity and cultural beliefs around concepts of health and healing (Atindanbila and Thompson 2011). According to the WHO (2003), about 80 per cent of the rural African population accesses the services of these healers compared to modern health care services. What remains unclear and requires further enquiry is the idea that, if an organization like the WHO is very clear on the important services that this group of providers offer to their citizens, what then is the basis for making such impractical changes to how TBAs should practice?

Also available are thirteen licensed chemical stores, which provide services and, due to proximity, cost and self-medication issues, they are normally the first choice when people have health challenges. Chemical sellers are individuals who may have basic knowledge in pharmacy or no training at all on appropriate dispensing of medicines; they own private drugs stores and dispense retail, over the counter drugs to patients. They are somewhat regulated by the pharmacy council of Ghana. Basic and first aid services are also provided by 170 Ghana Health Service trained community-based surveillance volunteers distributed throughout the District. These surveillance volunteers are community members who are selected in collaboration with their various communities and the Ghana health service. They are trained in basic skills to identify diseases, register births and deaths related to pregnancies and birthing, carry out social

mobilization (social mobilization refers to the organization of community members and events directed towards issues related to health and all other development activities at the community level) and report unusual events in their various communities (Kyei-Faried et. al. 2006; Maes and Zimicki 2000).

According to the Talensi-Nabdam District Health Directorate (2010), statistically maternal health has improved over the past few years. Between 2008 and 2010, the District recorded an increase in numbers of women accessing prenatal, delivery and postnatal care services. Only one institutional maternal death was recorded in the last four years compared to other Districts in the region (Upper East Regional Health Directorate 2010 Annual report). However, despite the improvement, the following continue to contribute to the low utilization of maternal health services by women: high poverty levels, proximity, illiteracy, traditional beliefs, customs and practices, attitudes of health care providers towards patients and, as well, weakly supported reproductive health policies and malpractices (TND Assembly Annual Action Plan, 2005; Yakong et. al. 2010).

My specific study setting included six villages mainly in the Nabdam part of the District encompassing a population of approximately 29,580 people (TND Assembly Annual Action Plan 2010). Health facilities serving the study area include one health center, two Community-Based Planning and Services [CHPS] zones, three clinics (one private clinic and 1 mission clinics). All of these health facilities provide various types of reproductive health services in the area. At the time of my research, all health facilities were accredited by the national health insurance scheme and the few patients who could afford to pay insurance premiums had ready access to health services. Other service providers include 41 traditional healers, 34 TBAs, 56 CBSVs and two

licensed chemical sellers. Research interviews were done in four of the health facilities with the exception of traditional healers and chemical sellers.

Purpose of this study

The purpose of this study was to understand how Ghanaian cultural traditions, concepts of gender, moral behaviours and kinship intersect to influence rural women's reproductive health care decisions, specifically in the Talensi-Nabdam District (TND) of Northern Ghana. The research questions guiding this study explored: (1) the relationship between women's reproductive health care decision making and the configuration of gendered relations in rural Ghana; (2) the roles of kinship in women's reproductive health decision making; and (3) how gendered relations and kinship influences contribute to both maternal health and service utilization in rural settings. I used ethnographic research methods to conduct this study.

Theoretical framework: General overview

The main objective of this study has been to understand the influence of gendered relations, Ghanaian traditions and kinship on reproductive health decisions, and the implications for maternal health and family well-being from the perspectives of rural Ghanaian women. An improved understanding would produce strong evidence to stimulate discussions around rural women's reproductive health in Ghana and sub-Saharan Africa in general, in order to influence and improve maternal health programming and reproductive health policy reform. The findings would also contribute to increasing awareness for the need to develop a gender-sensitive framework for medical and nursing education and practice, and to serve as a tool for advocacy activities for women's rights and well-being. With my research objective in mind, I located the study within the philosophical traditions of critical ethnography and critical medical

anthropology. Critical ethnography not only carries out research for the sake of describing a group of people, a culture or for creating knowledge but also provides a forum for paradigm shift and opens up opportunities to foster advocacy and change for members of society who are most at risk of the implications of inequity and disparity, simply because they live in challenging contexts. Thomas (1993) asserts that, unlike traditional ethnographers who investigate culture with the intent of describing it, critical ethnographers do so with the view of influencing change. In a similar view, Douglas (2002) states that, "critical ethnographers hope to create a practical, value-laden science that generates the knowledge needed to foster a democratic society and a critical citizenry" (472). In addition to knowledge creation, critical ethnography aims at consciousness-raising and challenges the status quo, which, in the long run, can effect changes in policy and practice for the benefit of society's marginalized. Such research also takes into consideration the historical, geopolitical and sociopolitical factors, as well as the taken-for-granted issues that create and sustain the structures that stand in the way of progress in a larger societal context.

I began my study by theorizing that complex cultural norms, beliefs and the social construction of gender combined with unrealistic health policies have implications for rural women's reproductive health in Ghana due to their social positioning. These cultural structures and policies create a fertile ground for unequal distribution of power and resources that have negative implications for improvement in rural women's reproductive health. These mask the need for change, which critical ethnography strives to address.

Critical medical anthropology is also an appropriate approach to this study. Critical medical anthropology strives to understand and respond to issues and problems of society with regard to health, illness and healing. It also strives to understand how sociocultural and dominant

sociopolitical and health care system and structural factors influence the construction of health, illness and healing and, as well, factors that combine to create an environment that fosters social inequality and health disparity (Csordas 2009; Farmer 2005; Pfeiffer and Nichter 2008; Scheper-Hughes 1990; Singer and Baer 2007; Singer 1986; Wiley 2009). According to Singer (1995),

> critical medical anthropology can be defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behavior and meaning, human physiology, and environmental factors. This effort is peculiarly anthropological in the sense that it is holistic, historical and immediately concerned with on-the-ground features of social life, social relationships, and social knowledge, as well as with culturally constituted systems of meaning (81).

Singer further claims that the "mission of critical medical anthropology is emancipatory: it aims not simply to understand but to change culturally inappropriate, oppressive, and exploitive patterns in the health arena and beyond and sees commitment to change as fundamental to the discipline" (81). Willey also theorizes that, the "pleas for social transformation and activism are both implicit and explicit in critical medical anthropological work" (1992:217). Reflecting on the above arguments and theorization, the main aim of my research is to better understand, from a rural Ghanaian women's perspective, the factors that influence their reproductive health decisions. The findings resulting from this research will lead to recommendations and critical policy discussion to reform maternal and reproductive health program development as well as create better health care access and opportunities. Locating my research within the traditions of critical ethnography and critical medical anthropology is an appropriate choice given these research objectives.

Brief overview of ethnography

Ethnography is one of the oldest anthropological research methods used to explore cultures and subcultures (Creswell 2007; Fetterman 2010; Madison 2005, Simmons 2007; Wolcott 1999). Ethnography emerged from cultural anthropology and is used to understand the behaviour of human beings in the context of a culture in a natural setting (Hammersley and Atkinson 1995; Simmons 2007; Roper and Shapira 2000). Within the field of anthropology, the roots of ethnography can be traced to early 1900s (Denzin 1997). In ethnographic studies, the ethnographer explores the daily routine and activities that humans enact and make sense/meaning of their social world (Hammersley and Atkinson 1995). Such cultural description may attempt to become representative of the group of people participating in a particular study at a particular time period, while bearing in mind that the social world is flexible and cultures change over time.

The use of ethnographic research methods is growing as a method of choice for studies across disciplines and cultures. Cross-culturally, ethnographic research methodologies have been employed extensively in researching a variety of topics including social organization, such as kinship and lineages systems (Fife 2005; Gipson and Hindin 2007; Maynes et al. 1996), religion (Pearson 2001), health and illness (Allen 2004; Roper and Shapira 2000), health care seeking behaviours (Grewal et al. 2005; Inhorn 1999; Schooley et. el. 2009; Sundby 1997; Yakong et al. 2010), health care providers' attitudes (D'Ambruoso et. al. 2005; d'Oliveira et al. 2002; Doane and Varcoe 2007; Sauls 2007) and other health-related issues such as sexual and reproductive health issues in diverse settings (McPherson 1994). The contribution of ethnographic findings is immense to health care systems and programs and for social science as a specialized discipline (Burnard 2004; Fetterman 2010; Hodgson 2000; Simmons 2007; Roper and Shapira 2000).

Historically, ethnographic fieldwork is characterized by multiple perspectives, diversity, controversy and the continuous tension between scientific and interpretive inquiry. The above interplay provides an opportunity for forward movement and continuous critique. However, in the past few decades, the use of ethnographic methods in research has become politicized with regard to where research should or could be conducted (abroad and within) and who (native versus non-native) qualifies to conduct such research, thus leading to the divisive term "ethnography at home" and "abroad" (Okely 1996; Messerschmidt 1981). In the next section I discuss briefly ethnography at home as a method used in this study.

Ethnography at home

Ethnographic field research has been politicized and regionalized over the past decades as "ethnography at home" and "abroad" (Messerschmidt 1981). The regionalization has been informed by the common norm that anthropologists or ethnographers, who are the main researchers conducting the ethnographic research within the field of social sciences, conduct such research outside of their own cultures—abroad—where they seek to understand exotic cultures (Hadolt 1998). Ethnography at home refers to ethnographic fieldwork carried out by researchers who are from the same society as the study participants (Hadolt 1998). Hadolt argues that, from an anthropological perspective and in relation to ethnographic fieldwork, the term "home" has several connotations. Hence, several other terms have also been used to describe ethnography at home, such as insider research, auto-ethnography, self-ethnography; indigenous anthropology, native research, introspective research, endogenous research, in-cultural research and research competence by blood (Messerschmidt 1981). Doing ethnography at home can also mean that the researcher shares a similar culture with the people being studied, is a native from the same country, is from the same profession or discipline, shares the same disease process or

39

has experienced the same loss as the study group (Dwyer and Buckle 2009; Messerschmidt 1981; Peirano 1998).

In recent times, there has been a shift by researchers from the discipline of anthropology, particularly medical anthropology, who have cultivated an interest in examining issues in their own cultures to create anthropological knowledge informed by an insider's perspective (Fainzang 1998; Hadolt 1998; Van Dongen and Fainzang 1998; Zaman 2005). Although perceived as a recent happening, literature shows that researching at home can be traced to the post second World War era but later gained popularity in the early 1960s (Munthali 2001; van Ginkel 1998). Perhaps researching at home may have always existed but never gained any recognition for some obvious reasons. A number of arguments have been advanced for anthropologists returning home, to the extent that some authors labeled the new shift as "the repatriation of anthropology" (van Ginkel 1998:253) or "partial homecoming of the discipline" (Marcus and Fischer 1986:113). Van Ginkel argues major factors that necessitated the repatriation of anthropology included decolonization processes of the previously colonized, political, economic and academic developments (253). The above factors led to some host nations placing severe restrictions on foreign researchers due to a perceived role played by some anthropologists in association with colonialism and possibly a suspicion and fear of new forms of colonialism in postcolonial regions (Zaman 2008). Subsequently, political instability leading to security breakdown, common in some challenging contexts nations, can also contribute to discouraging foreign anthropologists from studying abroad (Munthali 2001). Other authors argue that factors of global economy have led to decreased funding for anthropological research abroad, as well as cuts in institutional budgetary allocations affecting universities and other higher learning institutions, which can also contribute to anthropologists choosing to study at

home (Fahim and Hermer 1980; Messerschmidt 1981; van Ginkel 1998; Okely 1987). In the past few decades, increased student enrolment, particularly graduate students requiring study sites for research but with limited funding to travel abroad and, perhaps more importantly, international graduate students who have the desire to carry out development research in their native countries, are some of the reasons behind this current shift (Lincoln and Gonzalez y 2008; Munthali 2001; van Ginkel 1998). In addition, van Ginkel argues that, at the time of this shift, it was appropriate for the discipline of anthropology to question and rethink its theories and methodologies and to recognize the fact that anthropology is, after all, "the study of all humankind and not some special segments of it" (1998:254); hence, the need for the current methodological shift.

However, despite the above arguments, this shift raises debates and creates tension among social scientists and academics. These tensions and debates lead to questions pertaining to whose interest is being served in the conduct of research and whom is the research for? (see Fine et al. 2000). According to some theorists, it is time to decolonize methodology, as well as embark on a new worldview and understanding of the social world and its needs through multiple lenses that are devoid of dominance (Aguilar 1981; González y González and Lincoln 2006; Lincoln and y Gonzalez 2008; Pearson 2001; Peirano 1998; van Ginkel 1998). However, anthropology at home has often been critiqued for several reasons that lead to the perception that it is an undesirable research design (Hadolt 1998; Allen 2004; Borbasi et al. 2005) and thus, is often disregarded as a methodology that can contribute new knowledge to ethnographic literature. One concern stems from the fact that insider ethnographers, in other words, native researchers, are intrinsically biased because of their preconceived ideas, lived experiences and closeness to the culture (Chavez 2008). Their position as insiders can interfere with their ability

to intellectually distance the self from the familiar environment to look at issues with "fresh eyes" and ask critical questions (n9). There is also the perceived fear of researchers "going native" (Brannick and Coghlan 2007; Breen 2007; Kusom 2003; Pearson 2001; Zaman2008). The phrase "going native" refers to "becoming so immersed in the group culture that the research agenda is lost or that it becomes extremely difficult or emotionally draining to exit the field and conclude the data collection" (Mays and Pope 1995:183). In other words, the researcher ceases to balance the roles of participant and observer, thus making it impossible for the research agenda to be properly accomplished. The origin of the phrase "going native" as an ethnographer has often been credited to Bronislaw Malinowski (1922) during his anthropological fieldwork experience in the New Guinea from 1914 to 1918. Reflecting on his fieldwork experience, Malinowski alluded that, for a researcher "to grasp the native's point of view, his relations to life, to realize his vision of his world" (p. 290) anthropologists should "go native." Malinowski's description of this phrase is an indication that, in order to gain a better understanding of the issue under study, researchers need to be fully engaged with their participants, rather than detached and restrict oneself to an observer role only. However, in recent times, the interpretation of this phrase has been viewed differently and creates the misimpression that such a close relationship of the researcher-researched results in poor judgment with negative implications for the research outcomes.

Other criticisms of ethnography at home also include the complex nature of researcher-researched relationships and its implications for research outcomes (Al-Makhamreh and Lewando-Hundt 2008; Cherry et al. 2011; Jacobs-Huey 2002; Simmons 2007), and still others simply dismiss ethnography at home as an inappropriate research methodology with the associated lack of objectivity (Brannick and Coghlan 2007). Objectivity has been perceived as a

major determinant of quality research (Pearson 2001); hence, for research to be considered valid the researcher must show a high level of neutrality and objectivity; identifying with study participants or cultural groups can be perceived as detrimental to the outcome. Unlike positivist researchers who do not interact with their molecules under the microscope or their study subjects because they believe that by doing so renders the results subjective, ethnographers do interact with their study entities and are, in fact, the research instrument itself. Munro (1994) argues that the real debate is not only an intellectually-based debate but also a debate situated within the political contexts usually responsible for structuring the production and utilization of knowledge (233); hence, the question again: Whose interest is being served in research?

Although the construction of "at home" ethnography attempts to acknowledge the fact that those researchers have easy research journeys, several factors come into play that can make the researchers strangers in their own land, irrespective of their geographical or cultural identity. For example, Smith (1999), van Ginkel (1998) and Narayan (1993) contest the construction of researching at home and suggest critics underestimate how several factors intersect in research fields irrespective of one's insider status. They argue that factors such as education, ethnicity, class, social positioning, gender, marital status, sexual orientation, appearance, speech, personality, political orientation, theoretical orientation and socioeconomic status of the researcher complicate one's status as insider in her/his own culture. These factors, for that matter, can impact research outcome even if one is an outsider. Both Smith and Narayan argue that it is an overstatement or understatement to conclude that one is an insider simply because she/he shares the same culture or language with the researched. On the other hand, most insider researchers are often professionals who have had their educational training in different environments and return to their native countries to conduct research (see Oriola and Haggerty

2012; Al-Makhamreh and Lewando-Hundt 2008). It is possible that researchers who have been away from their native cultures for a number of years may have conflicting worldviews and new/emerging cultures that make them insider-outsiders to their own cultures. In addition, the social world is flexible and ever changing and how groups function within a given culture is affected by these changes and flexibility, which can displace one's cultural identity at any given time and has implications for both insider and outsider status. As Allen (2004) argues,

> situations are neither totally familiar nor totally strange and the researcher's insider–outsider status changes at different points in a research project and is different with different groups and different individuals (15).

Reflecting on the above factors, I argue that there can never be a true insider or outsider, as has been claimed. It is therefore an oversimplification to critique the product of ethnography at home based on the researcher's geo-cultural identity and, consequently, the suggestion that the epistemological contribution of such research lacks merit. I suggest, rather, that critiquing the credibility of such research should be based on the researcher's explicit—whether insider or outsider—plans to employ reflexivity throughout the research process. As Pearson (2001) points out, in a study of a religious group where the researcher identified as an insider,

> I must make the point that objectivity as an absolute cannot exist; research, especially research which involves people, will always have some effect on the researcher and will always be filtered by the researcher's own subjective views. It is therefore necessary to apply a rigorous self-reflexivity in order to bracket out personal beliefs and values, whether one is an 'insider' or an 'outsider' (58).

The concept of reflexivity has been widely applied in qualitative research (Carolan 2003; Coffey 1999; Freshwater and Rolfe 2001; Guillemin and Gillam 2004; Lather 1993; Mahoney 2007; Pellat G. 2003; Zaman 2008). The definition of this concept remains complicated. However, Guillemin and Gillam (2004) refer to reflexivity as "a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated"

(273). Being reflexive means stepping back and critiquing oneself in relation to the research project so as to enable the researcher to beware of taken-for-granted issues that could impact the outcome of the research. In order to critically assess one's research process, a researcher should ask: "how have I affected the process and outcome of the research? How has the research affected me? Where am I now?" (Pellat 200329).

The purpose of the above discussion is to enhance the quality and credibility of the outcome of the research. Several researchers have illustrated the benefits of reflexivity to themselves on one hand and to the research on the other (Carolan 2003; Mahoney 2007; Pellat 2003). I argue that despite the debates, unlimited advantages of insider research on knowledge contribution have been documented across disciplines (n10) and this methodology must be considered as a mainstream research methodology in social science and health research and devoid of unwarranted criticism. My positionality within this research has been fourfold: born and raised as a member of the community and culture where I conducted the research; a professional insider; a mother, and a gender-based insider with an additional interest in rural maternal and child health. Despite the above, I was also, at the same time, an outsider due to my higher education, marital status and professional background compared to the women in my research area. However, I strongly argue that the above status did not make me fully at home due to the interplay of the factors mentioned above; neither did it have any negative implications for the outcome of my research.

The research methodology

In my ethnographic research, as in any qualitative study, I explored a specific culture from the perspective of culture bearing participants. Central to the study was meaning making, understanding and carefully capturing and meaningfully interpreting the views of the participants

I engaged with in the topic under investigation. The women who participated were selected because of their requisite knowledge of the subject area. Their knowledge is based on their lived experiences, their varied, multiple and social reality, where they are viewed, in this context, as experts (Creswell 2007; Gills and Jackson 2002; Hesse-Biber 2010; Higginbottom 2004). In this regard, Hesse-Biber (2010) asserts that:

> This approach is committed to multiple views of social reality whereby a researcher's respondent becomes 'the expert'—it is his or her view of reality that the researcher seeks to interpret. Social reality is assumed to be subjective and varied; there is not just one story but multiple stories of lived experience (455).

Drawing on the above reasoning, I used a combination of methods to choose my participants to enable me to gain a better understanding of women's social reality, especially their reproductive choices. First, I purposefully selected my study participants based on their prior knowledge of the topic (Morse and Field 1991; Creswell 2007). Purposive sampling technique, also called judgment sampling, is a type of method where the researcher makes a deliberate choice of an informant due to the qualities the informant possesses, her knowledge or lived experience with regard to the subject matter and her willingness to participate (Bernard 2002; Creswell 2007; Fain 2004; Lewis and Sheppard. 2006; Tongco 2007). Secondly, in order to gather evidence from women with varying backgrounds, I also used maximum variation sampling method (Holloway and Wheeler 2009). This method seeks to include a wide range of participants with differing experiences and backgrounds, who can contribute to the topic being investigated in a variety of ways to enrich the data.

Following the above traditions and line of reasoning, my primary aim was to create knowledge based on women's perspectives informed by their lived experiences and social reality. This new knowledge would contribute to improving maternal health service delivery for

rural Ghanaian women and around sub-Saharan Africa through health care providers' practice reviews and maternal health care policy changes. Carefully taking into consideration the above arguments, I engaged 27 women with one-on-one, in-depth, open-ended interviews, as well as focus group discussions with six young women. I also used participant observation methods to gather data. Structured interview questionnaires were used specifically to access demographic data.

While my primary objective, in this current research, focused on women's perspectives and experiences with respect to their reproductive health decisions, I also chose to examine the experiences of four midwives who provide reproductive health care in rural settings. Their experiences are important because, in one way or the other, they contribute to and shape women's perspectives and decision making with regard to reproductive health choices; such perspectives could not be described by the women themselves. The inclusion of midwives became necessary due to women's responses to certain questions regarding the health care system and service providers, specifically midwives. Although not initially planned, their inclusion was timely and offered me an opportunity to gain a holistic understanding of the factors that both facilitate and impede women's decision making on their reproductive health choices. Because they provide such services, midwives, for the most part, are in constant contact with women who access maternal and child health services at the rural clinics. Their views are crucial to gaining a broader and better understanding not only of the socio-cultural factors from women's views but also the systemic factors that impact maternal and child health service uptake from the service provider's perspective. Although mentioned earlier, this was not the primary focus of my research. However, when it emerged as a need, I consulted with my doctoral program supervisor while in the field to seek guidance regarding the emerging need to include

midwives. My supervisor found the need for such evidence as a reasonable idea and suggested the inclusion to ascertain the evidence required from the midwives to fill in the gaps on the health care system. The diversity in evidence also helped to identify measures needed for practice and policy reforms to improve maternal health. As well, the divergent perspectives provided a clear image of historical and political issues influencing health service provision and access that have implications for maternal health in rural settings in Ghana and the rest of sub-Saharan Africa.

Eligibility for inclusion

Women who were eligible to participate in the study were (1) of child bearing age; (2) between the ages of 15 and 49 years; (3) older women who have had children before and / or could offer traditional childbearing knowledge support to other women, such as traditional birth attendants and who possess historical knowledge on childbearing with respect to the influential factors I sought to understand; and, (4) women who currently lived in the Talensi-Nabdam District, the chosen setting for the study. For midwives, I chose one from a health facility where I recruited some of the women participants and the remaining three were chosen from other facilities also providing services to women but which were not included as venues for recruitment of women participants. The method of selecting midwives was equally purposive. The criteria for recruiting included midwives who practice in rural settings of the TND. Other observational data, from hangouts with women and midwives who were not necessarily selected based on the above eligibility criteria but had the requisite experience, were also included and will be discussed later in the dissertation.

Access to study participants

Access to my study participants was relatively uncomplicated, perhaps in part, due to my insider status. Several studies have documented the relative privilege that insider researchers may have over outsiders with regard to participant access, due to their familiarity with the study area (Allen 2004; Chavez 2008; Voloder 2008; Zaman 2005). The research site was also where I conducted previous research—a common practice by anthropologists—and that may have also earned me the women's trust and thus, contributed to the relatively easy entry. In addition to insider privilege, I do have a positive presence in the District as a well-known advocate in rural northern Ghana for women's and children's health and general well-being. Based on my previous research there in 2007, upon which this current research is built, I used the study's findings to initiate a women's and girls' empowerment and community development initiatives, Project GROW (Ghana Rural Opportunities for Women) for "hard to reach areas and economically vulnerable populations" at the community level; an initiative that aims to create economic, health and educational opportunities for women and girls in rural, deprived communities in northern Ghana. In my previous study, I asked women who participated in the research to name items/resources that they thought would help them to generate income to improve their living conditions. It was in response to these lists that this current initiative came about. Inspired by the statement of American Anthropological Association (AAA) that "anthropologists may choose to move beyond disseminating research results to a position of advocacy" (2009:4), I chose to establish the above project. However, beyond the activities and initiatives that may have earned me credibility in the hearts of the community members, is my personal passion for the advancement and well-being of women and children, who are the most vulnerable in rural Ghana and, to a large extent, throughout sub-Saharan Africa.

Anthropological researchers are particularly concerned about participant exploitation and coercion in fieldwork (Fife 2005). As I prepared for this research, I was particularly concerned that my previous work history and insider status may have some level of influence on women's choices to participate simply because the majority of them are beneficiaries of the above mentioned Project GROW. However, this concern did not appear to be a factor for women's high interest to participate in this study. Women's participation was influenced by their personal interest and readiness to share their stories and have their voices heard, because they have very rare opportunities to do so. Their participation also depended on time availability. My general observation was that, even though there were a few women whom I recognized from my previous research, the majority of participants were new, suggesting that my initial concern that insider status can be viewed as having the tendency to influence participants' decisions to participate in a coercive manner, was unfounded.

Recruitment procedures

I recruited participants from six villages within the Talensi-Nabdam District but mainly from the Nabdam area. Consistent with cultural customs, traditions and appropriateness, I met with the traditional leaders—both male and female—of the potential study villages in a formal procedure necessary to secure access to participants (see Yakong 2008). I explained the purpose of the research to the traditional leaders, who then granted me permission to commence the research in the respective communities.

Point of entry

Through the women's empowerment project mentioned above (Project GROW), women have an organized group and conduct group meetings occasionally. I enquired about their meeting dates

and took advantage of those meetings to meet with women to discuss the study and enlist their participation at the community level. Those who were interested to participate willingly contacted me through their group leaders at a later date to inform me about their interest. For the women I recruited at the health facility level, I visited the facilities and discussed with nurses the purpose of my research and asked if they were willing to pass on information regarding my research to potential respondents who access care through their clinics; they agreed to do so. When the clinic was operating, I sat at the back of the clinic building under a tree waiting for anyone who was interested to participate. Women who were interested to participate in the interviews contacted me directly after accessing care in the clinic. When I reached a point in my interviews where I felt that women's responses indicated the need to explore the experiences of midwives in providing reproductive health care to women, I visited the selected facilities and approached midwives, discussed the need to include them in my study and invited their participation. Only one midwife was reluctant to participate. Although her reluctance was not openly stated, it was evident in her facial expression and body language. It took me a couple of visits and several hours to provide further explanation and assurances, specifically on the fact that the study findings would not implicate them in any way with regard to their employer and that under no circumstances would I use any material from the research that contained identifying information about them or the health facilities where they practice. It was at this point that these midwives consented to participation.

Fetterman (2010:146) argues that research participants can be implicated by way of how ethnographers' report their findings. He cautions researchers to be mindful of the presentation of such findings so as to protect the identity of research participants who provide invaluable information that can have implications for the web of interrelationships and systems in which

they find themselves. It is not uncommon that participants get sanctioned in the community or family for revealing pertinent information to researchers. In addition to the above fears that I suspected the midwives held, I also gathered, from one of the midwives, that some previous researchers had shown poor relational attitudes towards them post-research, and this may have been a contributing factor in their reluctance. For example, one midwife claimed that:

> researchers often come here and take information away from us but we never hear from them again after they are done with their research and achieved their goal. They do not even call to say how are you doing? (Midwife Samantha).

This assertion may have been associated with a lack of reciprocity (see Fetterman 2010) on the part of researchers, which can have serious implications for future researchers. The above claim may also have been the reason for the reluctance shown by the other midwives but, unlike Samantha, those midwives may have decided not to openly communicate it. Cross-culturally, reciprocity is a crucial issue and may be acted upon differently in different cultures. Nonetheless, I argue that it is critical for researchers to recognize, pay attention to and find ways to show some form of reciprocity to their participants. Failure to do so, whether intentional or unintentional, can result in serious consequences for future researchers. Two of the other midwives in this study were nurses I had known during my time of practice in the health care system and I wondered, apart from the above claim, if they also found it uncomfortable to be interviewed about their practice by a colleague.

Ethical considerations

I positioned my ethical framework in this research within the ethical code of conduct developed by the AAA (2009) for anthropological research around the globe. Informed by the above ethical framework, I received the first ethics approval (University of British Columbia BREB number

H11-01443) from my program institution for this research. Upon arrival in Ghana to begin the fieldwork, I visited the Director of the Ghana Health Service for the region in which my research site was located. This initial visit was to brief the Director about my research. As required by ethics, in my second visit I submitted a summary of my research proposal along with my ethics approval certificate to the Health Director who, after critically examining my proposal, granted me a verbal approval to commence my fieldwork. In his view, this type of research did not pose any adverse consequences to potential participants. I subsequently sought non-formal ethical clearance from the traditional rulers and land owners (Tindanas), Chiefs, Queen mothers (Tindanpoks), elders, opinion leaders and women's groups' organizers of the various locations in order to have access to the study setting and participants as deemed culturally appropriate.

After these ethical clearances and my explanation of the purpose of the study and their responsibilities as participants, women and midwives alike agreed to participate and granted me verbal consent to do the study. This method of consenting might appear inappropriate within the conventional, positivistic and standard ethical requirements to ensure that participants are protected from potential harm and that they have access to full information about the research and researcher, their rights and responsibilities. However, this method of consenting is a valid and widely recognized method of consenting commonly used within the discipline of anthropology when dealing with respondents who are non-literate. The intent is to recognize cultural diversity, especially in challenging contexts nations and even in some minority western cultures as well (see Fife 2005). Within the rural Ghanaian context, this method of consenting is a necessary and culturally appropriate approach to obtaining consent in this study area due to the high prevalence of illiteracy among rural Ghanaian women and cultural sensitivity to (i.e., distrust of) a formalized contract (see Fetterman 1998; Fife 2005; Yakong 2008). However,

contrary to the argument that level of literacy may play a role in the use of formal methods of consenting, in this study, participants with high literacy competence, such as the midwives, who were provided with a script to read about the study, were equally disinterested in signing written formal consent forms, a revelation that needs further investigation. However, consistent with the argument held by AAA (2009), "informed consent…does not necessarily imply or require a particular written or signed form. It is the quality of the consent, not the format that is relevant" (3). In order to increase the quality of participants' consent, I ensured that participants had the opportunity to continuously review their consent whenever necessary and during our time of dialogue—with both women and midwives—so as to avoid coercion, doubts and fears. All names of participants and study sites, such as the clinics and villages have been assigned pseudonyms to maintain high levels of confidentiality (Fetterman 2010). I also obtained permission from women to use their photos in this study. Although I wished to share my transcripts with my study participants for their input, particularly with the women who were my main focus in this study, I did not have the luxury to do so, due to women's lack of reading and writing skills in English, a limitation beyond my control. Currently, there is no formal writing system in the local dialect that I could have used in writing this thesis for the benefit of the majority of the women who do not read and write in English. However, following completion of my studies, I will return to study site to talk about the findings of the research with participants.

In place of honouraria to compensate women for their time and in keeping with cultural traditions, I provided food items and ingredients for women to cook with, rather than monetary compensation. This method of compensation was a preferred choice by women themselves who felt the need to share the cooked food with their peers who were at the interview area but were not necessarily participating. Hence, food was cooked each time we had an interview and the

presence of food brought many other women to hang-out as a form of socialization and to share their experiences. On the part of midwives, I offered culturally appropriate gifts—nursing pocket notebooks and pens—to thank them for their time.

Method of data collection

The key methods used in collecting ethnographic data include participant observation, open-ended interviews and document analysis (Morse and Field 1991; Higginbottom 2004). In this study, I collected data through participant observation, informal face-to-face, in-depth interviews, including focus group discussions, with the use of an open-ended interview guide and structured interview questionnaires—purposely for demographic data—auto-ethnography and life history narratives. My decision to end interviewing more participants for data was reached when there were no more new ideas emerging from participants, a point referred to as data saturation in qualitative research (Francis et al. 2010; O'Reilly and Parker 2013). I kept extensive reflexive field-notes (see Morse and Fields 1991; Richards 2006) during interviews, hang-outs and walks-around, which I included in my analysis. I also reviewed reproductive health reports from the Ghana Health Service to extract data for analysis. All interviews were carried out in Nabit, a local dialect spoken by over 39,000 people in my study area. I transcribed and translated all interviews simultaneous from Nabit to English, a task that was time consuming but rewarding because I gathered deep insights through this task.

Interviews site

The women who participated in the study at the village level came from six different villages namely; Bazibeog, Baming-la, Sopuyango, Yenputami-et, Beogpuzaar, and Beogkinna. These villages were far apart from one another; however, the women collectively chose one site to be

interviewed. This chosen site was beneath a tree where they often socialize and hold regular

meetings. Their reason for this choice was that they wanted to be away from other family

members, especially their husbands and in-laws. Being away from these other family members

provided them freedom to chat about things they would not ordinarily have shared in public, due

to cultural restrictions on what young women can or cannot say when they are in the midst of

older women. I conducted 15 individual interviews, plus one focus group made up of six young

women, beneath various shade trees depending on what activity was happening in the

community during the time of interview. For example, the most preferred tree was close to a

grinding mill where most women gather daily to grind their grains. The closeness of this tree to

the grinding mill made it challenging for the interviews to take place, because of the noise of the

grinding machine. Thus, any time the machine was on, we moved further away and looked for

another convenient tree. However, our next choice of tree for a less noisy site for our focus group

discussion presented a different scenario. As we began to settle down beneath this particular tree

for our discussion, a woman who was learning how to ride a bicycle (so that she could qualify to

receive one from a humanitarian project) almost ran into us. I had organized this bicycle training

program as part of the activities of Project GROW to help women access bicycles to increase

their mobility and improve their access to clinics with their babies for health care, to farms and

markets where they must commute long distances. By the time we resettled underneath another

tree for safety, we had spent over 30 minutes of our interview time, and particularly in studies

done in challenging contexts where food production is paramount, the concept of time and its

accountability can be problematic. I interviewed the remaining six women at the health clinics

where we sat at the back of the clinic, a place which the nurses helped the women choose,

because it was obscured from the rest of the clinic's view and would provide the women with some level of privacy to share their experiences.

I interviewed midwives in their offices. One midwife granted me her interview after she ended her work for the day, while I interviewed the other three before they began their work day. All interviews were audio taped and lasted approximately one and half hours to two hours. However, during both interviews with both women and midwives, we frequently encountered interruptions, which could not have been predicted. Interruptions would occur due either from crying babies, since most of the young women were nursing mothers and carried their babies with them, or from other women who passed by and stopped to share greetings or came to share the food cooked for the participants, a cultural requirement that cannot be ignored (see Yakong 2008). Time used for such greetings can range from 15 to 20 minutes or more, depending on what news the greeter has to share with recipients and vice versa. For midwives, such interruptions came equally from patients wishing to see them or other staff members seeking information from.

I also carried out participant observation of women's daily life activities during interviews and hangout periods. "Hangout" in this context refers to a time when I casually interacted with women without necessarily labelling such conversations or interactions as a scheduled research interviews. These hangout areas included the grinding mill site where women gather to grind their grains and sell cooked food, at the health clinic facilities where I sat each time to wait for participants and at one particular hair dressing salon where women discussed social issues related to their lives. Another place of hangout on Sundays was at the church where most women attended church services. In anthropological research methods, researchers enter the field with an open mind, ready to learn from the people what is perceived to be the most

pressing issues impacting their existence and well-being (Fife 2005). Hence, the field is seen as fluid and flexible. While in the field, changes are often required to meet the needs of the people, rather than the researcher's needs or interests. I saw my fieldwork as a reflexive process and I gave much attention to what was important to the people and whose interest this work served. Hence, in many instances I reframed questions to ascertain information on issues that were viewed as pertinent in women's lives but such questions were not captured in my initial interview guide and the inclusion of which would provide a particular type of evidence relevant to the study. The interview script served solely as a guide to my dialogue. All field work took place from July to November 2011.

Data analysis

I used thematic analysis (see Morse and Fields 1995) in this study. This method of analysis requires that, as a researcher, I step back and carefully reflect on the participants' dialogue and the context within which they construct their lived experiences. This critical examination of the dialogue helps to identify and categorize themes, which are usually revealed by the data but not defined by the participants. Morse and Richards (2002) suggest that the closer the researcher is to the data, the deeper the understanding gained from the dialogue, which helps identify emerging themes from the data. Drawing from Morse and Richards's thematic analysis framework, I analyzed my data based on themes which includes topic coding, creating categories and abstracting.

Socio-demographic characteristics of participants

In this section, I present the socio-demographic characteristics of my study participants. Women's ages reported in this research were based on educated estimates because none of them

knew their exact date of birth. This method of calculating ages is not uncommon in rural Ghana because the majority of the rural populace, especially women, lack formal literacy and are unable to keep track of things like dates of births. On the other hand, dates of births and exact ages are rarely talked about culturally; hence I would argue that unlike now, in the past keeping track of things like dates and figures with regards to age rarely carried any cultural significance. As such, ages are usually estimated, often based on historical and other significant social events that take place in families, communities and in the country (see Yakong 2008). Examples of such events may include the independence of Ghana, the "enskinment" of a chief, births in families or death of an important person in the society. Thus, women's ages reported in this study cannot be viewed as fully accurate; however, such inaccuracy has no impact on the study's outcome.

Of the 27 women participants who answered questions related to the study topic, 13 women were between the ages of 15 and 30 years old and eight were between 31 and 49 years old. A few women above this 15 to 49 year old reproductive age group also participated based on a wide range of issues that they could address because of their knowledge of the topic. One woman was 50 years old; three women were 62 years old; one was 72 years old, while the oldest among them was 74 years old. Fourteen (52 per cent) women identified themselves as Christians of different denominations while thirteen (48 per cent) identified as traditional religious practitioners. All women at the time of the study resided in six different villages in the Nabdam part of the District. The ages of the midwives ranged from 38 to 55 years and they all identified as Christians.

Relationship status, family and living arrangement of research participants

As shown in Table 1. below, the majority of the research participants were in active marriage unions at the time of this research. Seventeen women were married (63 per cent) and in a

monogamous relationships, while nine (33 per cent) women were in a polygamous marriage. One woman was single (4 per cent) and three women were widowed (11 per cent). The three women who were widowed were still considered culturally married to their deceased husbands, and thus were identified as married.

Table 1. Relationship status of women who participated in the research

Relationship Status	Total women: 27	Type of marriage		Per cent
		Monogamous	Polygamous	
Married	26	17	9	96
Single	1	—	—	4

With regard to the age at which women entered into marriage relationships, twenty-two (81 per cent) women were married when they were 15 to 20 years old, with the exception of one woman who married at the age of 13 years (4 per cent), while three (11 per cent) were married between 21 and 30 years old. These findings corroborated findings in a study in 33 countries in sub-Saharan Africa that showed the median age of marriage for the majority of women is between 16 and 20 years (Bongaarts 2007). Table 2. illustrates women's relationship profile. Of the midwives, one was in an active marriage relationship; one was single, one was widowed and one did not disclose her relationship status.

Table 2. Age at marriage of women participants in the research

Age at marriage	Number of women: 27	Percentage
13 years old	1	4
15 – 20 years old	22	81
21 – 30 years old	4	15

In terms of women's reproductive lives, 22 (81per cent) had their first pregnancies between 15 and 20 years of age, while five (19 per cent) had their first pregnancies between 21 and 30 years of age. Thirteen women (48) had between one and four pregnancies; 12 women (44) had between five and eight pregnancies, while two women (7) had nine to 10 pregnancies. Nineteen women (70) had between one and four living children, while eight women (30) had between five and eight living children. Table 3. illustrates women's reproductive history.

Table 3. Women's reproductive history (pregnancies lost or child deaths were reported but were not included here for analysis)

Age at first pregnancy	Number of women: 27	Percentage
15—20 years old	22 (78 per cent)	81
21—30 years old	5	19
Number of pregnancies		
1—4	13	48
5—8	12	44
9—10	2	7
Number of living children		
1—4	19	70
5—8	8	30

I excluded the midwives' reproductive health profile analysis here because such information has no significance in the study outcome.

In terms of living arrangements, all except two women interviewed lived in a household system. This system is a compound housing system in which more than one household resides. Members of the households may share a common goal, practice communal eating and share sleeping places (see Lloyd and Gage-Brandon 2010). Such living arrangements are common practice in rural Ghana and consist of both nuclear and extended family (husband, wife/wives, children and grandparents), usually of the same lineage and headed by a male as the landlord who, for the most part, is the final decision maker of the house. The number of people the women lived among in a compound ranged from five to 23 people.

Education and work

With more priority placed on the advancement of the boy-child versus the girl-child, the majority of women have limited access to education, particularly in rural Ghana (Ghana Statistical Service (GSS) and Noguchi Memorial Institute for Medical Research [NMIMR] 2005; Yakong 2008). This lack of access to education for women is reflected in the educational background of my research participants. Sixteen (59 per cent) of the research participants had never been to school, while 11 (41 per cent) had some form of primary education but could not read or write (see table 4 below). This lack of education also limits women's opportunities to compete in the formal job market (Manuh 1999) and impacts their socio-economic status. Women in this study who had almost no education of any form were limited to subsistence agricultural farming to support their families and earn an income. At the time of this study, all of the research participants identified as subsistence farmers (100 per cent) with 10 (37 per cent) having additional petty trading— including sale of items in smaller quantities such as grains or cooked food— businesses to

supplement their income. Midwives have been practicing for 6 to 15 years but had moved from one location to another in a few occasions. This movement is a routine practice in Ghana health care system whereby the employer reserves the right to move employees to places where the employer deems appropriate irrespective of the employees' choice.

Table 4. shows women's educational background

Education	Number of women: 27	Percentage
None	16	59
Some primary	11	41

Chapter 3. The socio-cultural context of growing up female: Implications for women's health and well-being

Culture is a critical factor in the formation of identity. A people's system of beliefs, values and practices define who they are as individuals and as a collective group. This social identity is passed on from one generation to another, sustained through particular cultural systems of learning and reinforcements. Although these systems of beliefs, values and practices strive to sustain a unique culture and its identity, culture also serves as a bridge and a barrier to the development and dignity of individuals and groups within the culture, especially specific groups, in this instance, women. However, in the current globalized world and the possibility of cross-cultural learning, attitudinal changes take place that can lead individuals and groups to demand changes to current customary practices that may have negative implications for their Well-being. These demands can threaten the sustainability of traditional systems depending on whose interest is being served when intended changes take place. In this chapter, I discuss the situatedness of growing up female in rural northern Ghana and how the socio-cultural expectations, roles, norms, taboos and myths affect and shape the lives of girls and women both positively and negatively.

Raising Girl Children: Enculturation, social values and knowledge transmission

The process of enculturation of social values and practices passed down from parents and other caregivers to children is structured and purposeful. This process constructs how the child functions during adulthood and their relationship with the opposite sex. The upbringing of children is gender-based. During this passing on of traditions, young girls and boys are raised with differential social values and gender roles based on the fundamental socio-cultural conception of masculinity and femininity (Boakye 2009). Girls are raised to be submissive, shy,

hardworking, carry a feminine body type and be soft spoken; they are reminded often to be wary of how they speak to men in public and, most importantly, to be morally strong so that they keep their virginity until marriage. Boys are raised to be strong, dominant, hardworking and competitive; they can show signs of being sexually virile but not sexually weak. Unlike young women, young men must show strong signs of sexual desire, otherwise they are viewed as feminized thus women, as potential wives, might doubt their ability to be fertile. This can generate gossip around the community, which may lead to difficulty for the young man getting a wife. Young men must also nurture qualities that enable them to woo girls for marriage. For example, they must be polite and protective of the girls they are interested in; they must also be respectful towards older women who are viewed as potential mothers-in-law. Failure of both sexes to manifest these masculine and feminine qualities may attract negative comments and attitudes from peers and, subsequently, bring embarrassment to their family.

The roles and responsibilities for raising children are also gendered. Women, as mothers, grandmothers and aunts are responsible for raising girls and instilling them with social values and expectations of women; whereas boys are raised by fathers, grandfathers and uncles with similar values and expectations passed on to them to become the future landlords for the lineage (see Fortes 1949). It is therefore common to see young girls involved in adult women's roles in household work such as cleaning, washing clothing, cutting firewood, fetching water, cooking, learning how to serve their male kin and playing a motherly role by caring for their younger siblings. Boys also engage with their male mentors to learn men's roles, which mostly involves outdoor activities such as wrestling, rearing animals and birds and playing soccer. At this point, young boys also learn at an early age how to become suitors. When the boys are in a group, they ask girls they meet in the fields to choose among them the one they most admire. Like girls who

learn from their female mentors how to become a "good woman or mother" at an early age, boys also learn from their male mentors how to be dominant. Thus gendered attitudes in both sexes are internalized and normalized throughout their childhood into adulthood.

Space related taboos and norms with embedded cultural meanings also occur during this time of passing on traditions. For example, women and girls are restricted to the inner perimeters of the household, such as the kitchen, where they can occupy, have control over and conduct all kinds of activities considered to be women's work. It is within these perimeters that older women teach some of the activities considered to be feminine. Men and young boys are restricted to the outer perimeters of the household, areas such as the men's hut where manly activities take place. Men and boys are barred from entering the kitchen unless specifically invited. These designated, gendered places have specific cultural meanings and taboos that when violated can have real consequences. For example, the kitchen area serves as a safe place for women because it is a taboo for husbands to fight—including arguments and beatings—with their wives while the women are in the kitchen area. People believed if a man beats his wife while in the kitchen area, he will lose his virility or sexual potency. So it is common for wives to run into the kitchen areas in order to escape beatings if they are being chased by their husbands in a fight. They may remain in that area until tempers settle down. Another belief with regard to the kitchen area is that, if a woman uses the stirring stick used to make the traditional staple food (made of millet or corn flour) referred to as *tou zaafi* to hit at the man, she can make him impotent. Since the stirring stick is also located in the kitchen, men who are not careful and enter this area to beat their wives may find her fighting back with the stirring stick.

Men and boys sit in the men's hut to converse and make family decisions and, unless invited for specific reasons, women and girls are prohibited from entering the hut. The men's hut

also serves as a sacred place for men to interact with their family ancestors and where their ancestors might reveal to them information about the family and what to do to maintain health; thus it is a place where in the process of their interaction with their ancestors, men gain spiritual powers. Boys learn from during their ongoing visits with their fathers in the hut, which is where fathers initiate the boys into manhood. Because of this strong connection between men and their deceased patrikin, wives, who are not considered members of their husband's kin cannot be part of such sacred places because their presence will interfere with these conversations and revelations. It is also in the men's hut that major family decisions are taken, which only men make unless women are invited specifically for some reason. In addition, men hold that women are not capable of keeping secrets and, because of this, they are excluded when men sit to make major decisions concerning the family. Although women can be invited occasionally to join the men's huts in some family deliberations, their input is not sought. During the presence of women, men withhold parts of important issues to be discussed until after the women leave the hut so they do not get to know those issues. Women's role is just to listen to the discussion, to serve as witnesses. Women, therefore remain recipients of decisions but not participants in the process, although these decisions bind them. Young girls thus learn from an early age that their role in the household and with their future husbands is limited to receiving and implementing decisions made by their male kin, whereas young boys learn that they are being trained to be the decision makers and controllers of the family in adulthood.

Customarily, the gendered socialization of children, where the male child is placed at a superior level to the female child, has implications for family decisions and choices, decisions that will usually tend to favour the male child over the female. For example, even though education is perceived to be a fundamental human right, because of limited resources in rural

Ghana, it is common that most families choose to send their male children to school before their female children. In more extreme cases, those few girls with the rare opportunity to go to school may be withdrawn for forced marriages for economic gains that might be used to support their male counterparts' to stay in school or to enable parents to pay bride price for their son's wife. I argue that the gendered-style of raising children and selective choices that favour males over females observed in and around most parts of northern Ghana, contributes to and further complicates how boys begin to view and relate with girls, thus shaping their adult relationships with their wives. Also, the tendency for women to normalize as well as internalize such attitudes irrespective of the circumstances and the associated hardships is also evident. The end result of these attitudes and choices have implications for maternal and child health; as well as implications for women's desire for equal value and pride if the current cultural attitudes do not alter.

Rites of passage: Female genital mutilation

Female genital mutilation (FGM), also known as female circumcision or female genital cutting is widely practiced in most parts of Africa, with Egypt showing the highest prevalence among young women (Jackson et al. 2003; Jones et al. 2004; Toubia 1994). According to the WHO, there are approximately100 to 140 million girls and women in the world who have undergone FGM, with an estimated two million girls who are at risk from this practice every year (2001:4). FGM is a broader term used to describe all procedures that involve partial or total removal of labia, clitoris or other injury to the female genitalia for cultural or other non-therapeutic reasons (Jones et al. 2004:144). The purpose of this practice has been associated with cultural transitioning of young women from childhood into womanhood as well as control over female sexuality (Jackson et al. 2003; Toubia 1994). In Ghana generally and this study setting in

particular, the commonest form of FGM is the cutting of the clitoris, also known as clitoridectomy—which involves partial or total removal of the clitoris. Until the passing into active law over a decade ago banning and criminalizing the practice of FGM in Ghana (Ako and Akweongo 2009), clitoridectomy was a common practice in some parts of rural Ghana as a form of puberty rite to initiate teenage girls into womanhood following their first menstruation and before they were considered matured for marriage. In the past, families of young girls, especially mothers and the girls themselves, looked forward to having their clitoris cut off in order to prepare them for marriage, the ultimate goal for girls to look forward to. Unlike boys, girls strive to abstain from sex until after their initiation because it is a cultural expectation that they remain virgins until circumcised. It was also believed that circumcisers had the ability to detect girls who were involved with men sexually before the circumcision took place. Girls who lost their virginity before this important rite of womanhood attracted a penalty, such as the payment of a goat. The loss of virginity imposes stigma and shame on girls and their families and potential suitors may shy away from them. These perceptions serve as a form of social control over girls' behaviour and sexuality and prevent them from engaging in sex before marriage.

The preparation for this female rite of passage involved accumulating special foodstuff, soup ingredients and Shea butter to feed circumcised girls during their time of confinement for healing. During the period of preparation, girls of the same age group secretly prepared together to undergo the procedure. Although it forms part of womanhood and every family expects their daughter to be circumcised, girls are expected to secretly escape to the circumciser's house before their parents hears about their plan to circumcise. However, they are expected to inform at least one person in the family about the plan, usually a sister-in-law, who will in turn tell the girl's parents and other family members who then go to the circumciser's house to offer their

69

daughter support. It is not clear why there was the need for girls to keep their intentions secret because it was an expectation that every young girl go through this rite of passage. During the procedure, girls were supposed to endure the pain and any girl who cried out attracted shame. After the ceremony, girls were kept in a secluded place for confinement and could not return home until their wound healed. During this period of confinement, potential suitors would send gifts to the family of the girl they were wooing, to take care of the newly circumcised girls. This procedure was viewed as a source of pride for young women and their family. Non-initiated young women get limited respect among their peers for "carrying their clitoris around" into marriage and uncircumcised girls were not permitted to take part in some activities in the communities. For example, if non-circumcised women harvested certain types of produce, when the vegetables were in their prime, the vegetables did not thrive. So it was common for some vegetable growers to suspect that their vegetables were not doing well because a clitoris-carrying adult female might have touched them. Apart from restrictions to participate in some community activities, FGM also has cultural reproductive health significance. Non-circumcised women were viewed as prostitutes and such women have difficulty during labour and giving birth because the clitoris obstructs the passage of the baby.

Despite the passage of law against FGM in Ghana in 1994 (Osam 2007), giving the appearance the practice has been eliminated and that a few offenders have been prosecuted, the practice still exists in secrecy, particularly in rural communities and in predominantly Islamic communities with entrenched cultural and religious values (Ako and Akweongo 2009; Jackson et al. 2003). Some families take their girls outside of Ghana to the nearest neighbouring countries to perform the rites where laws against FGM do not exist. This is compounded by weak law

enforcement within Ghana, thus making it a difficult situation to control and monitor (Ako and Akweongo 2009).

Although the practice of FGM has existed for a long time in Ghana, it is not clear where and how it originated. Some argue that it was imported from other countries with cultural links to Ghana since 1900 (Jackson et al. 2003). However, despite the links and perceived cultural significance there are a number of severe, irreversible health related and psychosocial implications of FGM for women, as well as a public health concern. These consequences are, of course, forms of violence against women, which most women have internalized and promote themselves. Health issues for circumcised women include severe bleeding and pain leading to shock and eventually death; anaemia as a result of the bleeding; local and systemic infection and septicaemia; delayed healing, gangrene and tetanus; chronic pelvic and urinary tract infections leading to kidney damage; dysmenorrhea; and, narrowing of the vaginal canal leading to painful sexual intercourse and subsequent infertility (Toubia 1994). In societies where this practice is performed on very young girls—approximately two to 15 years of age—it is common for death to occur. For example, Memuna, a girl who was about 12 years old and a classmate of mine during my primary school days in an area where FGM was common was declared dead a few hours after the procedure. This sad news was told to us in class at the beginning of the week immediately after the operation. The narrowing of the vaginal canal as a complication of FGM mentioned above also corroborates my experience with a young woman who lived in this same area as Memuna. I was working in a hospital on this particular day when a young man came with his new wife and revealed to me that his wife's vaginal canal had been sealed due to FGM. This problem was realized only after the marriage because the young couple had not engaged in any sexual activity before marriage as it is culturally inappropriate to do so. Other health

complications include obstructed labour, which can lead to foetal death; tearing of the perineum during labour and delivery; and, subsequently, the formation of a fistula (Toubia 1994). In Ghana, Nigeria and other parts of sub-Saharan Africa, fistulae in women are common and attributed to obstructed labour, as well as complications of FGM (Danso et al. 1996; Harrison 1986; WHO 2000). According to Danso et al. (1996), the majority of women who suffer this condition in Ghana are young women between the ages of 20-24 years old; all cases attributed to obstructed labour. This occurrence may have been as a result of FGM, although this is not specifically mentioned in Danso et al. Fistulae have significant implications for women's physical and psychological well-being and negatively impact on their social and marital relationships. For example, some women might be divorced by their husbands due to fistula while others may find it difficult to associate with peers and even family members due to persistent smell emanating from chronic urine incontinence (Danso et al. 1996). In countries with high rates of FGM and limited access to quality maternal health care, these kinds of complications from FGM can be a contributory factor to increased maternal and infant mortality. Although some allege that circumcised women can face psychological problems and are unable to achieve orgasm (WHO 2000), Toubia (1994) argues that there is limited evidence to draw such conclusions. Toubia suggests that this lack of evidence could be associated with denial and compliance with social norms because women are not permitted to express such feelings publicly and may not reveal their experiences as evidence. FGM, despite its cultural significance, violates girls' rights, poses negative health outcomes to girls and women and must be viewed as a public health hazard in those communities around the globe where it is practiced.

The social context of marriage and its implications for rural women

Similar to many other African societies, the people of Talensi-Nabdam are pronatalist with culturally shared values for marriage and childbearing as the goal of both males and females. The kinship system for this ethnic group is patrilineal (Fortes 1949) with rules of exogamy thus, people must marry outside both their matriclan and patriclan (Ensminger and Knight 1997; Sarkar 1997). Historically, marriage is considered the overall goal for young women and involves a series of processes starting with an extended period of courtship and ending with some amount of economic gain for the bride's family, usually for her father through her bride price. Although the value of a male child outweighs that of a female child in this setting, the economic gain that comes with bride price (Goody 1968; Tertilt 2002) and the culturally prescribed gifts that come from sons-in-law during funeral celebrations of parents and other extended family relations of the bride is one reason that girls are, to some extent, also valued. If girls did not bring a bride price and, if their husbands were unable to bring those culturally prescribed gifts to their affines funerals, then the little value that is given to females would plummet.

Bride price: the implications for women's reproductive health

As mentioned earlier in this chapter, bride price is a common traditional marriage rite in most African cultures and in other regions across the globe whereby the family of the groom provides wealth to the family of the bride in the form of animals, money or other culturally appropriate items (Hague et al. 2011). In most parts of northern Ghana, the payment of bride price is a joint decision by patrikin and resources may be pooled from members of the clan. In cultures that practice bride price, such payments have been identified as one of the main causes of violence against women (Hague et al. 2011; see also Wardlow 2006). Bride price, although beneficial to

the girls' fathers and brothers, is overall a disadvantage to women. The husband's family and

patrikin usually view women as commodities purchased for a specific purpose and women must

function as such. For example, studies in northern Ghana have illustrated how women's

reproductive rights have been compromised as a result of the payment of bride price and the

expectations that come with it, such as the number of children expected from the woman

(Phillips 2012; also see Yakong 2008). In situations where women decide to go against the

demands on them to bear as many children as their husbands and kin require, these women may

face severe consequences, such as beatings, their husbands marrying additional women, divorce,

as well as other equally demeaning results. In Uganda, for example, the payment of bride price

has been found to have profound negative impacts on rural women in particular and is the main

cause of domestic violence against women (Hague et al. 2011).

In rural northern Ghana, apart from receiving the main bride price, such as cattle, during

courtship, the girl's family receives other items including cola nuts, tobacco, a number of guinea

fowl and alcoholic drinks. Following the movement of the bride to the groom's house—whether

in normal or forced marriage—males, usually brothers and cousins of the bride, visit the family

of the groom during the night and receive two to three goats—usually the number is decided

through bargaining, an approach that is typical of a commercial business transaction. These goats

are slaughtered for consumption and part of the meat is carried home to the brides' family.

Following the goats, a chicken customarily seals the marriage and four cattle—usually one male

and three females—may be collected immediately or delayed depending on the circumstances

leading to the marriage. Unlike the unique case of 13-year old Mna-ingyela, discussed below,

whose mother was directly involved in receiving payments for bride price, customarily, mothers

are generally not involved in the decisions regarding their daughter's marriage and do not receive

any of the bride price that goes to the father or family head depending on lineage rules and the family's living arrangement.

In cases of a divorce, the return of the chicken actually ends the marriage as it was the chicken that sealed the marriage; thus, it is a cultural taboo for married women to eat chicken, a practice that can deny women an important source of protein in a diet of already limited protein in this culture. However, the four cattle must also be returned no matter how long the woman lived with her husband or her contribution towards accumulating wealth for him. The only exception is when a woman has living children, in which case, only one cow will be retained by the bride's family regardless of how many living children she had with the man. The one cow represents the children she bore for the man, a form of exploitation of womanhood and women's labour for the benefit of husbands and their patrikin.

Types of marriage

Polygamy is common in Africa, the Middle East, Asia and the Pacific Islands but also occurs in Europe, North America and other parts of Western societies (Broude 1994; Slonim-Nevo and Al-Krenawi 2006; Zeitzen 2008). Polygyny is an ancient practice, now associated with rural settings, usually also with age disparity, whereby younger women marry older men who have already existing wives (Dodoo 1998; Slonim-Nevo and Al-Krenawi 2006). Although there are some educated men who practice polygyny, the majority of polygamist men are not educated, suggesting that polygamy is now associated with social class and lack of education (Dodoo 1998; Slonim-Nevo and Al-Krenawi 2006)

The two main types of marriage in Ghana are polygamy (polygyny) and monogamy (Dodoo 1998; White and Burton 1988). Although currently diminishing among youth, polygamous marriages are still common in northern Ghana. The number of wives per man can

range from two to ten depending on the ability of the man to pay bride price but not necessarily his ability to care and provide support for the woman and her children. Several socio-cultural reasons contribute to polygyny, including men`s social positioning, their desire for more children, social status/prestige and men's promiscuous behaviours. The practice of polygyny is complicated by societal acceptance of such behaviours, which contribute to this practice (Fortes 1949; White and Burton 1988). Although women may not support their husbands marrying more than one wife, the decision is not made with permission or input from a man's current wives. Women are expected to live harmoniously with their co-wives and any expression of jealousy may attract social isolation from family members, forcing the majority of women in polygynous marriages to remain silent, even though the practice may have impact on their emotional well-being.

Despite the cultural support for having multiple wives, it appears that polygamous values are changing among some youth, particularly young women. A focus group discussion I convened with six younger women, demonstrated that women are contesting men's polygamous behaviours. They revealed that they would not allow their husbands to engage in such behaviours if they get to know about it. Lamisi, age 25, stated: "my husband will be afraid to carry another woman home. I will fight her and he knows it. He can have affairs outside but not in the house with girlfriends or marry many women. I do not care what people say about me but I will fight him and the girl." Naabmah, age 19, joined in to say, "He [her husband] tried it [polygyny] the other time and did not have it easy. I made sure the girl left the house immediately. Even though my mother-in-law thinks that I am crazy I do not care." The narratives of these two women suggest that there is some female resistance to polygamous marriages in recent times. It is possible that polygamous marriages may no longer be sustained among the youth, even if men

want to engage in such relationships. However, Lamisi's statement is suggestive that men can continue to be promiscuous but not marry multiple wives. This practice does not rule out health consequences, such as sexually transmitted infections, including spreading of HIV, if women are simply satisfied with not having co-wives but their husbands engage in extra marital activities outside the home.

Older married women had a different opinion on marriage values and felt it was worrisome that contemporary young women are breaking cultural rules and are not ashamed of it. Daboug, a 70-year old widow and a mother-in-law who had lived with her husband and eight co-wives, told me that, during her time, it was a nice thing to have co-wives and they lived together peacefully. She wondered why young women are now protesting against their husbands having other wives. She stated:

> In my time we treated each other [co-wives] like sisters and helped one another. We were never involved in any fight. It would be shameful to fight over a man. With co-wives you have someone to help you when you are sick or when you have a baby. We helped each other care for the children. We even helped and wooed girls for our husband to marry. It was a shame if your husband had only one wife. He was teased as someone who was either too poor or too ugly, such that no woman wanted him, except you. It was such a pride to be able to get a girl for your husband. We helped one another on the farm to accumulate more wealth for the family. Now I find it so embarrassing how daughters-in-law are strongly against their husbands bringing in more women to help them. I do not really know why they fight. Is it because of sex, or what? Times have changed, for the worst.

On her part, Nabil, a 50-year old woman, thought it was becoming routine for young women to fight against the idea of co-wives. She said:

> Apart from my own daughter-in-law, who is always fighting her husband, I have witnessed a lot of those behaviours in our neighbourhood and I think we should let them do what they want to. It is their husbands and it is their time. Our time is past.

The diverging opinions between younger and older women on the issue of polygyny are a clear indication that marriage values are changing with contemporary youth. The practice of polygyny

has influenced women`s reproductive health decisions, including competition among women/co-wives for the number as well as the sex of children (Whiting 1993). Resistance may lead to further decline in polygyny and its impact on women`s reproductive health decisions. However, types of living arrangements—whether young women live with their affines and other extended family or only with their husbands—may also be influential on young women's ability to succeed in their protest against polygyny.

Alternate form of marriage: Female to female marriage

Female to female forms of marriage exist in rural northern Ghana, but are very rare. This form of marriage involves one woman taking another woman for a wife and she performs marriage rites for her wife. This form of marriage is viewed differently from that of lesbian relationship and takes varied forms. In one form, the female husband may assume a masculine sexual identity and may dress as a man or engage in performing traditional masculine roles such as divination or sacrificing to gods. In another form, women who are unable to bear children due to incurable infertility may take another woman for a wife to bear her children. Female-husbands are normally resourceful, own their own houses and are capable of paying the bride price and covering all other associated marriage rites. They assume the social position of husband/masculine, including the responsibilities of caring for the wife/wives and children born to her. This type of marriage can also be either monogamous or polygamous. Unlike lesbian relationships, in this type of relationships the two women do not engage in sexual practices. However, it is not clear if female-husbands have any sexual relationship outside of their marriage. The wife/wives observe the same marriage rules as in male to female marriages. In order for the wives to bear children, the purpose for which they have been married, the female husbands have special arrangements in which they choose another man outside the lineage

78

whose responsibility is to impregnate her wife. This man assumes no formal relationship or obligation toward the children. This decision is made only by the female husband and she reserves the right to choose and to change to another man for her wife, should she decide to do so. As in male-female parents, children from this marriage also honour their female father in a culturally appropriate way.

Age at marriage

Within this Nabdam culture, there is no well-defined age of marriage for either sex. This lack of age definition may be attributed to the fact that keeping track of children's ages, as well as taking age into account to determine a girl's readiness for marriage has not been a practice since time immemorial. Although studies in 33 countries in sub-Saharan Africa suggest that the median age of marriage for the majority of women is between 16 and 20 years (Bongaarts 2007), in practicality, a girl's physical development, such as the development of breasts and the onset of menstrual cycle, are the key determinants of a girl's readiness for marriage, rather than age (see Fortes 1947; Ouattara et al. 2010 for a similar discussion). As in other regions in Africa, girls are generally married off earlier than boys (Jensen and Thornton 2003). It is a cultural belief that the younger the girl, the more fertile she will be and, since the main reason for marriage is to bear children, further delay can ruin her fertility. Her family's socioeconomic status is, to a large extent, another key determinant for when a girl is married. It is a common practice for girls in families with few resources to be married off at an earlier age than their counterparts with more resources. Resource-constrained families are also more likely to betroth their young girls or forcibly marry them off for the economic gain of bride price.

Studies of early marriages in several challenging contexts including Ghana, strongly suggest that such forced marriages have major negative implications for women's mental and physical well-being and their future development (Ghana news agency 2013; Ouattara et al. 2010; Gaffney-Rhys 2011). However, a wide range of arguments from some countries, particularly in the Arab world and from some Islamic groups in Ghana, strongly oppose the plea to ban child marriages for girls, suggesting that later marriage would ruin women's fertility (Daily Guide 2013; Gaffney-Rhys 2011; Jensen and Thornton 2003). This argument supports violence against women and disregards an international stance on protecting the rights and integrity of the girl child across the globe.

Betrothal marriage

Despite Ghana's 1998 Children's Act, which came into force in 1999 and prohibits any act or behaviour that is detrimental to or deprives children of equal rights, including forced marriages and child betrothal (Laird 2002), these types of marriages are common across rural communities in Ghana (Ghana News Agency 2013; Osam 2007). Marriage by betrothal is a type of marriage that gives girls no options as a result of a contract between parents, an individual or a family of the potential husband when the girl reaches a perceived marriageable age (Osam 2007). Betrothal can even take place before the birth of a girl. The betrothal process takes several forms. One form is associated with spiritual or traditional medical reversal of a reproductive health situation. For example, when a married woman is affected by infertility, a spiritual or traditional medicine man, who possesses the ability to cure infertility either spiritually or medicinally, does so and signs a contract with the father of the yet to be born baby that, should the unborn child be a baby girl in the future—it does not matter whether it is the first baby born after the treatment or subsequent ones—that girl shall be given to him for marriage. He may or may not marry this girl

80

himself; however, any family members, a son or nephew, can marry her. In the event that the medicine man dies before a girl is born, his family will ensure that, when a girl child is born, her family will honour the betrothal.

Another health related situation that leads to betrothal is when a woman experiences successive deaths of her babies and a medicine man reverses the situation. The family enters into an undertaking that a baby girl born after the infertility reversal shall be given to him for marriage. Also, when a girl is seriously ill and death is perceived to be inevitable, if any medicine man is able to cure her, then the girl can be betrothed to marry the curer.

In another situation, when a male visitor is present in a house where a woman labours and she gives birth safely to a girl, the baby can be betrothed to the man because it is assumed that the birth was safe due to the visitor's good luck presence. This kind of betrothal is referred to as *loor*, which literally means, 'tying of the girl.' If the visitor is interested in pursuing the marriage in future, he is required to provide herbs used for rituals for a newborn baby's drink and bath. He is also expected to continuously pay some kind of courtesies—usually in the form of gifts of food and guinea fowl to the mother-in-law to be—as the girl grows. In recognition of this, the girl is expected to marry him or someone in his family. In the case of the loor, it is not as serious compared to the other situations above, where the girl must marry into the curer's family otherwise ill health or death can result.

Another case where betrothal can occur is when a relative, usually a married woman takes a niece or a friend's daughter to her marital home to raise her. If the girl is not the woman's direct relative, such as a niece, when she grows up she is expected to marry the woman's husband or a member of the family as appreciation for the care offered her in that house. The girl can refuse if she does not like any of the men offered her for marriage but there will be

resentment from the family and curses that may cause her ill health. Also, a girl can be given to her paternal relative—usually an aunt, a cousin or a sister—who happens to have only girl-children or is unable to bear children of her own with her husband. The girl grows with the woman and marries her husband so she can bear children to fulfil her relative's reproductive goals. Also, a married woman can take in a young girl to simply raise her and give her in marriage to a friend's son or a young man who has been helping her in her garden over the years and has been good to her. For example, it is common for a woman to take a girl from her patrikin to her marital home to help take care of her children. In such cases, the girl grows up with the woman and her family. Later the girl's paternal kinswoman gives the girl for marriage into her husband's family.

Child betrothal is a socio-economic issue (Laird 2002). For example, a family with fewer resources can borrow from a wealthy family—usually food in large quantities over a period of time or animals—and, in the event that they are unable to pay back this debt, a baby or a young girl can be promised as debt repayment. The recipient family decides if the girl should be sent to live with them—if she is older—or be allowed to grow up to a marriageable age with her parents before moving her to their home. In this kind of betrothal, it is possible that a girl can grow up to refuse the marriage and another girl will replace her. If the recipient family refuses to take anything in payment of the debt other than marry a girl from the indebted family, a sister of the previous girl can become the next victim.

Forced-marriage, forced sex: Neglected human and sexual rights of the girl child

Early and forced marriage exists in rural Ghana and remains a concern both for women's rights and for women's health. For most women in resource-poor nations, marriage is not something over which they have any control or choice (Ghana news agency 2013; Issahaka et al. n.d). The

majority of the women I interviewed indicated that they did not choose their husbands; rather their husbands were chosen for them by family and kin, a situation that inevitably means forced sex by intimate partners. Forced sex, irrespective of whether a woman is married or not, is a breach of women's human and reproductive health rights. Although one of several forms of violence against women recognized internationally, forced marriages are common in most rural settings of challenging contexts nations and carry severe consequences for its victims (Osam 2007; Ouattara et al. 2010).

A forced marriage occurs when the consent of the girl involved is neither sought nor respected. In most cases, she may not know her potential husband, let alone have any affection for him. In rural Ghana and other resource-poor nations around the globe, such as India, Nepal, Benin, Burkina Faso and Côte d' Ivoire, studies reveal that girls are forced into marriage, often between the ages of nine and eleven years old, before they attain biological maturation (see Ouattara et al 2010). Apart from the fact that such girls are married against their will and do not know their husbands-to-be, they are also married off to older men, the age of their fathers or grandfathers. Older men are those with more power or more resources, such as cattle—the main items used as bride price in some parts of northern Ghana—or money for bride price, which benefits the girl`s family, especially male members. The young girl involved does not benefit from any part of the bride price. Although in most cases, if the girl would resist marriage, force, which may result in physical abuse by her brothers, is used to take her to the husband's compound. In routine marriages, bride price may not be immediately taken by the bride's family. But for a forced marriage, the bride price is transferred quickly, to prevent the girl from leaving her marriage because once payment of bride price is accepted, the girl cannot leave her husband. This practice reinforces the perception of females as commodities, where bride price is a type of

interaction between seller and buyer and once the bride or a "commodity is purchased," it cannot be returned. This practice also suggests that girl children can be used to settle debts incurred either spiritually (through curing or luck) or materially (through borrowing goods).

Around the globe, victims of such marriages can experience intimate partner physical and sexual abuse (Jensen and Thornton 2003; Ouattara et al. 1998). A study of intimate partner violence against women in ten different countries, in both urban and rural settings involved 24,097 women between the ages of 15 and 49 years (representing women's standard reproductive ages) found that the majority of women who experience such violence consequently suffer poor health outcomes (Ellsberg et al. 2008). In most parts of Africa, research shows that most young women are sexually abused before they reach the legal age of marriage or before they can engage in sexual relationships by choice (Koenig et al. 2008).

In early and forced marriages, sexual abuse is a common occurrence regardless of the girl's age, creating permanent psychosocial trauma that victims endure for the rest of their lives. Under these circumstances, the girl-woman loses control over her sexual and reproductive rights and choices. For example, on 15 September 2011, at a hairdressing salon where I often hung out with women for the purpose of this research, I met Mna-ingyela, who was 13 years old and a victim of a forced marriage. At the time I met her, she was an apprentice at the salon. She told me her experience of being forced into marriage to an older man, who she described as about 55 years old and already married with three wives. According to Mna-ingyela, two of the man's daughters were her own age. Mna-ingyela, was removed from school by her parents and married off to the man who offered the parents money instead of cattle. In contemporary Ghana, money is now being used in place of cows, the traditional form of bride price payment, which furthers

the argument that girls are a commodity being sold in the market. The girl tearfully related how it all happened:

> I was at home one night when this old man arrived to our house. I had never seen him before. My parents told me they were giving me to this man to be married and that he is taking me with him to his village the next day. I resisted but my parents beat me up. I was forced to go with him. The very day we arrived at his home, he sexually assaulted me and it has been so since. My mother followed up and took some money from him. I did not know how much she took but I know she took money because I heard them talking about money.

Mna-ingyela's story corroborates evidence provided in studies across several resource-poor nations around the globe (see Ouattara et al. 2010), which indicate that forced marriage, apart from having cultural significance, is also a women's issue related to poverty. A multi-country study in which most of the countries involved were resource-poor nations revealed correlations among high rates of intimate partner violence, sexual abuse, and poverty as a leading role in forced marriage (Ellsberg et al. 2008). The right to freely make sexual and reproductive health decisions is lost, because girls do not have the autonomy to manage their own sexual life. In many cases, where girls suffered similar fates to Mna-ingyeal, they live with the trauma for the rest of their lives. They may never have the opportunity to speak about their experience due to stigma and the cultural inappropriateness of discussing intimate matters, as is the situation in Ghana (Boakye 2009; Ouattara et al. 2010).The difference in my research is that Mna-ingyela was openly discussing her experience with her working colleagues and her mistress or trainer with whom she was studying as an apprentice. Her willingness to share her story resulted in support from her mistress to cope with her predicament. The consequences of forced sex also include unintended pregnancies and other gynaecological complications such as vaginal bleeding, experiencing pain during sex, chronic pelvic pain, urinary tract infections, other pelvic inflammatory diseases, and sexually transmitted infections such as HIV (Eby et. al. 1995; Glover

et al. 2003; Koenig et al. 2004). It is possible that Mna-ingyela would have become pregnant or

even had a child resulting from unintended pregnancy by the time I met her; however, her

readiness to talk about the situation led to the kind intervention of her mistress. The mistress told

me:

> I first got to know about Mna-ingyela's situation when she came to work with me one
> day and I observed that she could not walk properly. When I asked her what the problem
> was, she told me that her husband has been forcefully having sex with her all-day long. I
> had to secretly take her to the family planning clinic to talk to the nurses so that they give
> her pills to protect her from getting pregnant. I feel so sorry that she had to go through
> this but I did not have any other way to help her.

Although there are social services and security agencies that have the legal authority to

help protect women from domestic violence and other related abuses, it appears that such

systems do not live up to the task. The mistress further commented that she

> thought of reporting her [Mna-ingyela's] situation to the police and some organization in
> town where people say they help women who face domestic violence but I knew that
> even if I did report, they would not do anything. They just do not help.

This perception held by the mistress with regard to the attitude shown by security

agencies towards victims of domestic violence in Ghana, reflects Boakye's (2009) finding that

perhaps due to this kind of inaction, rape cases in Ghana are rarely reported to the police

services. Such indifference by police and other services might also be associated with the

endemic nature of corruption in Ghana in general and with the police service in particular, which

a broad spectrum of the media reports as being a major concern in the country (Joy Midday

News 2013; Ministry of Youth and Sports report 2013; Uneke 2010). As a result of the

mistress's comment, Mna-ingyela was prompted to share more about her sexual abuse

experience. She explained further:

> I never had sex before I married this man but, since I came, he forces me every day to
> have sex with him. In the beginning I bled profusely and cried every day. As soon as he

comes back home from work, he would ask me to stop cooking and come and have sex with him after which I would continue to cook. Throughout the night it continues. I get up each day very tired and sometimes cannot even go to learn my hairdressing. I plead with him but he would not stop. He tells me that I would soon get used to it and that he has paid my parents for me. He beats me whenever I attempt to refuse sex.

The payment of bride price has erased her sexual rights and made her a purchased item for the purpose of sex. Although at the time of the research, she was committed to learning skills to make a living in the future, it is possible that Mna-ingyela might give up using birth control to become pregnant in order to save herself from daily beatings. Her husband was expressing concerns that she was not getting pregnant, another reason for the beatings.

He said I have to get pregnant and wonders why I am still not pregnant yet, given the number of times he has sex with me. He suspected that I may have been doing birth control. He beat me up and threatened to take me to the clinic for medical examination to determine what was preventing me from becoming pregnant.

Mna-ingyela's mother, who had come to visit her son-in-law, received complaints regarding her daughter's poor attitude toward sex and came to the salon. She warned her daughter to be a dutiful woman and accept whatever her husband asked of her, otherwise she would be dealt with mercilessly. When she left, Mna-ingyela hinted to me that her mother had come to receive some money from her husband as part payment of the bride price. At this point she said, "I hate my mother. I do not even want to see her any more. It does not look like she is really my mother." She did not appear to get much help or sympathy from her mother about how her husband treats her and her mother's attitude reinforces the normalization of such actions. Consequently, Mna-ingyela's voice remains silenced and she is robbed of her sexual rights, her girlhood and her womanhood. Intimate sexual violence is perceived as normal by society, a private issue between husband and wife and should not be interfered with by the community; thus such actions receive little attention. Most girls, therefore, live their lives with unachieved future goals and remain domestic servants and sex objects to their male partners. According to

87

the United Nations declaration on the elimination of violence against women, such violence is

defined as:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual
> or psychological harm or suffering to women, including threats of such acts, coercion or
> arbitrary deprivation of liberty, whether occurring in public or in private life (UN
> 1993:1).

However, despite this definition, most member countries do little to protect women in

such situations, leaving victims like Mna-ingyela to their fate. Current research in Ghana on the

different forms and levels of violence against women across society revealed that there has been

an increase in incidences of reported domestic violence as follows: 360 in 1999; 385 in 2000;

648 in 2001; and 3,622 in 2002. (Amoakohene 2004: 2374). Matters related to domestic violence

of any form, especially against women, get little attention in Ghana. This inaction is related to

the cultural construction of masculinity and femininity, whereby it is culturally expected (and

accepted) for men to be violent and women to be submissive (Adinkrah 2012). However, "one of

the aims of the [UN] resolution was to overturn the prevailing governmental stance that violence

against women was a private, domestic matter not requiring state intervention" (UN 1993:1). The

Domestic Violence Act in Ghana (Manuh n.d: Stafford 2008), after several decades of debate

among legislators and the general public, was recently passed into active law. Men were the

dominant group opposing the passage of this law (Stafford 2008) and legal and political

enforcement remains weak on these matters. Despite the overwhelming negative consequences

for women (Sampson 2010), the lack of political will makes violence against women a trivial

issue, and thus little attention is paid to it.

Spousal rape, although a critical global issue, is endemic in Ghana and receives very little

policy attention because it has been associated with patriarchal privilege. Indeed, in passing the

law against domestic violence, spousal rape was deliberately removed due to public pressure,

88

mainly from men as the dominant group, against the passage of such law (Stafford 2008). When I was growing up as a little girl in this culture, it was not uncommon to hear young women crying in the middle of the night for help due to spousal rape but no one came to their aid. Rather, the women were chastised by men for not fulfilling their marital role and why else did they get married, anyhow. Although an active law in many parts of the world (Boakye 2009), the law against spousal rape is still in its preliminary stages in Ghana and is being revisited and debated. Existing evidence suggests women in Ghana, as in other African countries, do not have any legal protection against marital rape (Sampson 2010). However, even in the unlikely event that such law is passed in Ghana, from all indications, I argue that it may not survive the test of time, given the fact that it lacks support from the very male dominant group who are the perpetrators of such violence in the first place and men control the cultural, domestic and legal systems. In addition, most public sector security apparatuses, particularly those designed to protect women, are weak and often do not live up to the task. The failure to enact some of the laws beneficial to women—perhaps for undefined cultural reasons—is endemic in most countries of sub-Saharan Africa societies where male dominance prevails. "Violence against women is the most pervasive yet least recognized human rights violation in the world. It also is a profound health problem, sapping women's energy, compromising their physical health, and eroding their self-esteem" (Heise et al. 2002:5). I argue that the most damaging of these harmful effects for women is to have their bodies sexually abused throughout their sexual and reproductive life time. Women in these circumstances have to live with trauma and are forced to normalize what they cannot openly speak of, while their experiences are perceived as trivial in the eyes of the community and local governments, in spite of the consequences for their health and well-being.

89

Socio-cultural consequences of divorce for rural women

In the patrilineal kinship system of northern Ghana generally and in my study area in particular divorce has negative consequences for women (Fortes 1949; Stone 2006). The first step taken against a woman seeking a divorce is to deny her the right to see her biological child or children, unlike in matrilineal systems of some parts in southern Ghana where a divorced woman retains her children (Anarfi and Awusabo-Asare 1993). Customarily, in a patrilineage, a woman loses her right to her own children because traditional rules of descent and marriage (and payment of pride price) mean all children belong to their paternal family, which has full custody. The child's patrikin reserve the right to deny a woman from seeing her children, particularly her male children. This denial of one's children is a major reason that most women in this culture may decide not to divorce and not to leave an abusive relationship (Yakong 2008). If she does divorce, the children may be allowed to visit their mother's brother's house, that is, the woman's paternal home, where she could sneak in to see them. However, in most cases, perhaps as a way of punishment for the women, the children may be prevented from visiting their mother's paternal home too. In case of a remarriage, the children are prohibited from visiting their mother in her new husband's home, because of a belief that ill health may befall them should they see their step-father. For example, Tempoka, a 23-year old woman, who contemplated leaving her husband, due to a long standing unhealthy relationship, specifically noted the potential denial of access to her children as her main reason for deciding to stay:

> I would have left him long ago but for my children. I do not want to leave my children and walk away and not know when I will see them again. I just cannot do it. In our tradition here, when a woman leaves her husband, [she is] prevented from coming to that house again and the children too are prevented from coming to their mother. I prefer to stay and endure all the hard things than to go and leave them. My life will be incomplete without my children.

Tempoka's experience is not different from several other women experiencing similar situations in their relationships, who cannot walk away even though that relationship may have a negative impact on their well-being and integrity.

Another influence on women's decisions not to seek divorce is the return of the bride price (Bond 2005; Hague et al. 2011; Issahaka n.d.). In many cases, the woman's family will not be willing to return the bride payment they received. They may either have used the items already and cannot afford to replace them or they may simply refuse to do so. In that case, pressure mounts on the divorced woman to either return to her abusive husband or remarry so they can get another bride price to use as repayment. Depending on how many children she has had already in her previous marriage, it can be difficult for her to readily find another man to marry, because any suitor considering marrying her will base his decision on whether she is still fertile enough, given the number of children she has borne already and how many more she can still bear for him. Even though she may be interested in remarrying, her chances of remarriage can be limited due to their perceptions of her fertility. Due to the pressure to repay the bride price, her family, particularly her father and brothers, will be reluctant to receive her back home. As a result she may be beaten by her brothers and sent back to the husband, regardless of the circumstances that led to the divorce. In extreme cases, such women may relocate to areas where they can make a living and may end up on the streets or engaged in unhealthy sexual activities, a situation that often results in sexually transmitted infections, including HIV.

Women have limited access to property ownership in this traditional Ghanaian system. In the course of divorce, women lose any property they acquired while living with their husbands, even personal clothing. According to cultural norms, whatever a woman acquires during her marriage belongs to her husband. In extreme cases, the woman may be stripped naked of all the

clothing that she bought and particularly clothing her husband may have purchased for her as a gift. This is a degrading situation that may prevent some women from choosing to leave their marriage. Currently, there are no cultural rules that support property sharing in the case of divorce; thus, women are left helpless and without resources when faced with such situations.

To be single is a culturally stigmatized status that also prevents women from leaving a marriage. In traditional village settings, one can easily count the number of women, as well as men, who are not married. For an adult woman not to be married means there are specific reasons, known to the community, that are preventing her from marriage (see Fortes 1949). These reasons may be real or perceived but have major socio-cultural significance on a woman`s ability to find a partner. One reason is accusations of witchcraft; in fact, to be accused as a witch is the most serious form of stigma and can ruin a woman`s life chances. The accusation of witchcraft may or may not be directly pointed at the woman but, because witchcraft is believed to be inherited through the matriline, the accusation would also implicate her mother and matrilineal grandmother (Fortes 1949). If the woman or her family have a personal history of stealing, any form of severe affliction, especially mental illness—particularly epilepsy, which is believed to be transmissible, to the extent that people are afraid to even share a seat with an epileptic patient because they believe they can be infected through close contact—or, if there is a perceived infertility, all inhibit a woman's ability to attract a husband. Among the Talensi, Fortes (1949) found similar reasons are attributed to both men and women's inability to find marriage partners. Fortes relates that, unlike women, extremely ugly men were more affected in their efforts to find wives. Thus, the stigma associated with being single makes it difficult, if not impossible, for women to seek divorce.

Summary

The several factors revealed in my study with regard to women's lack of control over their lives suggest that, in rural northern Ghana, girls and women are, for the most part, generally forced to live their lives for the benefit of their husband's families and for society, rather than for their own benefit, a situation that robs women and girls of their rights and dignity in several dimensions of their lives. The socio-cultural conditions that limit women's agency in decision-making forces women to continually accept, internalize and normalize their way of being. This has enormous implications for their reproductive health and general well-being. This situation has been culturally taken for granted in order to serve the interest of the dominant male group. Despite the existence of social laws purported to protect women, the evidence shown in my study and others (Laird 2002), suggests that the mere existence of laws is not enough to help vulnerable women unless certain factors available to enhance the proper implementation of those laws are assured. For example, there must be a high sense of commitment from law enforcement agencies to be devoid of corruption and better socio-economic conditions are required to improve the lives of the poor majority. I also strongly argue that it is not just improvement in socio-economic conditions alone but also formal education, especially for women and girls that will break the pervasive circle of violence that currently forces the majority of women in Ghana and throughout sub-Saharan Africa, to accept the unacceptable in their lives.

Chapter 4. The invisible role of rural women: mothers, wives and producers

> I wanted to go to the clinic today for prenatal check-up but I could not make it there. It rained last night and my husband and I had to go to the farm to harvest groundnuts. I will see how the work goes so that next week or so I can go for a check-up again (Yenyeya).

The socio-cultural context of women's lives and living conditions affects their life decisions, including those of maternal health care access and utilization. In rural northern Ghanaian cultures, women's lives, work and roles are embedded in family and constructed and shaped by gender specific cultural rules, norms and beliefs. In a variety of ways, this cultural definition of woman and the expanded responsibilities that come with it, influence women's decisions and the choices they make either directly or indirectly and, thus, has implications for their well-being. However, this kind of evidence is conspicuously ignored by many social scientists. The dearth of this type of evidence may be a result of take-for-grantedness or an assumption by researchers that such information is common knowledge and need not be captured in research findings. This dearth of evidence for the cultural constraints affecting women's decision making also affects how health care policy makers formulate policies with limited information, as well as how those policies are implemented by health care providers. I was motivated to contextualize women's lives and work in relationship to their health and well-being because of Yenyeya's statement above; a woman who could not access prenatal health care due to cultural and familial expectations that she work on the family farm. It is no surprise that the majority of people, particularly those who enjoy a higher socio-economic position, such as health care providers, compared with women in most rural settings with challenging living conditions, often blame women for neglecting their own health. Health care providers may not have anticipated that daily work, such as routine farming activities, can often be a barrier to women making positive health care decisions for their own Well-being.

Intra-household provision of labour

A gender-based structuring of family and household responsibilities and the embedded socio-cultural expectations forces women to take on extra responsibilities in order to sustain their family. Although domestic work and women's labour have not been recognized in Ghana, women's crucial and ever increasing roles and responsibilities in the family cannot be underestimated. Women's roles in the family and beyond, whether in a rural or urban setting, in developed or in challenging contexts nations, have health consequences (see Avotri and Walters 1999; Messias et al. 1997; Waring 1999).Women's workload is often overlooked and categorized as routine because most activities women engage in are not assigned an economic or monetary value (Duncan 2004; Waring 1999). The invisibility of women's roles as mothers, wives and producers and their contribution to family subsistence and sustenance, and the consequent health implications of these roles are of particular importance to those who are already under privileged due to their particular circumstances, such as women participants in my study. Although evidence suggests roles and responsibilities of rural women differ from urban women (Boserup 1989), since rural women, due to their living circumstances, carry extra workload compared to their urban counterparts. From an insider researcher perspective, I argue that women in rural Ghana carry extra responsibilities that result in their inability to make decisions, especially those related to their own health care. Outwardly, rural women in this study may seem very delightful and strong. They may carry on with their daily life activities happily, regardless of their social position. However, their daily life experiences are embedded in challenges. In the following sections, I discuss women's traditional and contemporary socio-cultural roles and the implications that these roles pose for their general well-being and especially their reproductive health.

Gender and work: The division of labour within the family

Despite advocacy for gender equality and equity in Ghana, the division of labour in society and within the family is strictly gendered (Adinkrah 2012; Issahaka n.d). This gendered division of labour is more evident in rural settings where social and gender values are persistently enforced. Hence, there has not been any appreciable change with regard to the gendered structuring of labour rural areas. The traditional division of labour not only neglects current advocacy for gender equality and equity in Ghana, but it also has negative implications for women's well-being since cultural expectations of women's gender roles tend to attract additional duties compared to their male counterparts.

Distribution of daily work and activities is commonly structured, assigned and controlled by the family head—usually husbands or landlords—and communicated to each member directly or passed along through mothers-in-law. In the absence of mothers-in-law, senior wives take over this role if there is more than one wife in the family set-up. This distribution may occur either after the evening meal or in the morning. Usually, women wait for their work schedule from their husbands before they can determine whether there is space left for them to fit in their own schedules, including any health care activity such as attending prenatal care, which can be perceived as a personal activity by their male counterparts (hence inconsequential from men's perspective). Neglecting the day's household work to attend prenatal care, for instance, may be considered an excuse for laziness on a woman's part. Consequences such as denial of her ration of food, wife battering or reporting to the woman's parents about her inability to uphold her role as a woman may result. Because of cultural expectations of women's roles and responsibilities, it is culturally inappropriate thus, uncommon, for women to question their work assignments. An inability to question or even negotiate her work load can result in women working around the

clock to sustain the family leaving no time to attend activities for their personal well-being. This is the context for why women would rather suspend attending a prenatal care clinic to attend to household/production work, a decision that may result in adverse health effects.

Subsistence activities: Women as the focal point of production

In most parts of rural Ghana, subsistence based on informal agricultural farming (both crop cultivation and animal rearing) is the main activity to earn a livelihood for both men and women (Duncan 2004). Apart from subsistence farming, in most parts of northern Ghana there are no formal activities for earning a living. Besides the lack of job opportunities available in this area, women have an added disadvantage in that they possess limited employable skills outside subsistence agricultural activities. This is due, in part, to their lack of access to formal education. Previous studies in Ghana reveal that the majority of rural women are non-literate (Duncan 2004; Quisumbing et al. 1995; Yakong 2008).

Historically, studies have shown that women's access to formal education in most resource-poor nations, with particular reference to sub-Saharan Africa, has been attributed to the embedded socio-cultural, institutional, socioeconomic and political factors which create and reinforce conditions favouring educating boys and men over girls and women (Shabaya and Konadu-Agyemang 2004; Laird 2002). The situation is particularly alarming in northern Ghana as it is possible to find entire communities where not a single woman is educated (Shabaya and Konadu-Agyemang 2004). In rural Ghana, some of the socio-cultural barriers to education include negative perceptions that educating girls is of no benefit to her natal family because she will eventually marry and the benefits of her education would go to her husband and his kin. The perception held by most men is that educated women have access to diverse options for life, thus, making it difficult for men to control them. Men's extreme control over women's lives is such

that women are turned into servants rather than equal partners in life. Women's and girls'

multiple gender roles in the family and household leaves them with limited time to engage

successfully in academic activities compared to their male counterparts. Equally of concern is a

general societal disregard for women's intellect and their ability to engage in academic

endeavors. All these factors are structural barriers that prevent girls and women from obtaining

their educational goals (Moletsane and Manuh 1999; Tanye 2008). Also complicating education

for girls is the current breakdown in social morality. School girls are frequently sexually

harassed by male teachers and school peers, resulting in teenage pregnancies and high dropout

rates. This raises anxiety in some parents who, as a result, refuse to send their girl child to

school. The poor socioeconomic conditions, attributed to the structural adjustment programmes

introduced in the mid-1980s by the Ghanaian government with enforcement from the World

Bank and International Monetary Fund (Moletsane and Manuh 1999), contribute to the high cost

of living and the inability of poor families to afford school fees and related education costs. Such

structural adjustments play a major role in women's and girls' limited access to education

(Shabaya and Konadu-Agyemang 2004). Another major and systemic factor affecting all levels

of education in Ghana but with a particular negative impact on girls rather than boys, is the poor

quality of education. Unlike boys, girls carry extra household responsibilities helping their

parents care for their siblings, they are unable to seek extra instructions outside of the

classroom—a routine practice in Ghana due to poor teaching during normal school periods—to

help them gain a better understanding of their subjects, thus enable them pass their final

examinations. This poor quality of education is attributed to a lack of qualified teachers in

schools, as well as low levels of teachers' commitment, particularly in rural areas, which results

in students' failing their final national examinations. These high rates of failure result in the

inability of both junior and senior high schools graduates' to further their education. Thus, the majority of the rural poor who invest in their children, so that their offspring become their social security in their old age, resort to keeping their children at home, particularly girls, with the justification that such an investment is a waste of resources because the future benefit is insignificant (see Laird 2002; UNDP 1997). In such circumstances, girls are considered to be better off staying at home to help their mothers generate income to support the rest of the family.

However, despite evidence showing high illiteracy rates among rural people in Ghana, specifically girls and women (Jolliffe 2004; Laird 2002; Tanye 2008), most public sector jobs require formal skills and the ability to read and write in English. As a consequence, lack of formal education becomes a severe limitation for women. Lack of education in rural Ghana also has negative influences on agricultural activities, the main source of income the majority rely on for living and, consequently, poor food production (Jolliffe 2004; Quisumbing et al. 1995). The high level of illiteracy also has implications for women's personal choices and family health outcomes because education indirectly plays a role in improving living standards in a variety of ways. For example, educated women may have more access to information to make informed decisions regarding their reproductive health, compared to those who are not educated. Educated women would have access to employment opportunities to increase their income. Educating women would go a long way to reducing current abject poverty and increase access to nutritious food, quality health care, clean water and sanitation, including access to hygienic toilet facilities, a means of transportation and, consequently, increased life expectancy and decreased death rates. Educating girls and women clearly impacts numerous variables associated with rising living standards across the globe (Montgomery et al. 2000). In addition, women's education has positive impact on their reproductive health decisions and on their family health compared to

uneducated because educated women can have access to important printed information to make informed decisions (Martin 1995; Waiz 2000).

Successful agricultural activities in my study area and most parts of rural northern Ghana where there are harsher weather conditions and frequent drought, relies on one main season: the rainy season. This season commences approximately in May and lasts to October. This season can vary, sometimes unpredictably due to weather changes associated with current climate change issues (Citifmonline 2013; De Pinto et. al. 2012; General Agricultural Workers' Union of Trades Union Congress 2012). In Ghanaian society, every household owns farmland passed down through patrilineal inheritance to the male child/ren (Brown 1994). Women are excluded from ownership of farmland since, by customary law or northern Ghanaian traditional law, a woman does not belong to her husband's patriline. Thus, even in situations where civil law permits women's ownership of property, including land, customary law excludes them (Quisumbing et al. 1995). It is on this basis that women have limited access to fixed properties, such as land. Women therefore work to cultivate food crops on the farmlands belonging to their husband, sons and their male affines.

In terms of a gendered division of farming labour, men are responsible for the initial tilling of the soil, while women do the sowing as well as helping in farming activities, such as weeding. A number of research findings suggest that, in Ghana and around sub-Saharan Africa, women provide over 90 per cent of agricultural labour, with long hours of work on the farm, plus several additional hours spent on food processing and other housework. Despite this intensive labour output, women's contribution to farm production remains invisible because their work is considered non-paid work, and consequently cannot be quantified monetarily (Duncan 2004; Quisumbing et al. 1995; see also Waring, 1998, If Women Counted). In my previous research

(Yakong 2008), during my interviews with some women in the shade of a tree, I watched several women walk past with heavy loads balanced on their heads either going to or coming from their farmlands. Some women approached me, as culture demands, to exchange greetings and to let me know that they wanted to take part in the study but, due to their heavy workloads, they were unable to do so. For example, Assibi, a woman who appeared to be in her 20s, said to me, "I wanted to come for this interesting conversation but I have to go to the farm. My husband has already gone and I have to hurry up, if not, there will be a problem." Despite several other duties women have to perform at home before leaving for farms—cooking food for children as well as getting them ready for school, making food to carry to the farm and fetching water to the farm for drinking—they are still expected to be on time for farm work and any delays can cause a misunderstanding between husbands and wives. Another woman (Figure 3.), who appeared to be in her early 40s, carrying a big basin on her head containing seeds for planting, walked over to me while I was interviewing another participant, to share greetings and inform me of her inability to participate:

> Oh, I wish I could come and talk too, but I have to go to the farm. After the farm work, I also have to go and cut firewood for cooking. Until this season is over, there is just no time left for any other thing. It will be a fight [with her husband] if I do not get to the farm early enough. They [husbands/men] always say we women are always out there gossiping when there is work waiting for us.

Figure 3. Woman carrying basin with seeds to the farm, approaching to share greetings and excuse herself from participation to go to the farm. Seated is the researcher conducting interview with a participant. Photo credit: Kennedy Anaba, August 2011.

The above comments, including the quote at the beginning of this chapter, suggest that heavy workloads are a common theme affecting the majority of women in the village. This drew my attention to the fact that women's lives are affected by complexities of commitments, which women must observe and which are challenging and a hindrance to accessing maternal health care. It is important to bear in mind that, as much as the health care system has a professional responsibility to help women maintain optimum maternal health, there are several factors beyond the women's control that may be viewed as irrelevant from the perspective of the dominant health care system. For change to happen so that women fully access beneficial health care, it is

important that health care providers and policy makers become sensitive to the socio-cultural context within which women's lives are constructed and adopt ways to structure care that accommodates women's heavy schedules and health needs. It seems to me that not much has changed with respect to women's workload between the time I conducted this current study and when I carried out a similar study six years earlier in 2007.The only thing that has changed from women's perspective and mentioned by the majority of the women, is the existence of the women's project (GROW) mentioned in the previous chapters, which aims to improve their socio-economic, educational and health care needs. For example, one participant (Azumah, age 34) commented on how her experiences and ideas have changed because of the opportunity to share ideas with other women in their meetings. She said, "I find it helpful being a member of the women's group because we share ideas on what to do and how to find help if one has a family problem. We even talk about doing birth control without 'those men knowing it'," she laughed. To a large extent, the women's group project serves as a point of consciousness raising for women in this community. Although the women's project was cited as a source of support in reducing women's burden and increasing knowledge through information sharing, women's current living conditions remain a long way from realizing any form of gender equality and equity in rural Ghana and, indeed, in Africa as a whole (Issahaka n.d.).

Women's Gardens: Ensuring family food security

Food security is defined as "secure access by households and individuals to nutritionally adequate food at all times and procured in conformity to human aspirations and dignity" (Hesselberg and Yaro 2006:41). Apart from working on their husband's farm, women are expected to put in a number of additional hours to produce their own gardens. Even though they may not be able to work successfully on their own garden, depending on how many hours of

work they put into their husband's farms, having a garden seems to be the only way they can ensure food security, particularly for their children which is usually the major concern for women. Having enough food to last the family for the non-farming season can be the result of inadequate yield due to drought. Often, since produce from the main farm is strictly controlled by husbands, women either do not have access to it or the produce is sold by men for cash to spend on other things, like alcoholic drinks or presents for their girlfriends outside the marriage. Yenpokbire, a 32- year old woman told me that she was beaten by her husband because she disagreed with him selling their millet to buy himself "akpeteshie," a locally made alcoholic drink when they did not have enough food to last the non-farming year. In this situation, wives then have to find food for their children. Work on a husband's farm must be finished before women can work on their own gardens, which may be small pieces of land loaned to them by neighbours with bigger plots not in use or by their paternal brothers back in their father's house. The land may be taken back at any time by the owner, if it is needed. Women, therefore, do double labour to be able to produce enough food for themselves and their children until the next season begins. Despite the fact that they may have been able to harvest a good amount of food from the main farm, as a result of power differentials where men control and manage food from the family farmland, women cannot fully depend on that food for their nutritional needs. During interviews, I was told that women who have male children may be able to keep extra gardens and accumulate more food. According to a participant, young boys form groups during the farming season to work for one another's family and mothers of those boys can access the boys' group to work on their gardens; "boyless mothers" don't have this opportunity. Mbamah, a 48-year old research participant, worried that she might not get enough food for the year because she could foresee being unable to spare time from her husband's farm to work in her garden. She lamented:

If I had a boy, he would have been able to help out on my garden because boys in the community have come together as a group to work in turns for one another. Mothers of those boys simply provide them with food while they work on their gardens. Because I do not have a boy, it is not easy to access the group's services as it is a payback [reciprocal] kind of thing and how do I pay back? You know. The only way I can have access to enough food for my children for the rest of the non-farming season is if I get enough from my garden.

Although men do acknowledge the fact that women have heavier workloads, men will only help if it was evident that their wife is visibly ill (Duncan 2004). It was very clear that, apart from other factors that influence women's desire for a male child, such as family property ownership (Feldman-Savelsberg 1999; Inhorn and van Balen 2002; Leonard 2002; Nukunya 2004; Hollos et al. 2009), women who have male children are more able to work productively on their own gardens and have more food security because they have full control over produce from their own garden. Culturally, food produced from the general family farm is controlled by husbands. This control, in addition to the already scare food availability in this area increases the issues of food insecurity, a common challenge in the entire northern part of Ghana (Hesselberg and Yaro 2006). Food insecurity means "the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways" (Tarasuk and Beaton 1999:672). This most often affects women and children and results in poor maternal and child health. However, men and boys may stand a better chance of being more food secure than women and girls because, culturally, males are served the better part of the food and get to eat first before mothers and sisters. This means that even if food is limited, this group may still get more food to eat than their counterparts and thus, may not suffer food insecurity issues the same way as females do. Children, who face food insecurity, face the risk of stunted growth and impaired mental development and may end up with learning difficulties in school as well as in their adult life (Jamison 1986). Food insecurity is the main

contributing factor in maternal and child morbidity and mortality in resource-poor nations, particularly so in Ghana (Davis et al. 2013; Hong 2006; Van de Poel et al. 2007; Joy online 2013). I argue that the high incidence of maternal mortality found in rural settings is not just an issue of inadequate access to health care but is a much more serious issue of inadequate nutrition that, by itself, comes with severe health consequences.

Post-farming season

After the pre-farming season, women harvest the food produced. Women also serve as a means of transportation, carrying huge and heavy loads of farm produce on their heads to the house and, if need be, to the market for sale. Transporting produce by head loads can involve walking several kilometers on a daily basis. Pregnant women and women carrying babies or small children on their backs must still carry heavy loads on their heads. Although husbands may go to the farm with wives at the time of harvest, they return to the household with empty hands (and heads) while their wives serve as carriers, despite having worked longer hours and facing more work awaiting them at home. Occasionally, men might carry the harvest on a bicycle. Upon arrival from the farm, the man retires to rest and waits for the woman to fetch water for cooking and for his bath, to clean the living area, prepare food, serve him and the rest of the family, as well as bathe children and get them ready for bed—all prescribed gender roles women must observe before she eats or sleeps that day.

On my way to conduct scheduled interviews, I met a young woman and her husband emerging onto the road from the bushes on their farm. Where I met them was about a 20 minute car ride from the interview site but their final destination was beyond that. My estimated driving time was on the roughest possible path, excluding time walked from the site of their farm. The woman carried a three -year old child on her back along with a head load basin of millet, which

weighed approximately 30 kilograms. The man pushed a bicycle balancing a small load. To me, the woman appeared tired and was perspiring heavily. I offered to take the child in my car to the interview site just to reduce her burden. When she collected her child, she commented on how helpful it has been for her to occasionally have access to a donkey and cart from project GROW to help reduce the burden of carrying heavy head loads of farm produce:

> I normally rent a donkey and cart from the women's project to help carry my farm produce but failed to get one today because the carts are limited in number. It is not possible to get one every day because it is the peak of harvesting season and every woman wants it. Donkeys and carts have helped women a lot in this community to reduce the way we used to carry everything by head. You know, the men do not help us in carrying. It is our [women's] duty.

She paused and looked around, possibly to see if her husband was listening nearby, then she smiled and took her child home to her unfinished household work, cooking for the night and cleaning. Although women's stories and field observations made it unsettling for me, as I tried to re-enter my own culture, it appeared that women carried on with their usual daily life activities cheerfully, no doubt due to their long-term lived experience and the internalization of cultural rules and expectations of women as a focal point of the family. I probably found it more difficult to imagine women's acceptance of the male attitudes due to my increased awareness of the socio-cultural structures that lead to issues of injustice, inequality and inequity affecting women's lives in most of the world, knowing how women struggle with challenging contexts and the implications of those disparities for women's health and personal development.

Food processing and preparation for family consumption

In addition to serving as carriers in transporting produce to the house, women sort, husk, process and preserve raw foodstuff for later family consumption. Studies in Ghana suggest that, unlike men, women have a greater percentage of the entire workload to sustain the family; yet, women

remain marginalized with limited access to family resources (Jackson and Associates Ltd. 2002).

Increased workloads affect women's general health differently (Avotri 1999). Traditionally, food

processing may take several days to months depending on the yields in the growing season. The

process of preservation may also range from sun-drying and smoking to roasting and bagging the

final processed product for family use. As well, the responsibility for food preparation, such as

fetching water and cutting firewood and cooking food for the entire family is in the hands of

women. The number of people who eat from one pot may range from four to ten. Customarily,

on a daily basis, women stone grind millet and other whole grains into flour (Quisumbing et al.

1995). A few women who can afford to pay for the services of a grinding mill may choose to do

so, but many would have to walk several kilometers in order to access such services. However,

study participant Oni-ayen, cheerfully revealed that women's lives have improved in the past few

years because women in my study area now have close access to a grinding mill (figure 4):

> It has been a huge relief for me recently, as I do not have to grind my millet by hand and
> stone or walk several kilometers to grind my millet any more. Through the women's
> project there is a grinding mill in the community where I do my grinding. It is owned by
> us [women] and we decide how much to charge for grinding. So we charge a small fee so
> that everyone can afford to grind. We can even grind on credit and pay later.

Figure 4. A woman operates a grinding mill assisted by a man. On the floor are basins containing millet for grinding. Photo credit: Vida Yakong, August, 2011.

Some women appeared grateful that their lack of ready cash does not prevent them from grinding their grains because they can use credit due to their co-ownership of the grinding mill. There are limits to how much a woman can owe and how long she takes to pay her debt. This can be a stressful and degrading situation to some women who are unable to find money to pay.

Household food distribution: Gender, power and control

Post-harvest food storage and distribution remains the sole responsibility of the male family head. Although women may provide over 90 per cent of the farm labour (Duncan 2004; Quisumbing et al. 1995) and the processes of harvesting and preserving food, they have limited access to that produce and lack control over management of the household food produced.

According to custom, structures used for food storage, the barn or *boore*, remain gendered male places hence females, especially wives, are prohibited from directly accessing food from the storage unit. In the absence of the man, such responsibilities may be shifted to the son to access the food for distribution. However, first born sons are also culturally prohibited access to the boore; if the son did so, it is perceived that the son is already inheriting while his father is alive, an action of displacement that is a cultural taboo (see Fortes 1949 for similar explanations). In what may be considered an unfortunate family situation if a man has no son, a daughter may be assigned this masculine role and access the food storage structure. Wives who ignore this rule and access food from the boore can be sanctioned by family ancestors who are watchful of all family property and who reserve the right to punish wrongdoers. In this event, the afflicted woman is expected to confess and appease the gods in order to protect the family from any ill health. These cultural rules and roles explain why women desire male children who can enable access to family resources, a factor that can also affect women's reproductive health decisions.

Other factors are also associated with the belief that the barn is a sacred place where men hide items women are prohibited from seeing or having direct personal contact. These items are usually for ancestral, spiritual or healing purposes, such as talisman, amulets and healing herbs passed down to them by their fathers and other patrikin. Should women come into contact with the objects', their sacredness will be rendered impotent and their healing properties will be lost. Women's limited access to the barn for food is also based on a common suspicion that, because women have limited access to finances, they are likely to steal foodstuff to exchange for money for their personal use. Soup is an essential aspect of meals and, as discussed below, food rations given to women do not come with soup ingredients and women are expected to find other means to get money for the necessary ingredients to make soup for the family. Thus, husbands

110

frequently suspect women of stealing food from the storage structure for sale, a further reason to deny them access to the food barn

The quantity and frequency of food distribution within the household remains the decision of the husband, who is the household head. Within the household, each woman—if more than one wife—lives with her own children as a separate unit and is responsible for feeding them. Each wife contributes some food daily to the head man and his household from her ration supplied by the husband. Women may receive portions of food twice a week with accompanying instructions from the head on how much should be used and when her next ration is due, regardless of whether the food is enough to carry her through to her next allocation. This is a source of food insecurity within the household and a primary factor for the importance of women's own gardens. Typically, three meals are expected to be provided from the food rations—breakfast, lunch and supper—depending on food availability. A typical breakfast may be in the form of porridge made from cereals such as millet, sorghum, rice or maize flour, leftover *tou zaafi* made from millet or corn flour from the previous night and eaten with soup. Most meals are eaten with soup. Soup is normally made from a variety of vegetables including tomato, pepper, okra, onion, garden eggs—a type of local vegetable— and leafy vegetables—for example, *aleefi*, bean leaves, *beeit*, *beeriz*, *wogvaad*—both fresh and sundried depending on the season. Legumes such as *neeri*, groundnuts, cowpea, soybean and *bambara* beans are added to vegetables to make soup. Because of the cost, animal protein in the form of meat is added to soup only occasionally. Some of the vegetables are grown in the women's garden for household use. Generally, hot flour water made with shea butter and hot pepper is a routine breakfast for the elderly. Lunch can consist of rice, beans, or rice and beans together, bambara beans with other local ingredients such as *dawadawa* and "Keta schoolboys" generally referred to as *amani*, 'little

fish,' with salt and pepper and tomatoes, or bean cake popularly called *tobani*, eaten with salt and paper in shea butter. Fresh tou zaafi with soup is a routine meal for super. In the event that her portion is finished before the next distribution, a woman is required to find her own food to supplement the family. If she has no food to supplement from her garden, it is not uncommon for women to practice "maternal buffering," that is borrowing food from neighbours and friends, skipping meals, or going hungry the whole day (Maxwell 1996) to ensure that others, especially children, get enough to eat from the limited supply. Similar findings have been reported in rural Bangladesh (Shuler et al. 1998).

Research in three African countries reveals that women's nutritional status in male-dominant households compared to female-headed households can be precarious because of their limited decision making power in the control and distribution of food (Hindin 2000; 2005). This limited access to and restriction on the quantity of food consumed in the male-dominated household does result in malnutrition for both women and children. It is not uncommon to find women severely malnourished, most especially during pregnancy, which in turn results in anaemia and other health complications that ultimately can lead to maternal mortality. Again, in almost all cases in rural Ghana, the supply of foods for cooking does not include soup ingredients, although the combination of these soup ingredients are the main sources of the necessary nutrients for body nourishment. The woman would have to find her own soup ingredients elsewhere, even though she may not have any access to money, which is also controlled by the male family head. This reinforces why women are frequently suspected by husbands of stealing and selling foodstuff to earn money.

Despite the hard work women already do during the pre- and post-farming season, during the dry season women carry out other non-farming activities to earn more income in order to

provide for their families—which usually include her own children, husband and in-laws if any. They do this because it is not always clear what the men might do during the post-farming season to increase the family income and ensure food security. Studies suggest that, unlike men (who tend to consume their own income), a greater percentage of women's income is used for their family welfare (Muhammad 2007). To raise more family income, women engage in petty trading, cutting trees to make and sell firewood (see figure 5 below) or they may migrate to more economically successful locations in the country, taking on menial jobs that will sustain the family until the next faming season when they return home to begin farm work again. Despite the hardships, women generally appear energetic and cheerful and carry on with their personal and family lives dutifully. They may or may not have enough food to eat or money to pay for their essential needs, but they still manage to find peace within themselves. Their ceaseless, heavy workloads come with several health implications; yet, they carry on with positive attitudes and high hopes for change in the future. My observations during my interactions with women in the field suggest that they have a stronger belief and a more positive attitude towards life than I expected, given their challenging circumstances. An outsider, unfamiliar with women's ways of being and how much they appreciate life regardless of the challenges they face, might assume that women have all the essential things they need to live a fulfilling life. Culturally, children are raised to appreciate and be thankful for the little that they have; they are constantly reminded that even though they may feel that they have very little, there are/or may be others elsewhere in the world who may have access to nothing. Another line of thought and belief within the culture is also that, when we do not appreciate the little that we have and are grateful and show signs of happiness, we will not receive many blessings from one's ancestors, the main source of

blessings. The above line of reasoning and belief, which children grow up with, may be the source of their cheerfulness and positive attitude towards life.

Figure 5. A woman carrying firewood to the market to sell for more income. Photo credit: Vida Yakong, August, 2007)

Living space, women's space

Mud and thatch-roofed dwellings (see figure 6) are the vernacular architecture in the Talensi-Nabdam area (see Fortes 1949). Although this type of building does not require the skills of a modern architecture specialist, it does require experienced traditional builders to ensure that buildings are put up properly with regard to their measurements and the positioning of specific

rooms for various functions. Rooms used for divination or mortuary purposes have specific

designs and position within the compound (see figure 6). Typically, household rooms are

assigned according to age, gender and the social position of family members. The design of an

older man's and a woman's room will be different from the rooms for the rest of the family

members. The entrance of an older woman's room must be circular and have different door

coverings; whereas, the design of an entrance of younger women's rooms can be rectangular and

can have modern doors. House building and renovations are done during the dry season,

immediately following the rainy and farming season because access to water from the rivers is

easy at that time. Access to water in this region is limited; water bodies accumulated during the

rainy season dry up quickly following the season.

 The period just after the farming season is designated for men, women and adult children

to gather thatch material from the bush before it is burned off either by hunters or during a

specific traditional festival when burning the grass is a part of the ritual. This ritual burning of

the grass during this post-farming season festival serves as a welcome back home for the gods of

the land who were believed to be away from the homes protecting the field crops. During this

time for building homes, men are responsible for preparing the mud for the walls and thatching

the roofs, while women share the work of providing water, cooking food for the builders,

plastering and decorating the mud walls, gathering gravel and stamping the floors (see Fortes

1949). During this process, however, neighbours, friends and other kinsfolk come to offer

assistance which operates on a rotational basis as a back and forth process for women,

particularly with regard to providing labour, depending on how many neighbours are putting up

buildings at the same time. Because labour is expected to be rotational, community members

announce their intent to start their building; it can become a competition among members to start first in order to get the most out of the expected labour.

During the building process, builders are motivated by people playing traditional music while they work. In addition to the music, wives are expected to bring in beautiful young girls from their paternal homes to cheer the men on to put in their best efforts. The young girls clap hands, sing and dance for the amusement of the builders. While they dance, the girls checkout the men because, at the end of the building process, the young girls are expected to choose the men they most admired among the builders. Thus, each man is motivated to work harder so he stands a better chance of being chosen. Some factors women consider in their choice of men, range from physical appearance—handsomeness, body stature and strength—to industriousness and gentility. In rare instances, where men choose to bath naked in order to entice women, the size of their genitals might also be considered by women. Apart from a motivation for men to work, asking girls to choose is another way young men and women find life partners as the choice they make sometimes results in a marriage. Although the girls are expected to choose based on whom they admired, they are also secretly guided by the kinswomen who brought them. These women are involved in screening and making sure that these girls do not make choices based only on physical appearance but also on all other aspects of masculinity, such as if the man considered is a good man, worthy of marriage. Because their choice might end in marriage, the women consider men who are hardworking, respected and have a good family background. The women who bring in the girls from their paternal homes are proud of the fact they can bring more potential wives for their husband's kin. As patrikin, the women are treated as if they were actual affines, if the choice results in a marriage the girls' potential husbands give

them gifts and help in farming their gardens. Because of this recognition, bringing in girls during this building process is something that most women like to do for their own personal benefit.

However, the method of choosing among the men can sometimes result in the sexual abuse of the girls as they are normally required to sleep overnight with their chosen men. The girls are usually not of age and not willing to sleep with men they have just known briefly. This premarital sex can result in unplanned pregnancies and sexually transmitted infections. Because of the potential for sexual relations, it is not uncommon for young women who are not interested in exploring sex and are not ready for marriage to decide to choose little boys or deceased members of the family, a culturally acceptable practice so they can avoid such exploitations. In such instances, men become disappointed and may not be enthused to do the work. Because of the unforeseen circumstances regarding how girls are going to choose, timing of the girls' presence and their dancing and choice making is normally made toward the end of the building process, so if men are disappointed and decide to abandon the work, they don't affect labour to complete the building. Such sexual teasing done methodically, in turn, exploits men's labour.

Although the building process requires intensive labour, which can last three to six weeks, all labour is unpaid except for the provision of food throughout the building period. The provision of food for a long period of time can be expensive for families who may run out of food after the building process is done. This time of building, cooking and distributing food can be an extremely difficult period for women, particularly pregnant and nursing mothers who want to access prenatal care or take their babies to child welfare clinics, even if the woman or child is seriously or visibly ill, as they try to balance their work with health care schedules. Apart from the effects of all this labour on their physical health, another reason is that preventative health

care is often perceived as non-emergency and considered optional thus, women commonly

suspend routine health care until the season is over.

**Figure 6. Traditional house with children sitting by the entrance of their mother's room.
Photo credit: Vida Yakong September, 2011.**

Chapter 5. Maternal health and service delivery in rural Ghana

Thirty-five-year ago, the Alma Ata Conference in 1978 declared health for all by the year 2000 and beyond through the introduction of the concept of Primary Health Care [PHC] in challenging contexts (Hall and Taylor 2003; Lancet 1978). The main purpose of the PHC concept was to make essential health care available, accessible, affordable and culturally acceptable to individuals and families irrespective of one's social position. Theoretically, strong emphasis was placed on full community participation and respect for indigenous knowledge. Provision of services was proposed to be based on sound scientific and practical methodologies that are acceptable to all stakeholders of health. Not surprisingly, the year 2000 passed without the much expected goals achieved (Walleyet al. 2008). Access to health care for all failed to take place because the majority of people residing in challenging contexts, particularly those in rural settings, still have limited access to basic health care. Maternal and infant mortality rates are on the increase in most resource-poor nations after three decades of Primary Health Care (UNICEF 2012; WHO, UNICEF, UNFPA and The World Bank 2012).

Health care reforms and service delivery

The introduction of PHC resulted in a health care restructuring, new initiatives, programs and policy developments and implementations in sub-Saharan Africa and across the globe which aimed to increase access to basic health care by the majority of citizens (Awoonor et al. 2013). Some of the key initiatives designed and implemented to improve basic and maternal health care access in particular, included safe motherhood initiatives that were introduced across the globe in 1987 based on the realization that PHC was not realizing the goals of maternal health; especially, community-based health planning and service [CHPS] aimed at reorienting health care with more community level involvement, among others (Awoonor et al. 2013; Hogan et al. 2010;

119

Kruske and Barclay 2004; Simkhada et al. 2007). These initiatives aimed to bring general and reproductive health care closer to rural residents. In Ghana, for example, the CHPS concept is viewed as one of the best ways to make health care more accessible to rural peoples. However, despite the strategic and concerted efforts within various health care systems and the implementation of these new initiatives, health care disparity remains a significant challenge across Africa and other less resourced nations that share the highest percentage of the global disease burden, again, with specific reference to reproductive health care (UNICEF 2012; Davis et al. 2013). Recent studies from 181 countries across the globe showed that reproductive health care and maternal and infant morbidity and mortality ratios still remain a major challenge to most health care systems in resource-constrained nations; most significantly affected are sub-Saharan Africa and some parts of Asia and Latin America despite the declaration of the United Nations' Millennium development goals [MDGs] to address such specific health related issues (Davis et al. 2013; Hogan et al. 2010; Maine and Rosenfield 1999; UN 2000). Although all governments and nations have committed to playing a significant role in achieving these specific goals between 1990 and 2015, most nations are lagging behind with regard to achievements. Studies show that more than half a million women die each year from pregnancy and child birth related conditions and more than one woman dies each minute due to the same causes and almost all of these deaths occur in challenging contexts nations compared with one woman in 4000 in northern Europe and 3 and 8 per 100,000 live births in Canada and United States respectively (Hoyert et al. 2001; Maine and Rosenfield 1999; UN MDGs Report 2012; WHO 2004, 2010). In this chapter I discuss factors influencing maternal health care decisions and access in rural Ghana based on data analysed from field research participants and observations.

Factors influencing access to maternal and reproductive health care

Access to general and reproductive health care in resource-poor nations remains a challenge despite the existence of health care facilities, a perceived reorientation of health service delivery and the concerted efforts of local health care systems to increase access in many countries (Ensor and Cooper 2001; Gage 2007; Okiwelu e al. 2007; Simkhada et. al. 2007; Yakong et al. 2010). Several studies have attributed the lack or limited access to maternal and reproductive health care to a number of issues ranging from physical or geographical location, socio-economic factors, socio-cultural, maternal age and marital status, religion and belief system and health care system factors (Gabrysch and Campbell 2009; Gage 2007; McPherson 1994, 2007; Yakong et al. 2010). Although efforts have been made to improve some of these factors over the past decades, the findings of these studies suggest that not much has been achieved and change has been slow.

Physical/geographical access

In rural Ghana and around most parts of sub-Saharan Africa, physical and geographical accessibility to general and maternal and child health care remains an important influencing factor despite availability of health care facilities (D'Ambruoso et. al. 2005; Simkhada et al. 2007; Yakong et al. 2010). In Ghana, geographical access remains a major challenge affecting health care access. In 1990, well over 70 per cent of Ghanaians lived over 8 kilometers away from the closest health care facility, a distance that is not recommended by health care standards (Gabrysch and Campbell 2009; Nyonator et al. 2005). Studies in Indonesia suggest that bringing service closer to rural dwellers improves maternal health service utilization (Frankenberg et al. 2009). Although two decades have passed, very little improvement has been realized in modifying these factors to improve access to health care. Apart from the long travel distance, which prevents the majority of women from accessing health care, other complicating factors

include non-availability or the high cost of transportation, the poor quality road network linking towns to rural settings—compounded by seasonal flooding limiting access to the already existing poor roads—and the dispersed rural settlements common in rural Ghana in particular (Ghana ministry of health 1999; Nyonator et al. 2005; Yakong et al. 2010; Yanagisawa 2000). Women who live in my study area, as well as midwives working in rural communities, stated distance, poor roads and unreliable transportation as negatively impacting their access to and service delivery at different stages in their reproductive lives. These stages include prenatal care during pregnancy, labour and delivery and postnatal care. In the next sections I discuss women's perspectives with regard to the factors influencing decisions to access health care.

Women's perspectives on factors affecting access to services

As discussed in the previous chapters, there are a number of health care facilities in this study setting, both private and public, providing maternal and reproductive health services. The nearest health care facility to residents in this particular setting is estimated to be approximately 10-15 kilometers (Yakong 2008). Nearly all residents travel on foot to access care because transport is not easily accessible. It is obvious that, for people to access a clinic, they have to be able to walk the distance to do so. Distance also means it is more challenging for people living in this area to access emergency care, such as during labour and delivery, because it is nearly impossible for women in labour, especially difficult labour, to walk this distance.

In sub-Saharan Africa, the number of women who access prenatal services from a health care professional outweighs those accessing care during labour and delivery (Mills and Bertrand 2005). In Ghana, for example, studies show that a decade ago, 80 per cent of urban women compared with 31 per cent of rural women received supervised delivery services. In 2004, a

study conducted in rural northern Ghana demonstrated that 94 per cent of women received

prenatal care while only 44 per cent received delivery services from health care professionals

(Mills 2004; Mills and Bertrand 2005). Similarly, according to the upper east regional health

directorate's reports—part of the region where my study was conducted—the majority of

pregnant women access prenatal care services more than they access labour and delivery

(Regional health directorate 2010, also see table 5 below).

Table 5. Reproductive health services delivery in the upper east region (2008-2010) by type of service utilization (prenatal, labour and delivery) including Talensi-Nabdam district study area.

Municipalities\ Districts	Antenatal coverage			Supervised delivery		
	2008	2009	2010	2008	2009	2010
Bawku	9,897	10,152	9,656	3,517	4,317	4,921
Bawku west	3,805	4,095	3,863	2178	2,255	2,513
Bolgatanga	6,115	5,534	4,901	3,150	3,619	4,267
Bongo	3,506	2,915	2,860	1,808	1,920	2,405
Builsa	3,390	3,101	2,905	1,197	1,376	1,571
Garu-Tempane	5,727	5,980	4,810	2,175	3,076	3,329
Kasena-Nankana	5,532	2,737	2,468	2,394	1,687	1,958
Kasena-Nankana West	---	2,280	3,370	---	1,268	1,558
Talensi-Nabdam	3,756	3,872	3,292	1,325	1,799	2,082
Regional total	41,028 (102.1per cent)	40,666 (100.1 per cent)	38,125 (92.9 per cent)	17,744 (44.2 per cent)	21,317 (52.6 per cent)	24,604 (59.9 per cent)

Source: Adapted from the Upper East regional health directorate report (2010:59).

When I interviewed women who were currently pregnant and/or having babies, most of them indicated that they accessed prenatal services at a time when they could walk the distance but stopped prenatal visits when their pregnancy got more advanced because they found it difficult to walk so far. For example, Tiipogbire, a 24 year old mother of two children who lived about 10 kilometers away from the nearest health care facility, told me that, despite the distance, she accessed prenatal care for both of her pregnancies but could not continue when she was nearing birth. She also stated that she had both her babies at home with the help of a traditional birth attendant (TBA) because of the distance to the clinic. She stated:

> The two times that I was pregnant I tried my best and went to the prenatal clinic for care. Each time I went, they [nurses] asked me to come back for check-up regularly, which I did try my best. But when I was getting closer to giving birth, I found it tiring to walk that long distance. So I stopped attending.

In terms of giving birth at home versus at the clinic Tiipogbire said:

> When I was attending the prenatal clinic the nurses warned me not to give birth at home. I thought they were not really thinking about when and what time labour would start and how I am going to be able to make it there. Even though I would have liked to go to them for delivery, there is absolutely no way I could get there. How do I get there, especially if labour begins in the night? I just laughed in my head when they insisted that I should not give birth at home without considering the distance. I guess they do not even think about what we have to go through to get there. No cars come here so what are they talking about?

Teni, a 29 year old woman who was carrying her second pregnancy at the time of interview also stated,

> You know, it is easy to walk while pregnant even though sometimes I feel tired to do that but I have been going for prenatal care ever since I realized I was pregnant. But I do not have plans to give birth at the clinic. Let's not even talk about that. The nurses keep on saying that no one should give birth at home. Would you have walked that distance yourself while in labour? I do not know when labour will start and whether at that time we can have access to a vehicle over here to send me.

As shown in the women stories, the challenges associated with distance of travel and access to means of transport during labour or in any emergency situation cannot be

underestimated, and women's decisions are dependent on these factors beyond their control. Although it appeared that women were committed to accessing care for their personal benefit, they are unable to do so at all times as is expected by their health care providers.

Availability and access to transportation

Lack of availability and immediate access to transportation in most parts of northern Ghana is common, regardless of the nature of the emergency or the medical situation. Access to transport was a major barrier preventing women from accessing emergency obstetric health care in rural Ghana (Oiyemhonlan et al. 2013). The common types of transport available in this area are bicycles, motorbikes and donkey carts, similar to most settings in other resource poor nations. Cambodia, for example, is another region where evidence shows access to maternal health care is limited due to lack of transportation, compounded by high costs and poor road networks (Yanagisawa 2004). The Talensi-Nabdam district public health sector provides services for a population of approximately 100,000. At the time of my research, the district's public health system possessed one ambulance for emergency use by the entire population. On several occasions the ambulance was either mechanically faulty, had no fuel or had no driver readily available to move on demand. In the event that the ambulance was available to move, the cost of fuel, which is paid for by clients, was often more than they could afford. The cost is much higher when transport involved private commercial vehicles, such as taxi cabs, due to the poor condition of the road network. Participants in this study revealed that, in the unlikely event that a taxi cab was accessible, most drivers—in all cases, males—were not willing to carry women in labour for fear they may soil their cars with blood. Those who agreed to take women in labour to clinics would charge much higher fares to clean their cars should there be a stain. These factors discourage families from attempting to access any form of transportation to carry labouring

126

women to clinics unless the labour is complicated and cannot be managed at home by a TBA.

Tampoka, a 29-year old woman who due to difficult labour had her first childbirth at the clinic

three years ago, shared her experience of getting to the clinic:

> My labour stated in the night until dawn. My family decided to send me to the clinic but we could not get any car. My brother-in-law rode a bicycle to the nearest market to look for a taxi but there was none because it was not a market day. He continued to another town much further. The driver was reluctant to come when he realized that it was a labour case. My brother-in-law pleaded with him that his refusal could result in the death of the woman and baby. He agreed and came but was really mad at me; yelling at me to make sure I did not soil his car with blood. It was a nightmare. He also charged us so much such that my husband had to borrow money from neighbours and we struggled to pay back over several months.

> Tempoka, a 23-year old primipara, in an interview with me, indicated her wish to go to

the clinic to give birth because she was told at the prenatal clinic that she would likely encounter

problems if she attempted to give birth at home. However, her wishes did not come true. Her

labour started at night and, even though her family supported her attending the clinic despite the

distance (because they feared a home birth that might cause problem), they could not access a

car. She said, "Unfortunately my labour started in the night and we had no way to get a car to

take me to the clinic. But you know, by God's grace I gave birth safely with the help of TBA."

Although donkey carts can serve to carry women to the clinic in the absence of a car, my

observation was that these carts were never mentioned in their stories as another means of

transport for patients. When I asked Tempoka and Tampoka why they did not use a readily

available and less expensive donkey cart to go the clinic, they both said, "When a donkey cart

carries a patient to the clinic it is rare that the patient would survive." Six focus group discussants

responding to the same question regarding the use of donkey cart, all laughed and rolled their

eyes and whispered to one another. In a consensus they said:

Here it is believed that when you use a donkey cart to the clinic it is almost like a dead case already. Because of how people think about it no one wants to use a donkey cart to carry a sick person.

This belief has discredited the use of donkey cart as a means of transport to carry patients even though it can be helpful in the absence of a vehicle which is normally the case in this area. However, they admitted that it is used in some communities but rarely. Overall, women tend to access maternal health services for prenatal care more often than for labour and delivery, because they can walk and do not depend on expensive transportation to do so.

Women's Workloads

In addition to distance influencing women's access to maternal health care, workload was cited as another factor in limiting their ability to access care. In a focus group discussion, all six group members indicated that during the farming season they found it difficult to set aside time to attend prenatal care even if they had intentions to do so. Bane, an 18 year old woman, stated: "The farming season is normally full of work and asking for permission—from husbands—to attend clinics; when one is not sick is interpreted as being lazy. I try to go sometimes but not all the time." Dokpoka, a 19 year old woman, added:

> Unless I am sick I just forget about going to clinic at this time of the year [farming season]. You walk all this distance to the clinic and you are still expected to come back and go to the farm? No! I just pray that I am not sick. You know how men feel that one just wants to find an excuse and go to the clinic and leave work?

Kolpoka, 27 years old, told me that:

> I do understand that going to the clinic has benefits for pregnant women but I do not have control over work schedules at home. It is my husband who determines what should be done and at what time. When you as a woman do not abide by what they [husbands] ask you to do, it can become a problem. Just because one is pregnant does not mean that you do not work. They [husbands] tell you that pregnancy is not a disease to be going to the clinic every time while neglecting your part of the work at home. They say that you are simply lazy.

On her part, Dougpoka, an 18-year old woman, who was carrying her third pregnancy at the time of the interview and who had lost two of the pregnancies already in the past due to ill health said,

> Well, I tell you, I have been to the clinic only once and now that it is farming season, I am not sure if I can continue to go again even though the nurses want me to come regularly. I know the next time I go back, I am going to have a problem with the nurses because they do not understand these things. You dare not tell them that it was because of work that you could not come. They will yell at you and say that you are not serious about your own health. So you know what, when I go back again and they ask why I did not come, I will simply keep quiet. They will say all kinds of things but I know what I am going through. They will never understand it anyways, so why talk?

As discussed in the previous chapters, women's heavy workload and household responsibilities can be a barrier to accessing health care but this is not often discussed. Dougpoka's description reveals the perceptions of health care providers who do not understand women's living situation and how that situation might be a barrier to accessing health care. Rather, their experience suggests nurses blame them for self-neglect, which in turn, can further discourage women from accessing care.

Maternal and child postnatal care

Like prenatal care, women who seek postnatal care following delivery of their baby have been shown to be on the increase (Regional Health Directorate 2010). Typically, when women give birth at the clinic, they are required to report back after two weeks to be assessed by a professional midwife to ensure that mother and baby are doing well. In the case of a home birth, TBAs, although banned from practice, are expected to accompany women they helped at home immediately following delivery to the clinic to give reports and for nurses to assess the woman and the baby. In addition to the assessment, normally babies are also given their first immunizations. Most women access such care because they feel they can now walk the distance

129

and, secondly, because they need the immunizations for their baby. However, in recent times, the

health care system has established a system whereby women who give birth at home and attend

postnatal care are charged a fee for not accessing delivery services at the clinics. It was not very

clear as to whether this policy was a legitimate countrywide policy or limited to specific settings

and clinics. This charge, despite the factors that prevent women from giving birth at clinics, is

intended to be a form of punishment for women who give birth at home rather than at the health

clinics. As I discuss later in this chapter, the pressure on women to give birth attended by skilled

birth attendants arises from the claim that the increasing rates of maternal mortality are as a

result home deliveries, mostly conducted by TBAs (Kruske and Barclay 2004). Although the

intended purpose may be laudable from the perspective of the health care providers, it may also

become an obstacle for postnatal care for women and missing the child's immunization due to a

financial burden and a disregard for issues such as the lack of, or high cost of, transportation that

prevent women from accessing care. Poagbil, a 23-year woman who had delivered her new born

baby at home a few weeks before my interview with her, was reluctant to go for postnatal care.

She did not want to be charged a fee for birthing at home. She lamented:

> I am not sure if I want to go to the clinic because I do not want to be charged a fee for
> giving birth at home. I do not see what I have done wrong to be punished. I wanted to go
> because of the immunization for my baby but what is happening makes me feel like not
> going. Plus, I do not have the money to go and pay.

In a related issue, Nagbire, a 33-year old mother of five children stated:

> Although I have had all my children at home with the help of a TBA, I normally take
> them to the clinic as soon as possible to get assessed and immunized. After all, it is not
> difficult to walk the distance after birth; but, now that nurses are charging fees, I do not
> think that it is fair. They charge you for giving birth at home. So my plan is not to go this
> time after birth unless the child is sick.

Yenpokbire, 32 years old, corroborated Nagbire's statement that in each of her three deliveries

she went to the clinic with the TBAs so that the nurses could check her and give her baby

immunizations. But, because of the new fees, she was not sure if she would continue to do so in her subsequent births.

Socio-cultural and personal health beliefs

Socio-cultural factors that prevent women from accessing general and maternal health care are common in sub-Saharan Africa. Studies in Ghana, and other resource-poor nations, suggest that these factors have a huge influence on health care decisions (Jansen, 2006; Mills and Bertrand 2005; Shaikh and Hatcher 2005; Yakong 2008). Apart from other factors that affect women's access to clinics in this study, women's decisions to access care are also influenced by socio-cultural factors and personal beliefs. For example, women may not seek birth control methods when they are breastfeeding because it is believed that when women have sex while breastfeeding the breast milk will be polluted by the sperm, which can affect the baby's health. Thus, postpartum abstinence is often encouraged rather than birth control methods. Also during labour for example, women are expected to stay out of contact with bad spirits and persons who are believed to have been involved in 'sinful behaviours' such as adultery; more specifically, adultery in which a man or woman engages in sex before the final funeral rites of their diseased spouse. When women in labour or newborn babies are exposed to these kinds of people, they may cause them illness or even death (see Yakong 2008 for similar findings). Such people are known in communities and can be avoided during these crucial times in the life of the woman and her baby. In the event that the woman is on her way to or at the clinic to give birth, the possibility that she and her newborn coming in contact with such people cannot be avoided. In my interview with a Naoh, a mother-in-law aged 49 years, who did not mind her daughter-in-law going for prenatal care, was hesitant about her going to the clinic to give birth.

You know, there are all kinds of people living with dirt [adultery] these days and when these kinds of people see a woman in labour or the new born baby, it can be harmful. I do not know who is going to be there at the clinic so I do not want to expose my daughter-in-law and baby to such people. She can go for prenatal but I am not sure if I want her to go there and give birth.

Food related taboos were also identified as a reason for not wanting to give birth at clinics. When a woman gives birth at home, she is given hot water made with millet flour and Shea butter to drink immediately following birth. This water is required to help the woman expel blood clots and dirt after birth and, secondly, to help her initiate breast milk. When women give birth at the clinic they are given cold water to drink. It is believed that starting with cold water can cause ill health in a woman and limit the immediate production of breast milk. Nabil, a 50-year old mother-in-law, stated that because of the issue of cold water, it was not safe for her to allow her daughter-in-law to give birth at the clinic.

Inappropriate handling and denial to release placentas for women to carry home for cultural rites and appropriate burial also influence women's decisions to give birth at the clinic (Moyer et al. 2013; see Yakong 2008). Cultural beliefs hold that improper handling and non-burial of the placenta can cause the baby ill health. For example, when a woman gives birth at home, there are rituals involved in the placenta handling and burial. Customarily, the placenta is placed in a small new pot with a lid for the new mother to carry close to her lower abdomen outside of the main house into a designated place—normally a place used as compost for the family—for burial. This placenta must not come into contact with dirt or ants. Should that happen, the baby is likely to fall ill. By physical count of the placenta pots in this designated area, families are able to identify in later years and generations to come, how many children were born into the family, including all those who died. Care is taken not to break any of these pots. Women claimed that placentas are not handled respectfully at the clinic and they found it

difficult to express their feelings about it because health care providers associate such things with local superstition. For example, Lamisi, a 25-year old woman, said:

> When I asked the nurse to protect the placenta for me because I would like to carry it home, she yelled at me and said, 'What do you mean I should protect it? Is it food? You people come here with all these weird beliefs.' So I just kept quiet. I was not sure how she handled it afterwards even though I was able to get it to take home with me.

Studies in rural Ghana have confirmed nurses' refusal to release placentas to families and the possible consequences for maternal health care in northern Ghana (Moyer et al. 2013). This refusal creates fears in families as they are unsure what nurses do with the placentas. Nurses are unwilling to provide any respectful reasons for their refusal, except conveying attitudes that suggest that those demanding their placentas are superstitious and backward in their thinking.

Some women held a strong belief that, when they take pills, such as vitamins, calcium or iron, normally given to women during prenatal checks, this will help them build strong blood to carry their pregnancy to term, as well as help the baby grow well. Therefore, some women access prenatal care but will not go to the clinic for labour and delivery. A study in Papua New Guinea has documented similar findings with regard to women's beliefs around the use of prenatal medicines and perceived influence on women's ability to build strong blood to support them in their perinatal process (McPherson 1994). Mbamah, a 48-year old mother-in-law, told me it was important that her daughter-in-law go to prenatal care so she can get the pills to help her build more blood to carry her pregnancy to term and give birth safely, a belief that is widely held by the majority of women in the village. Naabmah, a 19-year old woman who just had her first baby at the time of the interview, also said she went to the clinic regularly for care, despite the distance, and that her aim was to get the pills for strong blood. She indicated that her friends who had prior experience with pregnancies shared with her the information regarding those pills.

She said:

> I already knew that I was not going to give birth at the clinic but I went there for prenatal care so that I could get the pills that they said when you take them they will help you get strong blood to carry the baby. Why would I struggle to get there to give birth when there is a TBA in our neighbourhood to help me? Most of these babies you [the researcher] have seen here were not born at the clinic. I just wanted the pills.

Naabmah's statement that most of the women with babies did not go to the health facility to give birth supports my observation during my time at the village.

Assipoka, a 28 year old woman with whom I spoke in my first scheduled interviews, told me that she was expecting her baby in the next few days and wanted to be among the first to be interviewed because she felt that she might not get the chance when she becomes a new mother. When I asked her where she was going to have her baby she said, at home. She went on to explain:

> I have three other children and this will be my fourth one. It is my neighbour who is a TBA and always assists me. Even though in all my pregnancies I went for prenatal care so that I can get the pills for strong blood, I do not go there for delivery. This TBA has done this work even before I married into this area. There has never been a problem with her doing it. I know that the nurses hate to hear this but I did not see it necessary to travel all the way there to do the same thing that can be done right here in my house.

True to her words, I had information on my next interview schedule at the village that she had given birth a few days after our interview. She was assisted by her TBA neighbour. When I visited her in her home, as culture demands, mother and baby were doing fine. The responses above suggest that TBAs continue to offer useful services to women in rural communities, despite the ban on their practice as a result of policy changes (Kruske and Barclay (2004). Although TBAs continue to offer help to labouring women, despite these policy changes affecting their practice, it remains unclear what the consequences may be if the health authorities get to know that women are getting assistance from TBAs in the communities. Regardless, Boodsomah, a 74-year old TBA, whom I interviewed, firmly protested against the ban, stating

that she will continue to provide services to women in her family despite the directive. This ban may have to be reconsidered if maternal health is to be improved in such settings.

Other health care system factors at various health facilities influenced women's decisions whether or not to access care. In some clinics, women were unhappy that midwives and community health nurses required them to purchase new clothing in advance for their unborn babies and for themselves, something that conflicts with the usual cultural practices and beliefs around preparation for confinement. It is widely believed that buying new things for unborn babies can lead to a miscarriage. Tempoka told me that she was surprised that the nurse would insist that pregnant women purchase new clothing for unborn babies and for themselves. She said

> I was shocked when she [midwife] said that I should buy new things for an unborn baby. We [people in this culture] believe that you cannot buy baby things down for a baby yet to be born. You could lose your pregnancy if you did that. I do not know where she [nurse] is coming from?

She continues:

> What I know in terms of preparing for confinement is that you gather firewood, Shea butter and foodstuff and ingredients so that after birth your family can use these things to take care of you but not clothing.

Based on their own education, midwives and community health nurses are thought to be educating women on preparation for confinement which includes buying of new items to prepare for babies, as well as gathering rugs to bring to the clinic. When they are in labour, the rugs are used for women to collect blood. They are also required to bring cakes of soap and Dettol for the nurses' as a form of payment; although in principle midwives are not expected to take payment. Midwives' classroom learning, theoretical knowledge and textbooks, often informed by western ideologies around childbirth, may have influenced their practice and expectations of women. It

135

may also have been inappropriately applied in this context or it is possible that midwives are disconnected from the women's cultural environment.

Apart from being asked to buy new items, women were also required to bring all those other items including rugs and soap with them for the nurses' inspection. This inspection is done in the open and in the presence of other women at the clinic, a routine activity that takes place before the clinic session begins. Teni told me that she felt uncomfortable having her items displayed for others to see. She said:

> I was so embarrassed to open my rugs for other women to see. The nurse told me that my things were not clean enough. She was also mad at me that I did not buy the new baby clothing and for myself.

In addition to the cultural inappropriateness, the above demands also had a financial burden on women who, unlike nurses, have no other means of income to purchase those items nurses request. Tampoka said:

> I find it difficult to get money for all these things. I cannot even count all these things to my husband and ask for money to buy them and I do not want to borrow money to do all these things because, immediately following birth I cannot do other things that I have always done, such as selling firewood to earn more income to back those debts. I may consider stopping the clinic visits.

These demands made some of the women change clinics and they had to walk longer distances with the hope that those other clinics would offer much more respectful services and possibly fewer demands and embarrassing practices, such as the display of rugs for others to view. I interviewed Assipoka, whose personal information indicated that she had moved from a clinic I had visited earlier, to her current clinic for prenatal services. When I asked her why she did not go for services at the other clinic which is much closer to her location she indicated:

> I came here because I could not deal with that nurse anymore. She kept on asking me to bring all these items to the clinic, which I could not afford to do. I tried to explain to her but she would not listen. She insisted that every pregnant woman must bring those things.

She yells a lot and does not care what your situation is. I just wanted to try this place too and see what they [nurses] do.

However, midwives felt that this was a strategy to get women to prepare for their new babies. Midwife Adisa stated that, "we ask [pregnant women] to get these things ready before they give birth so they have something decent to wear thereafter." This means that, from the midwives' perspective, there is nothing wrong with asking women to do this, because the women benefit from having new clothing to wear.

Health care provider-patient relationship

Poor health care provider-patient relationships are consistently identified by women as an influencing factor on their decisions to access maternal health care services. This factor is a long standing issue affecting service utilization in resource-poor nations (D'Ambruoso et al. 2005; MOH 1999; Ith et al 2012; Jewkes et al. 1998; Moyer et al. 2013; Oiyemhonlan et al. 2013; Onah et al. 2006; Shaikh and Hatcher 2005; White et al. 2006; Yakong et al. 2010). In Ghana, the poor health care provider-patient relationship dynamic pervades and affects all levels of care but is more appalling in rural settings where access to health care and options for providers is limited. Poor attitudes toward patients has also been attributed to power differentials and discrimination by health care providers, who feel they are at a higher social positioning compared to rural residents (Moyer et al. 2013; Yakong et al. 2010). Moyer et al. (2013) found that in northern Ghana, women who had less money, were uneducated and lived in rural settings were treated disrespectfully when they visited health care facilities compared to their counterparts in a different social position. Nurses and other health care providers place themselves at a level incomparable to those of the community members; thus, see no reason why they should stoop to respect those below their status. These attitudes translate into including

physical, verbal and emotional abuse, consequently, in the end, women decide to stay away from accessing health care. Women in this study cited a number of issues ranging from judging, name calling, yelling and disrespectful attitudes, from being ignored to physical beatings during labour as reasons that turned them away from some of the health care facilities. For example, Bogremah, a 17-year old married woman, carrying her first pregnancy at the time of interview, stated:

> When I went for prenatal care the nurse asked me why I was pregnant at this age. She said 'you young girls of this modern time will not sleep in the night'. I felt so embarrassed and so did not want to go back there again. When she asked me questions because I was already feeling bad I could not answer them to her satisfaction, so she was yelling at me.

During labour Bogremah's experience was no different from her prenatal experience, even though she decided to change clinic and provider to see what the different place might have to offer her. She recounted her experience:

> When I was in labour I said I was not going back to that clinic again so my mother-in-law took me to a different clinic; but it was no different. She [nurse] too, ignored me when we got there. She was angry that I did not remove my underwear before coming in. She shouted at me and said, 'do you think you are going to give birth in your underwear? If you were shy you should not have had sex in the first place.' She said she was busy and if I did not co-operate she was going to leave me alone or I could go back home. I do not know if I would like to go to any clinic for any care in the future. I felt so bad.

Yenpoka, a 39-year old woman, had a similar experience when she went to seek care at another clinic during pregnancy. She recalled her experience of going for prenatal care at a certain clinic:

> I met a nurse at the office who was busy doing something. I greeted but she did not respond, so I was afraid to ask more questions. I decided to sit outside and wait. All I saw was that she came out and closed the office door and was leaving for home. I approached her and she yelled at me and asked why I was sitting outside there if I needed her? I simply apologised because she would not even allow me to explain. I felt like a little girl before her, even though she was just a young woman.

Azumah a 34-year old mother of three children was slapped in her face during labour at the clinic. She was very tearful while recounting her experience to me. She said;

I started to push when she asked me not to, but I knew the baby was coming because this is not my first time of giving birth. When I told her that the baby was coming, she sat somewhere and shouted, 'do not push it is not time.' But I had to and she just rushed in and slapped me in my face. I shed tears that day, not because of the labour pain but because of how she treated me. You know I am not just a little girl for another woman to do this to me.

The issue of poor nurse-patient relationships was a common theme running through most women's narratives when it came to how their relationships with their providers influenced their decisions to access care. These poor relationships were a strong factor in women's decisions: most women preferred to seek support from TBAs who they felt treated them more respectfully, thus, corroborating previous findings on women's preferences for TBAs over nurses (Yakong et al. 2010). Women commented that they would go to clinics only if forced and if they were in trouble with difficult labour. In Cambodia, similar experiences have been reported, thus forcing birthing women to choose private midwives over public sector health care providers (Ith et al. 2012).

Inconsistent service availability

The Ghana health service mandates rural clinics to provide 24-hour service, in principle. However, in practice, the situation is different. During my field work I visited a number of clinics at random in the study area, so that I could have conversations with nurses at the clinics to learn about their work. One Sunday morning, about 10:00 a.m. local time, I drove to a clinic close to a church. The clinic's hours of operation indicated 24-hour service. Contrary to the hours of operation, it was closed to the public. Hanging on the gate of the main entrance was a huge padlock. The nurses' residence was also locked up from outside. The indication was that no work would be done on that day. I hung out with women at the church during their service. During this time, I observed several patients coming to the clinic, carried on bicycles or on foot

supported by relations. Some of the patients knocked at the big clinic gate and they seemed

desperate despite the visible padlock hanging there. When I asked women at the church what the

hours of operations were at this clinic, they told me that it was supposed to be operating a 24-

hour service. However, they also noted that the absence of nurses at the clinic was routine. One

woman remarked:

> Well, this is what happens over here most of the times, especially at the weekend and in the night. Nurses are supposed to stay here in the village but they do not. You see that house over there [she pointed to a building], that is their house. Most of the time, when you run there in the night, you find nobody and you will have to look for another clinic somewhere and that is if you have the means of transport to do so, especially if a woman is in labour, you know that cannot wait.

Another woman said,

> This is not new but we [community members] cannot talk about it to anybody; I mean we cannot report because we are afraid that if we do, it may even be worse so we just pray that whenever we go with a patient and they are there we count ourselves lucky.
> Some of the women said the nurses go to the market to do business to earn more income.

One woman added that, "you know today is a market day over here, so they may be at the

market. They go to do business for more money."

In my conversation with other women from different locations, the irregularity of service

provision was a common theme affecting most clinics in the study area, which in turn resulted in

lack of confidence in the health care system. Women often entertained fears when they were

making decisions to seek care. I met Tampogremah, a woman who appeared to be in her late 30s,

on her way out of a clinic where I had just arrived to conduct interviews. She disclosed to me her

experience while in labour a year ago:

> We [women] cannot rely on these people [nurses] for our health needs. I came here last year while in labour to be attended by the midwife. When I arrived I was told the midwife had gone to Bolgatanga [city] and would not be back until the next day. Because my house is not too far from here, I was able to get back home but delivered on my own.

An older woman narrated her experience on accompanying her daughter-in-law when they had to visit three different clinics before they had a nurse to attend her labour. She stated:

> We first visited clinic A where we were told that the nurse did not come to work that day. Then we continued to clinic B where we were asked to go to clinic C because that clinic B nurse had gone for a meeting in the town. At clinic C we found a nurse who finally referred us to Bolgatanga [a regional hospital] because we were too late and she was closing. I tell you, if we had known this, we would have just stayed home. It was because they [nurses] said we should not let her give birth at home that was why we had to go through all this.

This inconsistent service availability contradicts Ghana health service policy and commitment to providing maternal health services to women in rural deprived areas targeted at reducing the high maternal mortality rates in rural settings. The CHPS concept was initiated to ensure regular services availability in rural settings in order to bridge the gap between urban and rural settings with regard to health care access (Awoonor et al. 2013). The irregular service availability may lead to a lack of confidence in the health care system by community members and contributes to and reinforces the low utilization of services intended to benefit the people.

Mission health care services versus public

Historically, there appears to be a continuing systemic conflict between mission health services and public health services countrywide over a number of issues ranging from resource allocation —material, logistical, budgetary and human—and, quality service provision and patient-centered care (MOH 2006). Anecdotal and public opinion evidence suggests that compared to public health service, patients receive quality care from mission health services. Mission health services also appear to be more reliable in terms of services availability compared with the public sector. Although this argument has often been disregarded and considered anecdotal for political reasons, in this study, all the women confirmed this argument. They stated they preferred travelling long distances to attend a particular mission clinic rather than a public clinic that was

141

closer to them. They cited regular staff availability regardless of time of the day or night, availability of drugs, an onsite ambulance for patient referral in emergency situations, and a relatively collegial staff relationship. In my conversation with a midwife from a mission clinic, she confirmed that compared to the other public clinics, she observed that their clinic gets more mothers for maternal health services. However, she mentioned that, even though they are happy their services are perceived as having quality, she worried about the concomitant increase in workload resulting from limited staff and how this might affect their ability to provide quality services to their clients. Christiana mentioned that, "we depend on the public sector for staffing and there is lack of equity with regard to human resource allocation by the public health sector to us." At the time of our interview, she also revealed that all public sector nursing staff were being withdrawn from the mission sector for some obscure reason, thus leaving patients to their fate because the workload was now too high for her to manage alone. Another midwife from a different clinic in another part of the country who practiced midwifery in a mission clinic had similar concerns. She also confirmed that women who attend her clinic do so for similar reasons as noted above. In addition, she lamented that, even though they are happy their services meet the needs of patients, she worried that there is a long standing unhealthy relationship between mission and public health services clinics, which have negative implications for maternal health. Women risk their lives as result of this conflict. She mentioned that:

> Doctors and nurses from the public clinics where we [mission staff] are supposed to refer patients for further management, refuse to take our patients simply because those patients chose to come to our clinic. Because of this, patients who come here will also be refused there on referral. Some patients who end up going there are treated badly by the staff, with the reason being that they first came to our clinic (Yenimi).

The endemic conflict between these two health sectors has severe negative implications for pregnant women, in particular and ordinary Ghanaians in general, because it is these people

who suffer the consequences of the conflict. This needs to be addressed from a higher authority

levels, such as the Ghana Ministry of Health and Ghana Health Service, as well as the local

government, if maternal health and rural health are to see some level of improvement.

Birth control access and usage

Recent studies show birth control usage is declining in this region and other parts of Ghana

(Ghana health service 2010; Regional health directorate 2010; Oiyemhonlan et al. 2013).

According to some studies conducted in northern Ghana, because of the social value of children,

women feel obliged to bear as many children as they can to satisfy their social role

(Oiyemhonlan et al. 2013; Yakong 2008). As well, the effects of birth control methods have also

contributed to women's disinterest in using them (Yakong 2008). The majority of women in this

study confirmed that, even though their husbands and other kinfolk did not support the use of

birth control, they opted for this method because of hardships and lack of resources to properly

care for their children, for whom they have almost sole responsibility. They cited limited access

to and adequate food supply, high cost of medical bills and education as reasons why they opted

for these methods despite their family members' opposition. Another woman also stated that

instead of birth control methods she opted for abstinence. However, lack of information

regarding possible and actual side effects of methods discouraged women from using birth

control methods. In my study, a number of women mentioned severe and irregular bleeding as

reasons for not wanting to use birth control methods. All the women who took birth control

mentioned that they took the "injectables" (depo provera) methods because it was something that

their husbands would not discover. In my interview with the midwives they confirmed that

women normally prefer this type of method over the other ones. At this point, it was not clear if

side effects were particularly related to their use of depo provera and, if they were to use other

methods, results and their experience would have been different. For example, Asssipoka used birth control for a period of three months but abandoned it because of severe irregular bleeding, saying, "I had no idea that this would have happened to me when I take them and the nurse did not tell me about what to expect." Lack of patient education regarding birth control methods and their side effects (although midwives refuted this claim), as well as other medical conditions during pregnancy, have been identified as barriers to maternal health care decision-making and actual access to services and, contributing to underutilization of such services (Oiyemhonlan et al. 2013; Yakong 2010). The information deficit leads to uninformed decision making, not only affecting birth control but also extending to other maternal and child health services.

Why some nurses in these settings routinely deny patients information to help them properly understand and utilize services remains an issue with negative implications for rural women. It is possible that some of the nurses themselves suffer from knowledge deficits and are unable to share such information with their clients but would not genuinely reveal this. My personal experience and observation supports the above claim. For example, while in the field I attended a child welfare clinic to receive immunizations for my two-month old baby. First, the community health nurse who weighed my baby charted the weight wrongly; secondly, the nurse who immunized the baby did not share any information with me with regard to side effects and what to do should they occur, a routine practice that should happen after every immunization. Although, as a community health nurse myself, I knew what to expect and what to do, I wanted to challenge their knowledge and practice. When I enquired about what to expect, the nurse simply told me "nothing will happen after the immunization." I expressed shock at this answer. I also spent time at the clinic and observed that scales used for weighing pregnant women who came for prenatal care were not balanced and, as a result, wrong weights were assigned to them,

144

a practice that puts these women at risk. I brought all of these malpractices to the attention of the clinic manager; whether there has been any change in practice following what had happened is yet to be known. Hence, lack of information sharing and malpractices in the nursing field in rural Ghana is pervasive, cuts across all areas of service implementation and the consequences of these occurrences for patients are immeasurable.

Religion is another factor influencing women's decisions and access to birth control in rural Ghana and elsewhere in resource poor nations. Religious beliefs and to use birth control or not, may be personal or a consequence of the health care provider acting as gatekeeper of morality (Lema 2012; Stanback and Twum-Baah 2001). In this study for example, birth control was inaccessible to women at a mission clinic where their doctrine does not allow the use of birth control. Tempoka told me;

> I went there [clinic] to take birth control injection but the nurse would not give it to me. Instead, she started to talk to me about something called natural birth control which I did not understand. But anyways, she said here in their clinic, what they do is tell people to do natural birth control. So I could not get it.

Although Ghana population policy states that birth control methods should be made accessible to all citizens at all times (Government of Ghana 1994), religious beliefs and personal morality ideologies can prevent free access to such services, regardless of women's reproductive health needs. In a number of countries across sub-Saharan Africa, when providers use their personal religious and moral values to influence their practice, denying services can contribute severe consequences for women' reproductive health (Lema 2012). These studies conclude that, such practices contribute to the high maternal morbidity and mortality ratios in sub-Saharan Africa and remain the main challenge to achieving MDGs goals on maternal health. Thus, policy review is needed in this direction.

General health policy issues: Restrictions on Traditional Birth Attendants

Traditional birth attendants [TBAs], as discussed earlier, are usually respected, trusted older women who have given birth and who traditionally acquire midwifery skills through observation and apprenticeship with other practitioners (Akande 2004; Abodunrin et al. 2010; Davis-Floyd 2000; Kruske and Barclay 2004). The purpose of their knowledge and skills acquisition is to assist their family members, friends and the rest of their community members who need their services. Often, they provide their services free of charge but can receive gifts if offered from families they have helped. These gifts may range from foodstuff, to chickens or help with their farm work. TBAs, although highly experienced women who provide important services to their community members are labeled non-skilled and unprofessional by the biomedical health care system's ideology because they do not, by the definition of modern medicine, meet the requirements to be called midwives (Davis-Floyd 2000). Not so long ago, the services of TBAs were viewed by World Health Organization and other international health related agencies to have a positive impact on the reduction of maternal and infant mortality in resource poor nations (Kruske and Barclay 2004). These agencies supported the design and development of training programs informed by biomedicine throughout most parts of challenging contexts nations in the 1970s for TBAs so that they could practice within the context of science in their communities (Kruske and Barclay 2004). This training usually took approximately two weeks and TBAs were expected to know everything about doing safe deliveries when they went back to their various communities. Until now, they were considered part of the health care team but non-salaried staff, unlike in Pakistan where TBAs are employed staff of the health care system and receive salary (Kruske and Barclay 2004). Unfortunately, by 1997, policy makers within the WHO (Kruske and Barclay 2004) found them guilty of increasing maternal mortality and all training programs and

funding for TBAs was withdrawn, resulting in the redefinition of skilled attendants, which

excluded TBAs. According to research evaluating the practices of TBAs in Ghana, conclusions

were that training TBAs has no impact on maternal health and, thus, further investments are not

worth it (Smith et al. 2000).

Notwithstanding the above criticisms and conclusions on the practices of TBAs, studies

have shown that, globally, on a yearly basis, approximately 60 million women give birth at home

and another 52 million births occur without a skilled birth attendant (Darmstadt et al. 2009). In

most resource-poor nations, including Ghana, Pakistan, India and Nigeria, studies have shown

that most rural women give birth at home with support from TBAs (Abodunrin et. 2010;

Amoako et al. 2009; Campana 2003; Shaikh and Hatcher 2005). In the upper east region of

northern Ghana, where this study was conducted, recent studies show that only about 35 per cent

of deliveries are attended by professional health care providers (Moyer et al. 2012; also see

regional health reports in table 5). Yet, available evidence shows that, due to policy reviews,

TBAs are no longer permitted to practice in rural communities (Yakong 2008).

When I interviewed women and TBAs about the restrictions on their practice, they

worried that withdrawing their services will have serious negative impacts on maternal health.

Tangmah, a 27-year old woman who had delivered her now two month-old baby at home

supported by a TBA, said to me:

> Without her [TBA], my baby and I would have been dead by now. I could not have been
> able to get to the hospital as they [nurses] expected me to do in the middle of the night
> when labour started. They [nurses] would not help women at home to give birth even if
> you call them. But the TBA was right there when we called her and in no time the baby
> was delivered.

Another participant strongly argued that she does not see why TBAs should not be

allowed to work, when they are the only providers women can easily access when they need

them. She indicated that she will never go to the clinic unless the TBAs in the community refuse

to attend her labour. She stated that, apart from the fact that they have easy access to TBAs

services, she feels that TBAs offer quality care and know their work. For example, she said:

> I never heard that any woman died in the hands of the TBA in this community ever since
> we [women] have been working with them. But I hear that women die through child birth
> at the hospital too so what are they talking about? (Lariba 25 years old).

Apart from women's confidence in working with them, TBAs themselves felt that

stopping them from providing the services that they felt were a contribution to their families and

communities was an abuse of their rights and obligations. In an interview with Boodsomah, a 74-

year old TBA, who has been practicing for a number of years, so long that she could not

remember how long when I asked her, stated:

> I have assisted several women both within my own family and the outside community to
> give birth without any problem. I enjoy doing it. I have never failed in assisting a woman
> to deliver. But now the doctors [health care system] say it is not safe to assist women at
> home to give birth. They say it is safer for a pregnant woman to go to the hospital than to
> be helped at home. I continue to assist my daughters-in-law to give birth at home [the
> entire clan]. What I would not do is to assist other women outside the family. None of my
> children [daughters-in-law] have been to the hospital to give birth. I feel bad that I cannot
> help other women outside the family to give birth and feel that my rights have been taken
> away. I feel irresponsible that I cannot help people in my community who need my help.

When I asked her how she learned her skill she told me:

> My daughter, this is women's work. I just learned at home as an older woman. It is
> expected that every old lady know how to do this thing. You do not need any training to
> begin with. It is natural. Some time ago the health care system gave us [TBAs] some
> training on how to help women give birth safely. We went to Bolgatanga for about 2
> weeks to learn how to do deliveries.

Although this TBA did not mention the benefits of their training, it appeared the training did

provide some useful information, especially on aspects of hygiene, which enhanced their

practice. Prior to stopping them from assisting women at home, TBAs were required to

accompany the woman and baby to the clinic and render a report. Boodsomah stated:

After a woman gives birth I get someone to write the date and I accompany the woman and her baby to the clinic to report to the nurses and for documentation. What is wrong with this? Then about 2 years ago, they called all TBAs and gave us some things (soap, and disinfectants) to use for our hands and the baby's cord to prevent infection. After a year again, they told us not to help women in labour. Now we are expected to rather accompany women in labour to the clinic or call them [nurses] to come for the woman. The clinics are very far from this village. So my question or concern is: is the woman in pain or suffering or not and, how long is it going to take them to come for the woman? I have heard them but I will continue to help my own family. As I talk now, I just delivered one of my daughters-in-law last night and I feel really tired and sleepy. She finally gave birth in the middle of the night.

Studies in Ghana and other parts of resource poor nations suggest the majority of women in rural settings prefer the assistance of a TBA to that of a professional midwife (Yakong et al. 2010; Spangler 2011). When I asked Boodsomah what she thinks of this contrast she stated:

Most women who have been to the clinic complain that midwives beat them up during labour. I think that is inappropriate. How do you beat up a woman who is carrying another human being inside? Women continue to tell me that they prefer my support. They say that midwives treat them disrespectfully.

Women in my study, including TBAs, also feared that traditional knowledge with regard to birthing practices will soon disappear, because they are not allowed to practice and cannot impart that knowledge to the young women through apprenticeship. When I asked Boodsomah what she thinks will happen to the next generations with regard to birthing skills and practices, she responded:

Well it is good for women to go to the hospital. They say it is safer. But I am worried that older women's knowledge is fading out. Older women are now reluctant or afraid to even practise doing it. The majority of older women are losing their skills to support women in labour because of the fear they put in us. My fear is how would it look like in the future? Also, it may take a long time for nurses to come for a woman in labour because our village is far from the clinics. I think they are putting women and babies at risk.

Midwives perspectives on reproductive health care and their role

In Ghana, midwives are either registered general nurses with an additional midwifery certification or registered midwives without a general nursing certificate who offer maternal and child health services in rural settings. Other nurses with related backgrounds who offer the same services include community health nurses or community health officers. Though somewhat different with regard to background and levels of education, these categories of health care providers are generally referred to as "nurses" by the general public. Traditional birth attendants are not referred to as midwives; they are simply addressed as traditional birth attendants. Although in my study I interviewed only midwives in my discussion with regard to health care providers, I will be using the title "nurses" or "midwives".

The general perception of the four midwives I interviewed was that women's access to maternal health care had improved since they took over. Three of the midwives who work for the public health facilities had been working in their new stations for the past two to three years while the mission clinic midwife had been working at her clinic for close to seven years. They believed they were doing everything possible to break barriers that prevented women from accessing care, such as reaching out to them and improving their interpersonal relationships with women. However, they collectively identified barriers to effective service delivery as the lack of transportation, the poor road network, inadequate staff, a lack of supplies and equipment to work with, the lack of funding to effectively run clinics and introduce new innovations to improve practice, a lack of patronage by community members and a lack of incentives and the rural nature of the places they work. They also collectively noted that women attending prenatal and postnatal services were on the increase while labour and delivery service usage was not increasing. They were also concerned that women did not report immediately following

pregnancy to access care. However, on early prenatal reporting, another midwife pointed out

that, in the culture of the community, it was against their beliefs to report early pregnancy to an

outsider. It is believed that the pregnancy might spontaneously abort if divulged prematurely.

Regarding transportation, with the exception of the mission clinic which had one

ambulance, the four facilities relied on motorbikes as their means of transportation for their work

(see Yakong 2008). These bikes were used for outreach clinics, for staff meetings outside the

clinics and other activities related to work. This meant that if women were in labour at home and

families sent for help, there was very little the midwives could do because motorbikes could not

carry women in labour. At the time of our interviews, midwives did not attend labour at home

either. For example, Samantha, one of the midwives stated:

> I was called to attend a woman who gave birth at home in one of the villages and had
> retained placenta. I was able to get an ambulance from a different clinic but it took a little
> while to get it. On our way we got stuck. We had to continue the rest of the journey by
> foot but it was also too far. We managed to get there anyways but, it was a bit late; though
> she did not die, she suffered a lot. These are some of the problems we have here that
> sometimes makes it difficult to do our best. Imagine in an emergency situation like this
> where, as a midwife, I could help but how can I, if I cannot get there at the right time?

Samantha continued, saying:

> I have encouraged women to use donkey carts because those ones are able to travel
> through the rough roads where cars cannot go but there is a wide belief that when donkey
> carts carry patients, those patients will not survive.

Adisah, another midwife, stated that

> We [midwives] give women our phone numbers to call us if they are in labour but even if
> they call, we do not have the means to go. We only have a motorbike which cannot pick a
> woman in labour. So yah, it is difficult to really do what we were here for.

The majority of the women I interviewed did not appear to have access to cell phones and there

is no commercial phone system available to community members. Based on my observations and

my insider knowledge, it is unrealistic for midwives to provide residents with cell phone

151

numbers to call them when their family member is in labour, because very few people, mostly

men, have access to cell phone lines.

With regard to irregular service provision, two midwives agreed that they were supposed

to provide 24-hour services to residence but, due to family commitments and heavy workloads

with limited staff, they get tired and have to alternate with other staff. Samantha, who was the

only midwife among the other staff, commented:

> My family live in Bolgatanga and I work here [at the village]. I go on weekends to see my
> little boy and come back on Mondays. But I leave my phone on so, if there is an
> emergency, the other staff will call me to come back.

Another midwife confirmed that Samantha goes to Bolgatanga for the weekend and there

is no one on day duty at the weekend to attend labour or any other related medical conditions.

Christiana, who works at the mission clinic, provides 24-hour services.

> I live here every day and attend to all the labour cases that come here. Even though I get
> tired because I am the only one here, I still do my work. I may be cranky because I am
> tired but I make sure that no woman struggles to get here to find I am not here to help.

Unlike women who stated they go to the clinics but nurses are not available to serve them, some

of the nurses also claim that they feel demotivated when they "sit here every day and no patient

comes for their services." This claim was a particular issue for those midwives working in the

public sector.

Sub-Saharan Africa is experiencing an acute shortage of health workers, particularly

midwives and other categories of nurses (Gerein et al. 2006). This shortage reflects Ghana's

experience and may be associated with the fact that the majority of older midwives are retiring

from service and younger staff do not willingly accept postings to rural areas. Similarly, the

maternal health care service delivery in rural Ghana rests mainly in the hands of midwives and

nurses, and most facilities are understaffed and the few who work there are overworked

(Oiyemhonlan et al. 2013). The few staff also appeared unmotivated because of their heavy workloads, as well as a lack of incentives to work in rural areas. These may be the two key reasons for poor attitudes of midwives towards women. As well, there are illegal demands and charges that midwives impose on mothers as they compensate themselves for being in deprived areas, rather than in urban areas, where nurses may have more opportunities for advancement in their careers. Another important issue affecting midwives who live and work in rural settings is a lack of quality education for their children because schools in rural settings do not offer quality education that these midwives would wish for their children. This therefore means that midwives who have young children of school going age will have to leave their families in towns while they work in villages so that they can have access to quality education. This may be a reason why staff are often absent at their clinics because they have to travel between their work places and town where their families live to offer them the needed support. It may even be a worst experience for young unmarried staff to work at these rural settings too because they may also find it difficult to find men who they might want to marry, and hence a reason for them to put up poor attitudes so that if their work is not appreciated at their current stations they may be transferred to other places they consider much better compared to the villages.

Two midwives admitted that poor attitudes towards mothers and how some women are abused by health care providers can turn women away from accessing care. However, they gave reasons that contribute to the tendency of midwives to abuse women. For example, Christiana confirms that,

> I sometimes hit them because they do not listen to commands when you ask them not to push because the baby is not ready. I focus on getting the baby out alive and when a woman is doing something that goes contrary to that, I do not accept it. As a midwife I get hurt when I deliver a dead baby. I am attached to what we do.

Adisah shares that:

For me I would say, yes, I shout at them. If you come and misbehave, especially as I am alone, particularly in the evening or night when I am tired, I shout. Also if the labouring woman is not co-operating, I yell. I am afraid the baby would die or the woman will get a tear. I shout to correct them, so that I can have a safe delivery. At times, when the woman is misbehaving and you try to tap her a little so that she can relax, then they say you are beating them.

However, Samantha disagrees with the idea of shouting at and beating women while in labour. She felt that such practices are inappropriate and unprofessional. She said, 'I have given birth myself before and I know what it is when a woman is in labour.' Despite her disagreement, she confirmed that at some places women are beaten. She shared a story about when she referred a woman to another hospital for further management:

I referred a woman to another place after delivery. She was bleeding seriously and would not allow me to examine her for clots, if any, so that I can bring them out to stop the bleeding. And I am not used to forcing or beating women. I know that going into the vagina to scoop out clots is very painful but you have to. Besides that, you can get some bruises around the vagina and those bruises can cause pain too. So I called an ambulance and referred her to the hospital. When she came back to child welfare clinic she told me that she was beaten like a donkey at the Bolgatanga regional hospital. She said they used forceps (I am sure it was a delivery forceps) to hit her. On the day she came to the clinic I was delivering another woman who had similar problems and I wanted to inspect for clots and she was not allowing. That woman rushed in and told the other woman to better allow me to do it because if she goes to the Bolgatanga regional hospital, they will beat her like a donkey.

Adisah confirmed that charges, introduced for women who have given birth at home and then visited the clinic, are meant to deter women from doing so. She also confirmed that nurses normally asked women to prepare for confinement that includes buying new items for themselves and their babies. She said:

Yes, we asked them to prepare themselves by buying new things for themselves and their baby so that when they give birth, they have something clean to wear. This is something midwives are taught at school to educate pregnant women. I also asked them to bring clean rugs when they are coming to give birth because we do not have gauze and cotton at the clinic to collect blood when they give birth.

The four midwives were all unhappy that the use of birth control by women in the area is declining. They associated such decline to the culture's high regard for children and men's lack of involvement in birth control issues.

All Midwives stated that TBAs have been asked to stop practicing but should, rather, accompany women in their communities who are in labour to the clinics or call nurses to come for them. Those TBAs who bring women in to the clinic are compensated with a cake of soap and GHS2 [equivalent CAD$0.96). However, all four midwives denied asking women for soap, Dettol and other toiletries as gifts. Although midwives were somewhat frustrated by the multitude of challenges they faced in their work, as a group, they generally appeared committed to providing services in their areas of practice that would benefit women.

Summary

As in other resource-poor nations, in rural Ghana, factors influencing rural women's maternal health care decisions and access exist and are complex. These factors present several negative consequences for the lives of women in their reproductive age group. This study, as in previous studies (Oiyemhonlan et al. 2013; Yakong et al. 2010), reveals several layers of barriers that intersect to impede women's access to health care, as well as a health care provider's ability to deliver effective and efficient maternal health services to rural women. These findings challenge health care policy makers' understanding of local contexts and how these contexts might influence health care policies they put in place. There is also a need for the Ghana health care sector, as well as local governments, to modify and improve conditions that are unfavourable for access and service delivery in rural areas. For example, the poor road networks need improving, access to public transport system should be improved and provision of resources and logistics and would go a long way to increase access to and enhance service delivery in rural Ghana.

155

Also, the socio-cultural context of women's lives discussed in this chapter reveals that viewing rural women's lives outside of their lived reality may present serious misconceptions about women that can further complicate how health policy formulation and implementation are carried out to meet women's health needs. The nature of women's daily and seasonal work and the cultural construction of gender roles make it challenging for women to realize their own health goals as they must conform to societal norms and cultural beliefs and values whereby they live their lives for another, especially their husbands. Policy makers and implementers, such as maternal health care providers, need to be cognizant of, and take these social realities into consideration in order to find ways to support rural Ghanaian women's access to health care. Until all the cultural and contextual issues are addressed, there will be no effective change in the MDGs aimed at improving maternal and child health in challenging contexts settings. If not, the possibility that women will continue to abandon the health care system will be high in rural settings, thus perpetuating the situation of poor maternal and child health and increased maternal and child mortalities, all of which impact on national development.

Chapter 6. Infertility: The Neglected Link in the Maternal Health Agenda

Procreation and its associated activities are significant sociocultural expectations and desired by most women, especially within the contexts of sub-Saharan African cultures where child bearing is a rite of passage and an achievement of adulthood for women and men. Despite a desire for children and the socio-cultural role of adult parenthood, many women in sub-Saharan Africa—with varying roles, gender identities and social responsibilities—are unable to experience this significant and life enriching role due to infertility. In sub-Saharan Africa, among women aged 20 to 44 years, who have been married for at least 5 years, the prevalence of infertility ranged from 10 per cent in Togo and Rwanda to about 25 per cent in Cameroon and Central African Republic (Larsen 2000; 2003). In rural Ghana, for example, current research indicates that 15.8 per cent of women are infertile (Geelhoed et al. 2002). In traditional African pro-natalist societies, the fundamental goal of marital unions is to bear children and women not only want to but to some extent feel obliged to bear children (Oiyemhonlan et al. 2013). Hence, childbearing remains the major role for women in Africa; the inability to perform this role threatens women's identity, gender role and womanly well-being, and creates a context which segregates them based on their fertility status, excluding them from routine cultural activities and practices. This segregation results in social invisibility and affects their well-being. To date, there has not been a study suggesting that women in traditional African settings opt for voluntary childlessness. In the next sections, I present an overview of infertility in Africa alongside a discussion of rural Ghanaian women's perspectives on infertility with regards to gender, kinship factors and socio-cultural mechanisms put in place to help families cope.

Overview of infertility in Africa

Currently, infertility in Africa is a widespread and major social, public and reproductive health issue affecting both men and women (Inhorn and van Balen 2002). In spite of its prevalence, infertility receives very little attention from anthropologists, ethnographers and other health and social science researchers compared with other contemporary issues in society, such as HIV and AIDS, tuberculosis, family planning or drug abuse. In my review of the Ghana health system report on reproductive health (Ghana health service 2011; Regional health directorate 2010) there is no data captured on infertility. In my field interviews with women who accessed reproductive health care in rural Ghana, none of them had any information on availability of infertility treatment. For example, Azumah, a woman who has had multiple births and had attended clinics with all her pregnancies, mentioned to me that the routine health educational talks usually given to them at the clinic sessions do not include any information on infertility. According to Azumah, such information only focuses on disease prevention and birth control methods.

Although it is not clear why data on infertility is not captured, it can be concluded that this important health issue has been deliberately overlooked despite its socio-cultural importance as a result population control policies. In addition, because infertility in this region is masked by the perceived high rates of fertility reported by population policy makers and analysts, health policy experts and dominant donor countries, health systems identifying such a health issue may conclude that this information goes against local government efforts to control population. It may also affect funding organizations policies that could lead to a loss of funding. The perceived high rate of population growth also complicates the issue because it contributes to a fear of global population explosion and prevents policy makers and researchers from recognizing infertility as

a public health problem requiring urgent attention. The increasing incidence of infertility negatively impacts many women, particularly in a cultural setting where marriage, pregnancy and childbirth is the ultimate goal of both women and men; where women depend on their children, especially their male children for their connection to their husband's lineage and access to family resources; and, where without children a woman's life is almost equal to death. Infertility may result in a woman being divorced; it denies a woman the opportunity to achieve social adulthood and experience motherhood as a major social and gender role activity. These issues can create social and health consequences affecting a woman's psychosocial well-being. If the current rate of infertility in this region remains unchanged, the indication is that the heritage and lineages of many families will be threatened and may even be wiped out.

The debates around population and fertility issues in sub-Saharan Africa have been long standing, spanning pre-colonial, colonial and postcolonial eras. In recent decades, sub-Saharan African countries have been the foci of birth control efforts by the international community and by funding organizations due to perceptions about this region's role in the world's overpopulation discourse (Inhorn and van Balen 2002). As a result, health policies and programs, influenced by Western views of family and fertility regulations, are designed to influence contraception. These programs intentionally or unintentionally neglect the issues and concerns of infertile women who struggle to achieve motherhood as their adult gender identity (Inhorn and van Balen 2002). Major internationally funded population research in Africa focuses on family planning or birth control practices (Richey 2003), leaving out the question of infertility and, consequently, the social significance of motherhood. Examples of such funding organizations that complicate the infertility question include the United Nations Population Fund and United States Agency for International Development, which have been deeply involved for several

decades in promoting birth control policies in resource-poor nations. Rarely do funders raise

concerns about infertility issues and their impact on infertile women in Africa. The actions and

attitudes of international funding agencies towards fertility issues in Africa raise questions about

racism/sociocultural profiling and economic dominance. Regardless of these perceptions,

debates, power, and control, African countries still draw their economic, political and spiritual

strength from fertility and fertility still remains the backbone for development and women's

identity (Inhorn and van Balen 2002). Infertility carries psychosocial consequences for women,

particularly in rural settings, who depend on family for their existence.

The magnitude of infertility

There is overwhelming evidence that infertility is on the increase in most parts of sub-Saharan

Africa, creating what is termed an *"infertility belt"* (Kobeissi and Inhorn 2007). Larsen (2000)

posits that the magnitude of infertility in sub-Saharan Africa may be underestimated since

infertile women in such countries may not participate in studies due to their discomfort with

discussing personal issues in research interviews, especially because of the social stigma

attached to infertility. Hence, data from world and national fertility surveys may not be

representative of the real numbers and issues. This finding corroborates women's views on

infertility in rural Ghana. For example, Nabpoka, a 68-year old woman, had never children with

her husband but fostered other children who she refers to as her own, did not feel comfortable

talking about her infertility due to the perceived social stigma. It appears that women who

suffered infertility try to deliberately ignore it and move on with life. In some families in Ghana,

where family members support such women, it can be difficult to know that the woman never

had children. Infertility is a secret and the only way one can hear about it is through gossip,

which makes it difficult for researchers to approach apparently infertile women for interviews, and thus results in the issue being underrepresented in the literature.

Studies indicate that the majority of the world's infertile couples reside in challenging contexts nations, especially in sub-Saharan Africa (WHO 1991). Yet, in these countries, treatment is almost nonexistent. Where any treatment at all is available, it is financially out of reach for the majority of the population. Although sub-Saharan African countries are the most affected by infertility, they receive little attention from the global community on improving strategies for prevention and treatment opportunities. In Ghana, it is estimated that from two per cent to 15 per cent of women live with primary and secondary infertility respectively (Larsen 2000; Donkor and Sandall 2009).

Primary infertility exists when a woman has never become pregnant despite unprotected sexual intercourse over a period of 24 months; secondary infertility is the inability to conceive following previous pregnancies while experiencing regular unprotected sexual intercourse over a period of 24 months. Secondary infertility is predominantly higher among African women than primary infertility, with Cameroon and Central African Republic presenting the highest incidence on the continent (Rutstein and Shah 2004). This pattern calls for rigorous ethnographic investigations to unearth why such a variation exists.

Within the international community, the discourse around reproductive health with regard to sub-Saharan Africa focuses on controlling births rather than on improving the social factors that contribute to high fertility (van Balen 2000). Factors such as high poverty rates, neglected diseases leading to high infant mortalities, impoverished health care and service delivery systems, low literacy rates among women and low paying job opportunities, are all issues associated with high fertility rates in Africa and affect quality of life.

161

Causes and context of infertility in challenging contexts nations

Causes of infertility in both men and women vary from one society to another. From a biomedical perspective, causes of infertility are attributed to various factors affecting male and female body systems that facilitate the process of reproduction. These factors are linked to body make up, genetics, body chemistry and psychological factors (WHO 1991). While it is true that these factors form part of the causes of infertility in both men and women, they are considered the main causes of infertility in developed nations and account for only a small percentage of the world's population and overall infertility issues (WHO 1991). On a global note, the major causes of both primary and secondary infertility include the consequences of sexually transmitted infections (STIs), infections of the female reproductive system, parasitic infections, genital tuberculosis, and complications from unsafe medical practices during labour and delivery, unsafe abortions, female genital mutilation (FGM), and malnutrition in women (Skaine 2005). All of the above factors assume a gender and cultural dimension, which can affect women more than men. For example, women have limited control over complications (infections and infertility) from FGM and STIs contracted as a result of their husbands' polygamous relationships and promiscuous behaviours, all of which can result in women being infected and can lead to infertility. Some of the above factors can be modified if a concerted effort is geared toward making lives better for the underprivileged.

The impact of population and health policy on reproductive health and infertility

A major issue that population and health policy planners neglect in the maternal and reproductive health agenda in resource-poor nations is the negative impact of infertility on affected couples, despite the 1994 UNICPD agreements to treat infertility as a crucial reproductive health and human rights issue (UNICPD 1994; Hellsten 2000). Although the UNICPD concern over the

162

increasing prevalence rates of infertility and the emotional and social consequences infertile women face, infertility prevention and intervention strategies rarely receive any serious attention in challenging contexts nations by population and health care policy makers or the health care systems in general. Instead, the attention of individual nations with pressure from donor countries is on population control, regardless of the desire to experience parenthood and the resulting social consequences related to infertility.

A major reason for this neglect may well be the nature of developed nations' concern over the impact on global wealth of a population explosion. In addition, is their shared belief that women of resource-poor nations are the designated baby factories that threaten a global population increase (Inhorn and Buss 1994; Richey 2003) as well as their own desire and obsession with the accumulation of wealth. This fear that high fertility in such nations has a negative impact on the world's resources, needs to be recognized and critically examined given the disproportionate distribution of the world's resources, which favours developed nations (Pearce 1995). Until the problem of disparity in the distribution of wealth and resources is solved, policies targeting population control will have little impact. In 1983, Africa's population was considered too high, estimated to be among the highest in the world, hence the need for birth control policies (Sai 1984). Among developed nations, population decline is a concern that needs remedying (Foster 2000; Voas 2003). The interesting question to ask is why developed nations are interested in population control in other nations, when a decline in population is a source of serious concern to their nations. Looking into the future, it is possible to imagine that resource constrained countries will eventually be facing similar problems with population decline. Given the continuous existence of resource disparity, it is an open question whether there would be any resources for resource-poor countries to revisit fertility issues to solve the problem of decline.

163

The discourse around infertility prevention and treatment exposes major factors that influence the lack of availability and access to infertility services in limited resource countries. These include a lack of political will of international and national governments, high prevalence of corruption, nongovernmental and religious organizations and sociocultural factors. Most developed nations, such as the United States, pay for infertility treatment as part of their national health policy (Nachtigall 2006); whereas, in challenging contexts countries, national health policies pay little if any attention to infertility issues and, for that matter, treatment. Even in their population policies, infertility issues are made invisible because international donor agencies do not support it and are most likely to deny development funding to poor countries that promote infertility issues; such as in Peru, discussed below.

Israel is an exception and stands out as one of the countries in the world that makes infertility services available to its citizens regardless of their socioeconomic status (Nachtigall 2006). For countries in sub-Saharan Africa, international health policies focus on birth control technology as a way of checking population growth, which may not actually serve the interests of poor nations but those of the dominant countries (Morsy 1995; Inhorn and van Balen 2002; Richey 2003; Nachtigall 2006). These policies that are based on the dominant perspective ignore much needed attention to infertility as a national and public health issue, translate into national policies at local government levels (Hellsten 2000). In many resource-poor countries such as Tanzania, and Egypt (Morsy 1995), international donor aid has been linked to reducing birth rates. Thus, national governments are compelled to develop population control policies in order to qualify for donor aid. Fertility control is a condition of the international monetary institutions such as the World Bank, USAID and other funding organizations (Richey 2003). Following the 1994 Cairo Conference on population and gender issues, which encouraged improved maternal

health through education, socioeconomic independence, and freedom of choice in reproductive matters rather than simply dealing with population control, developed countries withdrew their donor aid because such ideas did not serve their interests (Bulatao 1998; Richey 2003). Furthermore, the World Bank perceives these countries with higher fertility rates as a disease in itself (Morsy 1995). Thus, the conditionality of donor agencies from resource-rich countries undermines the reproductive rights of the citizenry of poor countries, an issue well worth further study and revisiting.

An example of dominant perspectives influencing fertility rights is Peru, which suffered one of the most dehumanizing forms of national population control policies as a result of donor aid conditions to reduce population growth rates. Between 1996 and 2000, over 250,000 women, mainly from the rural poor, were coerced by government population policies, influenced by international agencies such as USAID into undergoing sterilization in order to check population growth (Miranda and Yamin 2004). In the case of sub-Saharan Africa, the influence of such international social and health policies prompted Ghana to become the first West African country to define its population policy in terms of reducing population growth and actively implemented family planning programs to achieve this goal (Population Council 1969; Gwatkin 1971). Ghana's perceived reason for its population policy statement, likely influenced by donor nations, was to "assure a decent and modern standard of living for Ghanaian families" (The Population Council 1969:1). Despite this claim, and the current decline in population compared with other sub-Saharan African countries (Ghana demographic and health survey [GDHS] 2007), not much has been achieved in the way of decent or modern standards of living. Maternal and infant mortality rates are still on the increase, particularly in rural settings. Food security remains a problem in most parts of the country, especially in northern Ghana where about 8 out of 9

children are malnourished. Only a few Ghanaians have access to good housing and potable water and waterborne diseases, such as guinea worm, remain endemic and among the highest in the world. Gender disparity in education, equal property rights and employment is persistent; access to health care by rural dwellers is limited; and, overall living conditions for the ordinary Ghanaian are nowhere near acceptable standards as promised by the population policy (GDHS 2008; GSS et. al. 2009; Heyen-Perschon 2005). In Ghana's population policy, Ghanaian women are placed among the most fertile in the world, thus creating panic for government to institute a population policy. However, this does not mean that couples do not struggle to achieve even a single birth and when they fail to have children, there are not policies to support them. Nigeria, whose population policy was written in collaboration with the World Bank, much later than that of Ghana in 1988 (Adegbola 2008) faces similar issues.

According to Walt et al. (2008), policy makers must at all times consider the local and contexts and needs and they must to be reflexive, not allow power to influence policies that affect people both at macro and micro levels in individual nations. Unfortunately, Walt et al.'s caution has been persistently ignored which has led to negative implications for locales of poor nations. Currently, the focus of global policies is on birth control, exerting pressure on poor nations to maintain sizeable populations, which results in a lack of political will from national governments to pay attention to the reproductive needs of their citizenry. Infertility is perceived as "nature's way" of controlling birth in low-income countries (Nukunya 2004) and the question that lingers in the minds of policy makers in developed nations is whether it is necessary to even promote infertility treatment for affected couples in these poor countries or support programs aimed to prevent infertility. This is particularly true in Africa where population growth is a major concern to the world and treated in some ways by a "disease" approach (Morsy 1995). As much

166

as population growth is a matter of concern to those interests it serves, it is also important to give infertile couples a chance to achieve their reproductive goals.

The governments of Ghana and Nigeria provide funding for family planning programs but remain silent on infertility issues. But the difference between Nigeria and Ghana is that 'Nigerian policy statement clearly places much less emphasis on the need for reducing the rate of population growth than does that of Ghana' (Gwatkin 1972:215) (n11). A Cameroonian government representative was among the first from resource-poor nations to raise concerns about the alarming nature of population decline in central Africa in 1969 at the World Health Assembly (WHA) in the United States. Historically, infertility has been a continuing concern in Cameroon from pre-colonial times (Fieldman-Savelsberg 2002). The Cameroonian representative to the WHA advocated for ways to tackle infertility issues in population policies in order to sustain the desired population of the country (Gwatkin 1972). The representative's advocacy contradicted views held by the dominant nations and their perceptions about the negative impact of population growth on the world's resources. Furthermore, he/she hypothesized that if challenging contexts nations are to succeed in achieving their development goals, then there is need to ignore population control policies. Despite the critical infertility issues, the government did not oppose the use of contraceptives if medically advised and considered a way to promote women's health. However, more recently, Cameroon has adopted family planning programs in their population policy due to economic pressure at both local level and from international organizations (Feldman-Savelsberg 2002; Richards 2002).

Within this same era, Gabon feared that the nation was soon going to run short of labour power should population control policies be implemented. Unlike in Ghana, in order to sustain the nation's desired population, the government of Gabon passed a strong law against the

importation of contraceptives, the violation of which resulted in severe legal action including imprisonment (Gwatkin 1972). Similar policies that disregard women's bodies, their sexuality and value is China's one-child policy, one of the toughest policies and family decisions in the world, which leaves many women with pain and thwarted dreams (Anagnost 1995; Ginsburg and Rapp 1995). The implications of China's one-child policy include diminished sex ratios, where there are more boys than girls, thus creating a context where there is shortage of wives for men to marry and, in addition, a high rate of old-age dependency on couples (Ani and Mamdani 2006). This means that a couple is compelled to care for two sets of old-aged couples representing each couple's family line. Similar to India's two-child policy, the one-child policy in China also promotes selective abortion and female infanticide to pave the way for the desired male child, that is as in Ghana, the most preferred sex in China's culture and who is responsible for maintaining the family's patriline and to care for parents in their old age.

In most resource-poor countries, policy makers and experts discount the meaning of family to couples and are most concerned with population control (Gwatkin 1972) thus, ignoring the impact of infertility for a woman and on family life. In the Netherlands, the Dutch national health policy disallowed infertile women above 40 years of age access to infertility treatments. A reason associated with the restriction of women within this age category from treatment benefits is a perceived extra cost on the health care system. Protestations from pronatalist's advocacy groups and affected couples, as well as some health care providers including physicians, did not repeal the policy to favour couples desiring children (Yebei 2000). Such policies are unethical and disrespectful of women's reproductive rights (Hellsten 2000) and must be critically examined and reviewed. According to Foster "motherhood and apple pie are, famously, things it is deemed impossible to be against" (2000: 209).

The antinatalist views of the West contribute to a growing anxiety about fertility in some resource-poor nations. More importantly, perhaps, these views create suspicion and mistrust for health promotions programs that are not geared towards fertility control, such as ordinary immunizations to prevent communicable diseases. For example in 1990-1991 Cameroon, "Grassfields schoolgirls climbed out of school windows to flee public health workers, prompted by a rumor that the government was plotting to sterilize the young women …under the guise of a vaccination" (Feldman-Savelsberg 2002:223). In 2003, Nigeria boycotted polio immunizations planned to eradicate polio in the African continent due to rumors that such immunizations were politically motivated by the west to sterilize young African women (Jegede 2003). Currently, Nigeria accounts for about 80 per cent of polio cases in Africa and 45 per cent in the World (Jegede 2007). If dominant policies are directed at controlling population, rather than understanding related issues regarding infertility, it is understandable that these policies might be viewed with suspicion that can spill over into other, more mainstream health initiatives. Trust is built when ALL health issues are recognized, not just those defined by donor states and organizations.

Studies have documented the adverse impact of national health reforms in the 1980s, which brought about the user fee policy to most challenging contexts as a result of structural adjustment policies dictated by donor countries (Nanda 2002). Upon the recommendation of the World Bank in 1987 to increase cost recovery as a strategy to finance public health services in resource-poor nations (Shaw and Ainsworth 1996; Nanda 2002), the impact of user pay fees for the most part has been negative (Nanda 2002; Nyonator and Kutzin 1999). User fee policies have led to a severe underutilization of health services, by the poor in general; and particularly impact poor rural women's reproductive health (Haddad and Fournier 1995; Russell 1996; Nyonato and

Kutzin 1999; Nanda 2002; Ridde 2003; Storeng et al. 2008). None of these policies made provision for infertility remedies. More often than not, policy makers lack the ability to analyze critical issues in the policy process or are uninformed of or ignore the local contexts which has huge implications for women's rights and health. Hence the need for critical policy analysis to tackle important social and health needs of locals, particularly those of importance to girls, women and children (Exworthy 2008).

Causes of Infertility in Africa: A Gender Relational Perspective

Women are more vulnerable to STI infections more than men due to a number of reasons: complications from FGM, forced sex, as in rape, a lack of power to negotiate safe sex (even with husbands, as in the case of Mna-inyela, the 13-year old victim of forced married and forced sex) and women's high poverty rates, which might compel women to engage in much riskier behaviors, such as the sex trade, for income. Example FGM, is a cultural practice that impacts fertility by introducing infections and pelvic inflammatory diseases (PIDs), which cause tubal blockage and can result in permanent infertility in women (Skaine 2005). In a case-control study examining infertility after genital mutilation among young girls in Sudan, Adimoral and Schoenbach (2005) demonstrated that FGM is the leading cause of primary infertility. These factors make the issue of infertility in Africa a cultural, economic and gender issue.

Studies demonstrate that on a larger scale in sub-Saharan Africa, the main causes of infertility in women are attributed to STIs and PIDs (WHO 1991). STIs can lead to infection and blockage of the fallopian tubes that result in infertility if not properly diagnosed and treated (Ohene and Akoto 2008). Unlike STIs, PIDs can be unknown, a result of STIs or other infections through the cervical orifice, the use of intrauterine contraceptive methods (promoted in resource-poor nations), caesarian section and other cultural practices such as douching (Viberga et al.

2006). In Ghanaian women, the main cause of infertility from a biomedical perspective has been associated with PIDs (Ohene and Akoto 2008). The spread of STIs, including HIV, in Africa and in other minority populations worldwide, has been attributed to racial disparity, social inequalities, poverty, war, media influences, sexual tourism, effects of globalization at a macro level, breakdown in social institutions and morals due to effects of colonialism and globalization (Farmer 1996). Thus, even when infertility is biomedical (a result of infections), the ultimate causes are still cultural and social; based on beliefs and behaviors that put a majority of women at risk due to their social positioning.

In addition to the above reasons, the spread of STIs in Ghana can also be linked to the promiscuous behaviors of men, and women who are in polygamous marriages stand a higher risk of getting these infections because of the husband's irresponsible sexual behaviours. Apart from a woman's co-wives, her husband may have other extra-marital relationships with girlfriends where he could get infected and subsequently bring it home to his several wives. In the case of an infection, medical treatment becomes even more complicated because first, women fear to approach their husbands and talk about possible STIs and, secondly, the other co-wives may not be informed about this infection as sexual issues are considered private within the family and thus, it is nearly impossible for the man to trace all those girlfriends outside to get them treatment. These sexual attitudes result in women experiencing recurrent or chronic infections that can lead to infertility. For example, during my nursing practice in rural Ghana, it was not uncommon to find women did not have the courage to approach their husbands to talk about an STI related issue, let alone to bring him to the clinic for any examination and subsequent treatment. It is therefore more complex and even useless if only the woman is treated without the husband because he will simply reinfect her.

171

Colonization of countries and people has contributed to social injustices such as economic inequality, sociopolitical dominance, the abuse of authority by colonizers, and exploitation of the marginalized. All of these injustices can contribute to a context that compels women and girls to engage in negative sexual behaviours that contribute to the rapid and endemic spread of STIs in most African countries. In Ghana and Cameroon, for example, studies have shown that STIs emerged following the arrival of the colonizers and labour recruiters in the 1800s (Inhorn and van Balen 2002; Pellow 1994). Although colonization is theoretically over, it exists through neocolonialist policies that continue to promote and reinforce subordination of African countries through aid and development funding conditions.

As discussed above, the high incidence of STIs can be attributed to polygamous marriages, a common practice in Africa (Bove and Valeggia 2009). In many cultures in the past, husbands did not have sex beyond their wives, however, polygamous husbands often have sex with women who are not their wives and bring infections home and spread them among their wives. However, attributing the spread of STIs to the practice of polygyny is an overstatement. Promiscuous sex and male sexual privilege promote the spread of STIs, an important factor in this discussion where the role of gender and masculinity privileges men over women.

Although STIs have been consistently identified as the main causes of infertility in sub-Saharan Africa, the majority of couples in Africa, including Ghana, do not attribute complications of STIs to infertility (Geelhoed et al. 2002), suggesting a serious knowledge gap and a major public health concern regarding the potential causes of infertility and its prevention. There is a need to address this knowledge gap to prevent STI occurrence and to reduce the economic and social consequences for infertile couples seeking treatment. Due to these unique

issues there needs to be a coordinated effort by government, nongovernmental organizations, and advocacy groups to address infertility issues in sub-Saharan Africa.

Sociocultural perspective on causes of infertility

From an anthropological perspective, a holistic understanding of infertility must link biomedical and non-medical factors. This understanding would provide a context for formulation of good social and health policies for prevention and treatment methods. Cross-culturally, causes of infertility are unique and underpinned by various cultural, gender and religious beliefs. In most African societies, factors responsible for infertility are attributed to non-medical causes such as punishment from family ancestors resulting from inappropriate social behaviors and wrong doing, witchcraft practiced by envious women and co-wives, ancestral punishments, unhealthy social networks, evil spirits and predestination by supreme beings (Feldman-Savelsberg 1999).

In my research, similar causes were identified by rural women in Ghana where infertility is attributed to such things as one's destiny, not everybody is made to have children; wrong-doing, such as practicing witchcraft, stealing or immoral behaviors such as adultery. Similarly, women engaged in irresponsible sexual behaviors, like prostitution, are believed to become infertile as a consequence of having sex with several men. Infertility is also attributed to a woman who is a victim of witchcraft practiced by jealous co-wives, a step-mother-in-law, envious neighbors or other family members; indeed, parents can curse disrespectful or irresponsible children with infertility. The current generation may experience infertility as a punishment visited on them because their grandparents or great grandparents, who sought out the gods in the past to seek favors, such as asking for treatment for infertility or for a child of a particular sex (usually a boy child) but failed to follow through with pacifying powerful gods/or shrines. The majority of health care providers often dismiss such perspectives as superstition

demonstrating a lack of adequate understanding (indeed, outright dismissal) of the sociocultural perspectives of infertility by policy makers and the international community. This dismissal results in uninformed social and public health policies that create additional suffering for couples desiring treatment measures to achieve their reproductive goals.

Social perception of infertility

The perception of infertility varies from one society to another and is affected by a multifaceted set of issues including beliefs and values. Whatever the society, in resource poor settings, it is the woman who is most often questioned about or blamed for her inability to conceive (Boerma and Mgalla 2001). Because of the prevailing perception about infertility across cultures, Mbamah felt that a man can never be infertile. She stated that "men can always bear children anytime they want. It is the woman that can have a problem with child birth." The biomedical interpretation of infertility simply relates to a woman's inability to bear children. In many cultures, the number and sex of the children born during a woman's childbearing age determines whether or not a woman is *culturally* perceived as fertile or infertile (Hollos et. al. 2009). In ethnographic accounts of women's experiences with infertility in Kenya and Nigeria, Sangree (1987) demonstrated that every woman is expected to bear six or more children, including at least one or two sons. A woman who has only daughters is therefore considered infertile since she does not meet these expectations. Inhorn and van Balen define this perspective as 'social infertility' (2002:13). A woman who is defined as "socially infertile" experiences the same social consequences as any other childless woman, despite the fact that she has given birth, mothered and has a living child(ren). In my interviews, rural women referred to a family without a boy as a "yard with bushes" or, as Daboug, a 70-year old woman put it, "without a boy, your yard

[referring to the family] will be viewed as a bush." Without a son, the family name is not represented at the parents' funeral and mourning ceremonies and Daboug pointed out that:

> It is a boy who will marry and also have children to sustain the family. It is the boy that will be in the yard that will give his parents a befitting burial when they pass on and inherit whatever they leave behind; so without a boy, your yard is viewed as a bush.

Assibipoka thought that:

> It would have been terrible not to have a child. Every woman's dream is to have a child. Although I also do know that having a child comes from God and not everyone is made to have a child, I feel that life will be meaningless without a child. I have witnessed childless women's lives in our culture and it is just not a happy one.

Any definition of infertility is therefore incomplete without critically examining the sociocultural perceptions of infertility from a cross-cultural perspective.

Women's perspectives on infertile women's relationships with kin

Infertile women's relationships with their kin folks ranged from sadness to being invisible and socially isolated. Kinship refers to the relationships between persons based on descent or marriage (Stone 2006:5). Kinship thus plays a major role and constitutes a determining factor on women's sexuality and fertility regulations. Ghanaian kinship ties are strong and in the absence of children those kinship ties will eventually die off. This perception was reflected in Kolpoka's statement:

> When a married woman remains childless, it is highly likely that her relationship with her husband's kin would also remain weak because it is the children that strengthen the family ties. Without children the rest of the family members will have very little to do with you. These family members look up to you [woman] to sustain their family and if you are not able to do so, then why would they stay connected with you?

Speaking from experience Yenpoka narrated that;

> When I was married, it took me almost two years to get pregnant. During this time I realized that my husband was not that much interested in me anymore because he may have felt that I am, after all, not going to give him any child, so what is the use? His

siblings showed similar attitudes. I was feeling isolated but luckily I got pregnant and everything changed from sadness to happiness.

Apart from staying connected with a husband's family, having children, particularly male children, gives a woman her full rights to access property in the family, without which she is powerless. Dable, who had only one girl child with her husband, explains that:

> I feel empty and powerless in my house because I do not have a boy. Although I am the one who worked with my husband to accumulate some wealth before my co-wife came, she controls almost everything in this house because she has a boy. Whenever there is a decision about something, I am left out. I guess the point is that, in the end, it is the boy who will inherit the family so I do not have much say anyways. I am just here and if they give me any share I will take it and if not, then that is okay too.

In patrilineal societies, as in northern Ghana, lineage membership is traced through the male line and only male children inherit from their fathers. Female children inherit from their mothers but this usually involves only material things such as clothing, dishes and other gender specific artifacts. While a woman might appear to have property, such as cattle, this wealth is really the property of her husband's male child(ren), even if that child or those children are not her son(s). Even though women value their female children too, all of these traditions reinforce women's desire to have male children of their own.

Social consequences of infertility: A gendered dimension

Gender is a cultural concept (Stone 2009). Because gender is culturally constructed, gender concepts are also socially specific. As a result, the cultural construction of womanhood, femininity, and women's role with regard to childbearing and infertility in many African societies is gendered. First, the concept of gender is linked to and influenced by complex ideologies, values and roles. In Africa, childbearing is a woman's required role and not a matter of choice, as might be the case in other societies; a woman's failure to bear children results in social consequences.

The social consequences for infertile women in Africa are severe, especially in Ghana (Donkor and Sandall 2009). Women are usually held responsible for their inability to bear children regardless of the perceived cause of infertility. In Cameroon, Feldman-Savelsberg's (1999) research exemplifies women's fear of infertility from personal, family and community levels. They may experience social consequences such as being accused of witchcraft, endure domestic violence, family resentment, loss of relationships and social identity, experience loss of property rights, economic consequences, divorce and lost social status at both family and community levels. And, finally, there is the loss of ancestral rights after death (Feldman-Savelsberg 1999). In most Ghanaian cultures "an infertile woman is labeled as abnormal or incomplete" (Yebei 2000:134) and is most likely to be divorced. In other African countries, more than 40 per cent of infertile women suffered divorce or separation; and, in some cultures, women must demonstrate their fertility even before being accepted for marriage (Rutstein and Shah 2004). In the Gambia, for religious reasons, women can be divorced if there are no offspring (Sundby 1997). In some instances, women are likely to remain unmarried following failure to demonstrate their fertility. Married women who are infertile are likely to have to endure polygynous relationships in cultures that permit polygyny.

When women suffer infertility, they no longer conform to the social construction of womanhood and their roles and identities are altered all of which in turn expose them to peer ridicule, family displacement, community and societal stigmatization. Yet, these consequences are ignored and receive little attention at national and international, social and health policy levels, or by health care systems. In Nigeria, infertile women are perceived as bad luck to living families and after death their bodies are buried in the bush to prevent transfer of their infertility to the land (Hollos et al. 2009). All this evidence reveals that the burden infertile women carry is

heightened by sociocultural constructions of womanhood and motherhood; yet to date, little attention is paid to addressing infertility issues.

Unlike Western countries where there are strategic social security structures to support couples in old age regardless of their family status (Inhorn and van Balen 2002), the situation in resource-poor nations is different. In these countries, especially in rural settings, children still serve as primary source of social security for aged parents. These social and economic factors underscore why infertile women in African communities, such as communities in Ghana live unhappy lives.

African patriarchal social structures pertaining to procreation always favour men over women during difficult times. Unlike women, who are often ridiculed by kinsmen and the general public due to childlessness, men are shielded from this ridicule as a result of patriarchal social structures put in place to protect them when they are infertile. In the next section I discuss these socio-cultural structures that protect men and their family.

Patriarchal mechanisms for infertile men and/or family continuity

In this particular culture in northern Ghana, there are patriarchal social structures constituted to prevent shame or stigma falling on infertile men, as well as to ensure the continuous existence of the entire family/lineage. These social structures allow men, but not women, to transfer their sexual rights to kinsmen or friends in order to have their wives bear children in their name, while protecting their identities as infertile men (Yebei 2000). In this process, a collective decision is taken, usually by family elders after several years of marriage without a child and, in some instances, after the marriage of an additional woman, usually a woman who has had previous births, in order to test his fertility. This decision is mainly a family decision and does not seek the man's approval to transfer his sexual rights. Thus, there is usually anger and initial resistance

from the husband to release his rights but a united force must be applied for the benefit of the entire family. After the customary transfer, the woman's husband is prevented from having sex with her; sexual access to his wife has been transferred to another. The process is kept secret within the family because a woman who has sex with more than one man limits her chances of getting pregnant. The new man is not also allowed to come to the house but the woman can visit him at his house for the purpose of getting pregnant. This process is also not done in consultation of the woman who has no choice. A period of time is allowed for the woman to get pregnant and, if she fails, she is taken away from the second man. If she does become pregnant, children born from this arrangement are her husband's children and the biological father plays no role in the rearing of those children, nor do the children have any right to inherit or participate in any rituals pertaining to their biological father. When I asked Daboug, an older woman, how those children refer to their biological father, she said, "that man would have nothing to do with the children. He was only a helper. It is the woman's husband that the children will refer to as their father." This transfer is viewed in this culture as another form of treatment for infertility.

Another response to infertility, if a family has only girls and needs a boy and, in a case where the man does not have the ability to marry a second wife (who ideally would bear a boy), one of his daughters can be asked to stay unmarried to bear a boy to succeed the family. In most cases, depending on how many pregnancies she had before delivering a male child, she may end up remaining unmarried and continue to live in her father's house. Similar to the instance above, the daughter's boyfriend will have no role in the child(ren)'s life because they do not identify with him as a father; it is rather the woman's father, in that case the child(ren)'s grandfather or an uncle from their mother's lineage. This type of arrangement allows children from this

relationship to have patrilineal inheritance through their mother's father, instead of matrilineal descent.

Women also have an arrangement to fulfill their cultural and personal reproductive goals in case of infertility. For example, a woman can bring her younger sister for their husband to bear children. Those children are also her children, because they are her direct, younger sister's children. For example, Dougpoka told me that her sister could not bear children and asked Dougpoka for her hand in marriage to her husband. Dougpoka was married to her older sister's husband so that she could fulfill her sister's reproductive goals. She narrated how she was married to her brother-in-law:

> I was in primary school [in the southern part of Ghana] when my sister, who had been married for several years, contacted my father that she wanted me to marry her husband because she has no children. My father sent for me to come and he gave me to my sister to add to her husband. I could not refuse because I thought I needed to help my sister out so that she will live a happy life.

At the time of the interview, Dougpoka was carrying her third pregnancy. When I asked how many children she intended to have, because she had to give birth for the two of them [herself and her sister] she said, "I will have to give birth to as many children as I can; some for her and some for me. She [sister] takes care of the children and my role is to give birth." She described their relationship as outstanding and said, "My sister treats me like her daughter and the children address her, not me, as their mother. I feel that my sister is now a happy woman and I am also happy that I have made her happy".

Kinship ties are strong among women as well as men and when Dougpoka reflected on her marriage, which she did not regret, she said she would have completed her schooling by now if she had not entered into this marriage. However, because of the family ties, she did not get married for her personal benefit, rather, so that her sister would be considered a mother. In her

case, her reproductive choices were determined by her family, which then affects the decisions and choices she makes for herself.

Coping with infertility in Africa

The social stigma and emotional stress accompanying infertility creates an unfavorable environment for women to accept and cope with in African settings. Despite the psychosocial difficulties, to date there is no organized mechanism to help infertile women cope with their vulnerable situation. Although adoption is considered a viable option for couples facing infertility in the Western world (Rutstein and Shah 2004), it is less accepted in many sub-Saharan cultures due to sociocultural and religious reasons. For example, in Yebei's (2000) study of Ghanaian infertile immigrant women living in the Netherlands, women revealed that, for cultural reasons, adoption was never an alternative for women to cope with infertility. For example, some of the participants stated:

> Adopted children can never be called your own…. You can't really adopt a child because of infertility. It's not like yours; you have to fight for it yourself. We say in Ghana, you can't take someone's intestines and exchange them for yours (139).

The above statement signifies that descent and other cultural ideologies determine what a child inherits from its biological parents (and lineage), such as blood from father and other characteristics from the mother. Without these biological properties, the child is not considered to have the right connection with the family ancestors and thus, would not have the right to worship or inherit from either the matriline or patriline within its adopted parents' family after their death. These consequences contribute to the reluctance of infertile couples to adopt for the sake of coping with infertility. The rejection of adoption cannot be ignored by researchers, practitioners and policy makers who make population control a priority. In southwestern Nigeria other reasons that discouraged adoption included "stigmatization, financial implications and

181

procedural bottle-necks" (Oladokun et al. 2009:79). In Oladokun et al.'s study, as in Ghana, women also revealed that "adoption does not remove the stigma of being barren or childless" (85). Other reasons include fear of betrayal by neighbours and gossip about an adopted child's "true" biological parents and the possibility of extended family members not accepting such a child. In most cases, families prefer their son to seek a second marriage or their daughter to remarry and try her luck elsewhere for a pregnancy, rather than adopt a child. Child fostering, however, is much more acceptable in African communities (Isiugo-Abanihe 1985).

Summary and implications for maternal health

Reproduction, mothering and motherhood remain African women's main role, the source of their gender identity and happiness and contribute to women's social positioning, status and security. However, the increasing incidence of infertility in this region robs women of their womanhood and pride. To overcome infertility and its accompanying social consequences, more ethnographic research is needed to inform policy. Access to education for both female and male youth may go a long way to empower girls and women's control of their sexuality and thus their reproductive health. Health care providers must play their role in educating women on infertility prevention and options for sexual health.

For the developed world, there is an urgent need for a paradigm shift with regard to perceptions about population growth, the stratification of reproduction and the social construction of the role of motherhood. The Millennium Development Goals on improving maternal health (WHO 2003) should also focus on female infertility as one of the most neglected maternal health issues affecting the well-being and lineage sustainability for a majority of women in Africa.

Chapter 7. Conclusions and recommendations

My previous research, insider status and my review of the literature on maternal health and reports from Ghana and other low income countries all confirmed that there is low utilization of maternal health services, despite a perceived availability of service. The consequences of the low utilization of such services are perceived to be the main causes of poor maternal health and increased maternal mortality in such settings. The findings from my previous study (Yakong 2008), in addition to my past practice experience and personal motivation statement in the preceding chapters necessitated this study.

Thus, in 2007, I set off to my own community in rural Ghana to explore women's experiences of seeking reproductive health care in order to gain a better understanding of issues affecting their maternal health care access to services. In this study, I looked at issues from a different direction and the shocking finding is that, although low utilization of services does exist, this is not just about women's lack of autonomy or negligence on their part to care for themselves, as is frequently posited by many health care providers, governments and policymakers who have not taken a holistic view of circumstances before drawing such conclusions. Rather, a multitude of complex factors, often underestimated by governments, health care providers, policy makers and implementers as trivial but are issues that perpetuate poor maternal health in rural Ghana. Because of local government and health care providers' concerted efforts to maintain status quo, women become victims of circumstances and often receive blame for being irresponsible. This time around, I made a conscious effort to gain a holistic understanding of the socio-cultural and contextual factors that influence and shape rural women's reproductive health decisions. I realized women are tired of telling their story over and over again for seemly no changes or remedy. I also realized that they did not need to tell me they

are doing their best to maintain their reproductive and family health since their stories, body language and appearance spoke to their struggles and resilience. From my personal perspective—informed by women's stories, field observations, my nursing practice experience—and as a cultural insider, I can confidently say that it takes courage, strength and some kind of resilience to be who these women are as individuals and as a collective group. They consistently explain their challenges, which can be physically observed by anybody who possibly cares to look; yet, they have often been ignored. There has been little improvement to the conditions overburdening women's lives for the past decades or even since the last time I carried out this similar research in the same location. Although my research was located in Talensi-Nabdam, the situation is not any or very different from any places in rural northern Ghana with regard to what women had to say and what I observed, both as a female researcher and as a cultural insider, professional nurse and anthropologist. These women research participants did not specifically state that because of their courage and self-determination they are able to cope with their living conditions. However, as I was immersed in the study and community as a participant-observer, I believe women do cope with courage and I made efforts to understand their situation while knowing that their condition could be different or made better, if it is not for the persistent neglect and lack of understanding by stakeholders and a culture of patriarchy, as they demonstrated throughout their stories.

Based on the data revealed in this research, I want to highlight these major issues in my conclusions and recommendations. Despite the fact that I discussed these issues in the preceding chapters, I want to emphasise these points here for the purpose of their significance. The four points are the 1) over naturalization and normalization of women's conditions and gender roles; 2) over medicalization of reproductive health and oppression of indigenous knowledge; 3) health

care system/policy failures; and, 4) the lack of political will to improve rural health. Following

my discussion of the above four points, I discuss the study's limitations and challenges, as well

as strengths and, finally, possible potential for policy changes and areas of further research.

Over naturalization and normalization of women's conditions and gender roles

The entrenched northern Ghanaian culture of patriarchy, with male dominance and female

subordination, dating back to time immemorial, underscores the current unfavourable conditions

that girls and women endure in rural Ghana. As I noted in chapters 3 and 4, girls in this culture

grow up knowing right from childhood that their function is first, to grow up as a "good girl,"

which means conforming to appropriate cultural and gender norms so that men will want to

marry them. This female conformity is sarcastically referred to in Ghana as a making a girl

"marry-able material or sex material." And, secondly, due to the enculturation process that lays

down the cultural expectations that shape women's lives, women seem to have no other option

but to internalize and appreciate their cultural way of being. As a result, women over internalize

these norms and contribute to the naturalization and normalization of gender concepts and

women's roles. Men, as the beneficiaries of women's over internalization, conspire with culture

and reinforce this normalization, which continues to entrench a context that enslaves women.

This enslavement includes not only their capacity to labour but also their sexuality. A clear

example is in the case of, the 13-year old girl married by force whose story I told in previous

chapters. Mna-ingyela was deprived of her childhood and put into a life of domestic abuse and

sexual slavery at the hands of her much older husband. Even though Mna-inyela tried to envision

a better life for herself through training at the hair salon, she had no control over her current

situation of a forced marriage or over her sexuality and reproductive choices. It is obvious that

her dreams have been cut short and her new role is to be a sex tool for a man the age of her

grandfather. Clearly, her reproductive rights and decisions are not hers but that of the man whom she has been sold to for financial gain. Child protection laws that could have protected her are dysfunctional due to socio-cultural and socio-economic factors (Laird 2002). Public debates on age of marriage for the girl child do not include the affected women themselves but are dominated by male legislators and male leaders of religious institutions, who are believed to be custodians of morality, and thus should make such discussions for girls and women. Evidence of this patriarchal bias revealed in this study is applicable to several settings in other resource poor nations where less value is placed on women compared with men and where bride price is part of the marriage system commodifies women's roles, their sexuality and their labour (Hague et al. 2011; Wardlow 2006; Phillips 2012; Ouattara et al. 2010).

Similarly, women are viewed as a primary source of labour, as discussed in chapter four and the proportion of work meted out to them by husbands outweighs what women can handle, to the extent that they no longer have time to take care of their health issues. Thus, it is a misplaced argument for health care providers to hold women responsible for contributing to their own poor maternal health through neglect. Instead, these providers need to work with women to find ways of making health care access better. The blame game often applied by health care providers, suggesting that rural women are negligent with regards to their personal health care, suggests a severe lack of insight and knowledge deficit on one hand and, on the other, a deliberate disregard for women's living conditions and its implications for their general sexual, reproductive and maternal health. In the light of this evidence, it is not simply the lack of clinic attendance, whether for prenatal or labour and delivery, that contribute to poor maternal health but the multitude of factors surrounding their lives that prevents them from doing so, such as workload, a lack of access to and control over food leading to poor nutrition before and during

pregnancy that all contribute to poor maternal health and, consequently, maternal mortality. Failure to view these factors holistically leads to reinforcement of the over naturalization and normalization of the women's life situation and gender roles and their impact on women's sexual and reproductive lives. As Issahaka et al (n.d.) posit, African women and, for that matter, those in most challenging contexts nations, are far from realizing gender equality and equity due to sustained inactions by governments and custodians of culture to make changes to existing social and political structures that subordinate and discriminate against girls and women in those locations. With the current evidence, there is a need to move beyond research to actions that would bring about consciousness raising among Ghanaians, predominantly men who double as custodians of culture and the policy makers who continue to marginalize and exploit women. A change in the mindset around gender relations so that women can be treated like equal partners in life and are able to realize their worth as equal life partners rather than servants, would go a long way to improve women's well-being. Refocusing on altering these understanding would go a long way to improve maternal health.

Over medicalization of reproduction: Consequences for indigenous knowledge and practice

Over medicalization of reproductive health around the globe where pregnancy and its related activities are viewed as disease rather than natural bodily process have implications for maternal health (Davis-Floyd 1992; Lock 2001; Martin 1987; McPherson 1994; Rapp 2001; Sargent 1991). In recent times, the basis of biomedicine is that childbearing women believe and accept that their bodies are incapable of handling pregnancy and child birth without medical intervention and their traditional birthing practices and experience are irrelevant. As MacDonald notes:

> Women's bodies have been scientifically constructed as essentially faulty; their reproductive bodies as potentially dangerous to babies; childbirth as so fraught with danger as to be unthinkable without biomedical surveillance and intervention (2007:95).

I do acknowledge the fact that modern science and western modes of maternal practices has many advantages (McPherson 1994); however, I argue that it is a misplaced decision by dominant health care systems and policymakers to erase indigenous knowledge with respect to birthing and maternal practices through a ban on traditional birth attendant practices in challenging contexts and replaced with "skilled" birth attendants. Skilled attendance is defined as:

> Care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care (Nyango et al. 2010:130).

A biomedical model would have us appreciate the importance of skilled birth attendants in improving maternal health but it is obvious that the above definition suffers from applicability issues because most of the elements (accreditation, equipment, transportation, referral services) are lacking or nonexistent in rural settings of Ghana. A clear example is that the majority of health clinics do not have at their disposal simple medical supplies, transportation for immediate referrals during emergency obstetrical situations, or even the capacity to collect labouring mothers from their locations to take them to the clinic. Thus, to have a sweeping policy about skilled attendants without critically considering women's contexts is a misplaced policy.

Also, the above definition stipulates that a skilled birth attendant needs to be an accredited practitioner, which in this context, refers to someone formally trained by a recognized health institution over a period of time—usually between one and three years—and who would have obtained a certificate from and, thus, the authority of a health care system to practice. In

188

this way, the definition is misplaced and undermines the importance of and respect for traditional knowledge. Traditional birth attendants, though not accredited by the biomedical system or possessing a certificate, are recognized and accredited by the communities they belong to and receive authority from their cultural custodians to deliver their services. However, upgrading the knowledge of TBAs to meet the requirements for accreditation is not impossible. For example, TBAs could be given further training—much longer than the previous training that took just two weeks—to upgrade their knowledge rather than withdrawing funding for that purpose. Here I emphasise that, for TBAs to fully benefit from this suggested training, unlike in the previous attempt, such training should be structured in such a way that local contexts are considered to make it easier for these women to learn and comprehend, rather than removing them from their familiar environment, which is unrealistic and affects their ability to learn. It is also an underestimation of their value and experience to reduce TBAs capabilities to nothing, simply because they have no formal certification.

Unlike most health care providers, such as midwifes, TBAs practice child birthing activity as a lived experience; they are women who have given birth themselves and have also acquired their skill and competence through lifelong apprenticeship. Given their circumstances in rural communities, it must be appreciated that they are likely to have some challenges due to a lack of materials to support their practice but their competencies cannot be doubted. It is also an understatement to conclude that all births at the health care facilities with skilled attendants meet all the expected clinical standards as claimed. For example, in other resource-poor nations across the globe such as Benin, Côte d'Ivoire, Ecuador, Ghana, Jamaica, Nigeria and Rwanda, several studies have shown that clinic-based maternal and reproductive health services are rated poorly with respect to clinical care standards (Gbangbade et al. 2003; Harvey et al. 2004; Hussein et al.

189

2004; Koblinsky et al. 2006; McCaw-Binns et al. 2004). In Ghana, for example, only 17 per cent

of births occurring in health facilities at the rural or primary level met the standards of what is

considered appropriate or ideal clinical practice (Hussein et al. 2004). It is also shocking to know

that, even at the clinic level in Ghana and Côte D'Ivoire respectively, that women are likely to be

attended by unqualified midwives who work without any supervision from those qualified and,

in addition, women seeking care at the clinic level end up giving birth unattended (Delvaux et al.

2005; Hussein et al. 2004; McCaw-Binns et al. 2004). Given the above evidence it is therefore

premature to conclude that any birth at the hospital takes place in the hands of a competent and

safe environment compared to the conditions under which TBAs work.

Throughout most resource poor nations, TBAs attend most childbirths for reasons

associated with issues demonstrated in this study, such as distance, the high cost of or lack of

access to transportation, unreliable clinic staff availability and poor attitudes towards women

(Abodunrin et al. 2010; Akande 2010; Nyango et al. 2010). I strongly believe the ban on TBA's

practice, without properly putting in place structures that will ensure increased access to "skilled

attendants" and all the definition for such "skilled" services entails in rural Ghana and around

sub-Saharan Africa, that efforts to improve maternal health and decrease maternal mortality by

75 per cent by 2015 as stipulated by the MDGs will continue to be a mere dream. As discussed in

this dissertation, it is evident that rural women are not necessarily rejecting modern childbirth

activities; rather, low utilization is a result of intersecting cultural, economic and gendered

factors beyond their control, factors consistently ignored by the same institutions that should

know better. It is important for us to note that these women value their children more than we

think and would under no circumstances intentionally neglect any activities, such as accessing

care that would contribute to enhancing the well-being of themselves and their unborn babies.

For example, if a mother, as demonstrated here, cannot access services for childbirth because of lack of transport or money to purchase transport, and yet, she cannot be supported by a local available TBA because they are deemed incompetent or thought to be responsible for increasing maternal mortalities in rural communities, is this not a disservice to women, who suffer the consequences of the activities of over medicalization? As women suggest in this findings, which was no surprise to me, women are dying in the hands of the so-called skilled attendants, so for them, what makes the difference?

As a consequence of the ban on TBA practice, fears and anxieties are growing among women in rural settings that women's knowledge and TBA skills in traditional birthing and maternal practices are quickly dying away. Because TBAs are turned into mere messengers, responsible only to accompany labouring women to skilled attendants/nurses, they are unable to pass on their knowledge to young women to continue to support women in need when the older ones pass on. Similar concerns have been identified in Northwest New Britain in Papua New Guinea (McPherson 1994). Also, under current circumstances, improvements to living conditions with regard to easy access to maternal health care services are far from realization. This means that women are in a more precarious situation than expected. As Boodsomah, the oldest TBA in my study put it:

> My fear is how will it look like in the future? Also, it may take a long time for nurses to come for a woman in labour even if we call them because our village is far from the clinics. I think they are putting women and babies at risk.

Considering the current situation, there is the need to improve those physical factors constraining women from maternal health care access, rather than adopt hasty policy which lacks analytical depth by local contexts and real needs. It is also important to revisit the training and material support for TBAs to enhance their skills in ways that would help them offer quality care

to women rather than restrict their services because, without their support for women at the remote areas in challenging contexts settings, women can be at greater risk.

Health care system/policy failures

Although I suspect the original intent of the health care system as mandated was to provide quality services to the people, current health care practices in rural Ghana demonstrate its inefficiencies and failures leading to mistrust and loss of confidence by its users in rural settings. From my findings, the Ghana health care system appears to have diverged from its initial defined goals. Although, there are some health care providers within the system who want the best for the people, the majority of practitioners are those who, in diverse ways, cause the system's failures and, as a result, efforts to realize the MDG goals on maternal health may be far from being in hand. The factors identified in this study that need serious improvements, include the long standing, systemic and sustained poor attitudes of health care providers, particularly nurses in most health care facilities, where providers feel superior to service seekers simply because they have an education and earn a salary compared to rural women who have neither. Hence, these providers assume they have a license to treat others disrespectfully as I described in chapter six and in previous studies in Ghana (Moyer et al. 2012; Yakong et al. 2010). At the educational level, medical/nursing educators need to reconsider their curricula to focus more on the significance of interpersonal relationships. This will go a long way to improving their ability to appreciate the role of good interpersonal relationships in their approach to service delivery.

At the macro level, the system needs to consider the unreliable nature of service delivery, where pregnant and labouring women make every possible effort, despite their limiting circumstances, to attend clinics that are illegally closed down, thus, leaving women to their fate. There is a need to examine the inadequate staffing at clinics, which puts the few available staff

under pressure and, possibly from exhaustion, they exhibit poor attitudes toward their clients. Clinics cannot operate effectively without required supplies, appropriate equipment and logistics, including transportation, such inadequacies make it even more difficult for service providers to make the necessary decisions to save lives. Yet, women are blamed for noncompliance in attending clinics. Health care providers should not act as gate-keepers, by imposing their religious beliefs on service users and not dispensing birth control methods to those desiring such services. Further, in many cases, policy makers and service providers blame women for not utilizing such services due to their traditional beliefs. Within this context, I believe it is only a matter of fairness that, when traditional peoples do not use some services due to their beliefs, then such beliefs should also be respected and accommodated if possible. Other factors include the corrupt behaviours of providers and misapplication by midwives of knowledge. By misapplication of knowledge, I mean using textbook knowledge acquired during training, to ask women to buy new cloths for unborn babies, when this is inconsistent with the cultural beliefs and practices of the women. Illegally, midwives ask women for gifts in the form of soaps and other items as a form of compensation for attending them. It may be appreciated that midwives feel dissatisfied with their condition of service and the salary they receive but it is also important to realize that those women seeking care do not earn any income and these demands are onerous and discourage women from accessing care. Requesting such "gifts," creates a poor image for the nursing profession and an ignorance of professional code of ethics and conduct. It is important that midwives find approaches for working with different cultures in ways that are appropriate without trying to impose other cultural (e.g. western) ways simply because, as health care providers, they think they know best and those who do not comply are conservative and backward.

The most complex and historical issue that affects the health care system in Ghana is the unnecessary competition between public and Christian health services, although all are intended to provide service to the citizens of Ghana. The only difference is that one focuses on profit making; thus, the general public and women in this study perceive that public services for some reason are unable to provide quality care whereas the other, Christian based health services focus on making services available to the people without any profit. In my experience the latter institutions ensures quality service provision and are more accountable to the people in terms of commitment to services versus the public service. Most public organizations struggle with weakened leadership issues and poor work ethic, lack intensive supervision and monitoring and make every effort to maintain status quo, the implications of which are poor quality output. This breeds discomfort between both institutions resulting in negative consequences for patients. If the intent of both organizations is to provide care that serves the interest of the people, rather than personal interests or maintaining status quo, then it is appropriate that these institutions work in partnership rather than engage in divisive activities influenced by local politics. Unless these two organizations realize that their first priority is the health of the people, before any other mischievous intent if any, the health of Ghanaians, particularly rural women and children, will continue to be endangered and those MDGs will continue to stagnate.

Lack of political will to improving maternal health

Many of the barriers to health care in rural Ghana can be improved if local government commits resources to improving these factors. For example, poor road networks, lack of a reliable transport system, lack of and inadequate staff and low remuneration, lack of medical supplies and equipment, lack of jobs for rural dwellers and food insecurity issues affecting maternal and child health, are all areas that government can improve to enhance quality of life. Ghana is

194

endowed with adequate natural resources that could have been used to develop the nation and its peoples to improve their quality of life. However, as a result of poor management and massive corruption in the public sector, these resources have been mismanaged resulting in severe poverty, especially among women and children in rural areas. Seasonal food insecurity is a common issue that affects the majority of rural Ghanaians and which could be eliminated with a shift in the mind-set of those, such as politicians, who are custodians of these resources. Because important social issues in Ghana often take political and partisan dimensions, even when those issues are directly affecting lives—such as food insecurity issues between the northern and southern parts of Ghana—it becomes difficult for a sitting government to take serious actions for fear of losing popularity. This fear leads to inaction and the lack of political will. The end result is that the underprivileged suffer the consequences of the negligence of government and, yet, these same people are held responsible for neglecting their own health and well-being. My field observations and stories from women suggest that, over the past six years since I did my previous research, to now as I write this document, there have been no appreciable changes to the various factors discussed here that affect women's lives and health in this community. The only changes women noted in chapter four, is the women's empowerment project GROW that has helped to ease some of their burdens. There could have been many more changes if government was development oriented and paid more attention to gender issues and welfare of children. For Ghana to actually experience the projected reduced maternal and infant mortality rates there is the need to consider addressing the factors I have discussed herein.

Another issue to be addressed is the lack of respect and value for girls and women. It is important that females are given equal rights and opportunities to develop themselves like their male counterparts so that the gender gap currently existing in many areas of development, such

as education opportunity, which is the pillar for improvement in quality of life, can be achieved. It is thus, important to transform the mindsets of Ghanaians, particularly males, around positive gender relations and this can be done through teaching, both in the educational system and among families. Parents, especially fathers, have to live exemplary lives, in order to effect these changes and impart those values in their children. For example, if husbands stop wife battering and treating their wives like servants, rather than equal partners, making decisions that favour their male children over their daughters and using family resources to benefit the entire family rather than girlfriends and concubines, this may go a long way to changing the mindset of youth from following a similar path in adulthood.

Study limitations and challenges and strengths

As in any study, this study had some limitations as well as strengths. Major limitations included financial constraints which limited my ability to travel more widely in order to include many more communities, as I had wished to do. Limiting myself to the Nabdam ethic group did not afford me the opportunity to capture data from the Talensi group for comparison, although I strongly believe that the issues would not be that different because of the similarity of circumstances and culture. Weather and poor road networks, affected my ability to reach out to some remote communities for observational data beyond having women from those locations come to a central point for interviews. By having women come to a particular location, rather than me going to their actual settings, I may have missed some observational data that could have added more and varied meaning to my findings. The constraints of weather also included the farming season which affected some women, who wanted to participate but, due to farm work, they could not find time to do so. Their participation may have added a varied data for analysis.

My insider status also posed some challenges to me personally. For example, community members expected me to be culturally correct in everything I did. Some women participants and midwives, too, felt that I should not have been asking certain questions because I should have known the answers already (Yakong 2008). For example, one old TBA stated that, "my daughter, you should have known this, do I need to tell you this one too?" Midwives thought, for some reason, that I was a spy, a common belief anthropologists face during field work (personal communication: Naomi McPherson, September 2013). These were challenges for me as, over and over again, I had to explain the purpose of my study for participants to appreciate why I asked questions the way I did. Another challenge as an insider was that, some community members presented me with their problems, which they wanted me to help them with financially. What made it even worse was that, because I currently lived outside the country and attended a university, they believed that I had lots of money. Also, because I do run the women's empowerment project, community members had the tendency to believe that I must have lots of money in order to do that kind of work to help people. It is not uncommon for most people in resource poor nations to think and perceive things as they did. Their line of thinking was, perhaps, influenced by the activities of the women's project where beneficiaries received varied resources for economic development. They are likely to feel that I should have enough resources myself to be able to do that much to help others, a perception that is common in Ghana.

Another main challenge for me was the amount of time spent in translating data from Nabit into English. Because this language does not yet have a writing system, I do not have any writing skills in Nabit; hence, I had to translate everything to make it meaningful in English. Because of this difficulty I may have missed some important meanings too. Through my previous work (Yakong 2008) and the GROW project born out of my previous research, the need

to have a writing system in Nabit was identified and, as a result, I am currently collaborating with two researchers; one is a master's student in anthropology who is focusing on creating a writing system/alphabet in Nabit to first, sustain the language and, secondly, make it easier for learning by the people. The second researcher is a PhD Candidate in education who is researching adult literacy so that the majority of women who have no formal education can learn basic functional literacy skills using the Nabit writing system combined with English to increase their access to information and ability to conduct business beyond their own environment.(n12)

Time was a limitation as long distance traveling was involved. In addition, the concept of time itself, as noted in chapter two, was conceived differently from the perspective of participants. Because of this, more time was spent on interviews than expected. It was also my intent to contact research participants, especially midwives who could read and write, to share their transcripts with them for validation of their stories. However, because of distance and the limited availability of information technology in Ghana, combined with the midwives' limited access and skills in computer and internet access and usage, I could not do so. As noted in earlier chapters, one of the midwives who was hesitant to participate, remarked that, "you people [researchers] come here and take information from us and when you go away that ends it. We do not even hear from you just to say hello." I took this remark under serious consideration, as a lesson from previous researchers and wanted to do something different. However, I plan to share the findings of the study with women and midwives when I return to the study area. By doing so, I hope that women and midwives will have the opportunity to reflect on ways to improve access and services delivery to improve maternal health.

However, despite the limitations there were several strengths of this study. These strengths include my insider status, which also doubles as a challenge, but my training as an

anthropologist afforded me the rare opportunity to view issues differently while relating to my

personal experience to make more meaning. My status also made it easier for me to access

participants on one hand and, on the other, women felt comfortable to express their experiences

without any hesitation probably with the belief that I, being one of them, would better understand

their situation. My previous work in this community, the first of its kind, also created a lasting

experience for women who now are used to and understand what it means to participate in

research. I am stating this because research is rarely done in this community and I believe it is

because of its remoteness. Also, because I speak the same language with participants, it was also

much easier to communicate with women directly rather than having to use an interpreter which

could lead to misunderstandings of meaning. Above all, I will return the community following

my doctoral work to share my findings with women and nurses for further discussions.

Summary

This study has unearthed the many hidden and taken-for-granted factors which impact women's

reproductive health care decisions in rural Ghana in a unique way. It provides varied

perspectives on gender issues and social expectations of women, kinship issues and the role of

health care system. It is my intent that the benefits of these new insights on rural Ghanaian

women's reproductive health care access and service provision will be immeasurable. However,

studying factors in maternal health care decision making and access while simultaneously

providing health care providers' perspectives on the same issues makes these findings rare for

research in Ghana and, thus, challenges the status quo. In spite of the challenge, it does provide

us the rare opportunity to challenge our own deep-seated beliefs to re-examine them thoughtfully

around the cultural construction and social expression of gender concepts and the impact on

women. Socio-cultural expectations of women in challenging contexts settings and our biases as

policy makers, custodians of culture and as health care providers shape these issues. The women have spoken their mind and what is left is for us as researchers, policy makers, politicians and advocacy activists to further explore the many and myriad ways to improve conditions that lead to a better quality of life for women and children now and in future generations. For this to happen, there is urgent need for future research to focus on first, breaking the institutional barriers to women's health and general well-being; and, secondly, to explore ways that can bring about an equitable distribution of health care staff and a reliable transportation system that can make emergency health care more accessible. We need to explore ways to improve women's socio-economic conditions; and, finally, to explore ways to invest in areas that can lead to women's access to literacy skills to increase their opportunity for jobs and access to more resources.

Endnotes

[1] Ghana Health Service 2011 annual report; Ashanti regional health directorate 2010; Western regional health directorate 2010; Upper East regional health directorate 2010; Upper West regional health directorate 2010; Volta regional health directorate 2011

[2] Crichton Susan (2013) defines "challenging contexts" as settings in which individuals, due to a variety of circumstances, conditions or environmental constraints, do not have
- Access to consistently available and affordable electricity
- Access to reliable, unfiltered or uncensored Internet
- Access to previous formal learning and / or opportunities for ongoing formal learning that support individual learning needs
- Access to non-formal, yet appropriate learning opportunities
- Access to or participation in learning activities due to cultural or religious reasons
- Access to transportation and mobility
- Access to prior learning
- Access to clean water and adequate sanitation
- Access to fair and just leadership
- Access to adequate nutrition and safe food supply
- Access to a safe environment free from hostilities and violence
- Access to support for the disabled.

I have chosen to use this new term because it reflects a more accurate description of what has previously been termed 'impoverished' regions, developing world or third world, perhaps with a lack of appreciation of "the other" who experiences difficult circumstances through no fault of their own; all of which offer a negative, if not backward perspective on people who lack essentials. The list is representative of quality of life, rather than reflective of the region, or the people who live there.

In addition to Crichton's list I wish to enlarge the concept to include other critical issues faced by people in "challenging contexts"
- Lack of access to equitable health care linked to poverty (user fees, low wages
- Lack of economic opportunities
- Lack of access to family resources due to gender-based violence
- Gender-based food security/insecurity
- Lack of access to appropriate clothing
- Lack of access to security
- Endemic corruption

[3] See the following for more details: Feldman-Savelsberg2002; Inhorn and van Balen 2002 Kobeissi and Inhorn 2007; Kokole 1994; WHO 1991; Yebei 2000.

[4] See Adongo, Binka and Philips 1998; Asenso-Okyere, Osei-Akoto, Anum and Adukonu 1999; Avotri and Walters 1999; Awedoba 2002; GMOH 1999; Hogan, Berhanu and Hailemariam 2001; Jansen 2006; Osubor, Fatusi and Chiwuzie 2006; Shaikh and Hatcher 2005; Sicchia and MacLean 2006; WHO 2000; Yakong 2008.

[5]A payment from the groom to the bride's family at marriage in most parts of Africa.

[6]See the following for more details: Pearce 1995; Maynes et. a. 1996; Feldman-Savelsberg 1999; Inhorn 1999; Inhorn and van Balen 2002; Hollos 2003; Stone 2006; Hollos et. al. 2009.

[7] Also see the following for more details: Johnson et. al. 1990; Pearce 1995; Feldman-Savelsberg 1999; Yebei 2000; Nukunya 2004; Rutstein and Shah 2004; Stone 2006; Hollos et. al. 2009.

[8] See especially, Fortes, M. (1949) The Web of Kinship among the Tallensi: the second part of an analysis of the social structure of a Trans-Volta tribe. London and New York: International African Institute, Oxford University Press.

[9] Aguilar 1981; Altorki and El-Solh 1988; Brannick and Coghlan 2007; Dossa 1997; Innes 2009; Kusom 2003; Maxine 2007; Messerschmidt 1981; Silverman 1998; Taylor 2011.

[10] See for example, Allen 2004; Bennett 2003; Brewer 2000; Edwards 2002; Ellis and Bochner 2000; Hodkinson 2005; Merton 1972; Pearson 2001; Platt 1981; Sprague 2005; Wolcott 1999.

[11] Gwatkin (1972) explains that other sub-Saharan countries, which remained neutral or declined in drawing hasty conclusions regarding their population's policy issues, have been perceived by dominant international communities as unconcerned. These countries include: Central African Republic, Chad, Congo (Brazza- ville), Dahomey, The Gambia, Guinea, Liberia, Mali, Mauritania, Niger, Senegal, Sierra Leone, Togo, Burkina Faso, and Zaire**. See Gwatkin for further details.

[12] For information on the Nabit writing system development, visit the following link
http://annualreport.ubc.ca/story/students-learn-the-abcs-of-alphabet-making

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