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MATERNAL HEALTH AND WOMEN'S RIGHTS IN THE GA DISTRICT

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DECEMBER, 2001.

PERSONAL DECLARATION

I hereby declared that this thesis is the result of my original research and that no part of it has been presented for another degree in this university or elsewhere.

Signature.....Date.12/02/2007.....

SUPERVISORS' DECLARATION

We hereby declare that the preparation and representation of this thesis were supervised in accordance with the guidelines on the supervision of thesis laid down by the University of Cape Coast.

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DEDICATION

THIS WORK IS DEDICATED TO MY FAMILY.

ABSTRACT

Every, year at least half a million women die from pregnancy-related causes of which, 99% come from developing countries. The root cause of this situation is due to the fact that the decision-making power women regarding the right to decide on how many children to have and when (whether) to have them, the use of contraceptives and the right to refuse sex with their husbands have been circumscribed by socio-economic conditions within which they live.

The study data were based on primary and secondary sources from four settlements in the Ga District – Kokrobite, Kweman, Dome and Amasaman. Field interviews, questionnaires, focus group discussions and personal observation were used to collect the primary data while the secondary data were derived from the hospitals, M/CH care clinics and other institutions such as the National Council on Women and Development(NCWD), Federation of Women Lawyers(FIDA), the 31st December Women's Movement and the District Assemblies.

In the Ga (the study area), women's sexual and reproductive health is not dependent exclusively on their own behaviours, but also, situations and behaviours of others. Thus, although decisions on some issues in the household such as breast-feeding and abstinence may be arrived at jointly, women will always respond to men's sexual demands irrespective of the implications because of the fear of reaction from their husbands. Also, as women have relatively low economic resources, they still rely on their husbands for economic support and so their control over their sexuality and reproduction is circumscribed by that fact. Thus, despite the fact that the women in the study area were generally aware of their reproductive rights they were unable to exercise these rights because of their low status in the society.

The socio-economic status of women such as level of education of both men and women and the type of residence were the main factors that have influenced health-seeking behaviour of women. For instance, the antenatal health seeking behaviour of women in the Ga district was influenced by factors such as the educational level of the woman, distance to health centre, parity, type of marriage(polygynous or monogamous) and husband's educational attainment. Moreover, the decision of the women to choose a place of delivery depends greatly on her place of residence, level of education, her husband and immediate family members. All these factors directly or indirectly affect women's status and decision-making in the home and society at large. The relationship between women's rights and maternal health is therefore not direct but is mediated by a set soocio-economic, cultural and political mechanisms.

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INTRODUCTION

1.0. Background of the Study.

In the last decade national and international concerns with issues such as population, women's rights and reproductive health, and as well as HIV/AIDS pandemic, have in large part intersected. Consequently, social science research on gender and sexuality, and their implications on health have grown enormously in countries around the world (Synder and Tadesse, 1993).

Human sexuality was largely ignored as a focus for social science research and policy-making for a greater part of the twentieth century. This is perhaps because the experience of sexuality is so intimately linked to the biological existence of human beings that the subject matter of sex has been relegated to the realm of the biological sciences. It is only recently, that is, the closing decades of the twentieth century, that this marginalisation of sexuality, its submission to the biological sciences, has began to give way to more far-reaching social and political analysis (Mann, 1997). It is during this period that the relationship between sexuality and health has become a central issue of research and activism among a range of diverse fields. During this period scientific disciplines and social movements that, hitherto, had little in common with one another,

increasingly merged in seeking to address the complex range of questions that have linked sexuality to health (Bunch, 1995).

The reasons for this recent upsurge in interest in health and sexuality are complex and diverse. One is the broad changes that have been taking place in the social sciences generally, as disciplines such as history, sociology, geography and anthropology struggle to find new ways of understanding the rapidly changing world. The second reason is the growing attention to sexuality as a key focus for social analysis which has been prompted by a set of movements within society itself (Guskin, 1999).

Another important turning point on issues on sexuality and health was at the World Conference on Human Rights in Vienna in 1983, where a declaration was made to eliminate gender-based violence, sexual harassment, and exploitation. This was followed later by the Declaration on the Elimination of violence Against Women (Basu, 1992).

The importance of these issues has prompted the International Community to convene various conferences during which these issues were discussed. For example, four major international conferences were held between 1975 and 1995 solely to discuss issues concerning women's rights and reproduction. At all these conferences, it was noted that despite the immense contributions made by women towards national development, they have never been recognised and acknowledged by policy makers and planners. It was also observed that women face problems that needed urgent attention. Women suffer

from all types of injustices and discrimination within the family structure, in seeking employment, education, and in gaining access to professional training yet, little or nothing has been done to address these problems (Dolphyne, 1997).

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, for instance, sex, sexuality and sexual health came out as important issues not merely in relation to violence and violation but also as a positive part of human experience to be preserved and nurtured. For the first time in any international legal document, the ICPD *Programme of Action* stressed sexual health as part of a host of rights that population and development programmes should protect. The *Platform for Action* of the Beijing Conference on Women reaffirmed the clear commitments to reproductive rights that had emerged in Cairo, though without any explicit reference to either sexual rights or sexual orientation. It was also recognised that women had little or no control over their reproduction because of their status in the family and society. Attempts were thus made to define reproductive health to have a universal acceptance. This was to ensure that governments, NGOs and women's groups from various countries agree on a common course in their attempt at addressing women's reproductive health problems (United Nations 1995).

It was further noted that an individual's health status is determined not only by chance genetic inheritance and geographical availability of nutritional resources, but also by socio-economic factors. For example, relatively affluent people, and those content with their lives, enjoy better health status than impoverished, frustrated, and oppressed people

who suffer disrespect in their communities. Thus, the determinants of earned income, including education, literacy and employment opportunities all show how women have been disadvantaged by their inferior gender role. Even within affluent families, women have suffered through male preference in inheritance, education preceding marriage and training to occupy positions of influence and power within the community (Dixon – Mueller, 1993). Hence, the problems women face are mainly due to certain social, cultural and economic factors, which do not allow them to have full control over their lives. For instance, some women are denied a commitment of family resources upon marriage as they attenuate association with their own families and assume a role of service within their husbands' families (Ghana, 1994).

Various attempts have been made by the Government of Ghana and NGOs as well as women's groups such as the Federation of Women Lawyers (FIDA), National Council on Women and Development (NCWD) and the 31st December Women's Movement to improve upon the status of women in Ghana. Of particular interest to these groups is women's rights and reproductive health. These issues are important because they do not only affect women but also population policies and the general socio-economic development of the society. For instance, the empowerment of women is a necessary condition if maternal morbidity and mortality are to be reduced. Also, an overall improvement in the role and status of women is one of the basic prerequisites for the successful implementation of any population policy (Ghana, 1994).

These issues are very important to geographers and, therefore, have become one of the domains of geography. The importance of geography to the study of women's rights and health is its attempt to provide insights into and the conceptualisation of women's problems in a time-space framework. It attempts to analyse women's issues by delimiting the spatial and temporal spheres in which women interact on daily basis. These are very complex issues because of the multiple roles and responsibilities of women at any given point in time (Phillips and Verhasselt, 1994).

1.1. Statement of the Problem

Many women in developing countries such as Ghana suffer from various health problems due to inadequate diets, poor or unaffordable health facilities and overworking (Footsteps, 1993). Some of these health problems arise also because women do not have control over their lives and so have little or no control over their reproductive rights (Awusabo-Asare et al, 1993; Orubuloye et al, 1994). This condition affects their reproductive health directly or indirectly. Women are unable to exercise these rights because certain socio-economic and cultural practices tend to relegate them to the background. At the same time women's health needs have received very low priority by policy-makers and implementers (Young, 1993).

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, attention was drawn to the fact that women's rights need to be enhanced to ensure the protection of their reproductive health. That is, women's rights are basic human

rights, which should enable them to enjoy a better reproductive health status. A sound reproductive health, it was noted, can be achieved if the health delivery system is accessible, affordable, appropriate and acceptable to women.

Ghana has experienced significant socio-cultural and economic transformation since independence. The inception of the Economic Recovery Programme (ERP) and the Structural Adjustment Programme (SAP) in 1983 after the collapse of the economy in the 1970s have also had a substantial impact on the people's welfare and coping ability. For instance, the introduction of the ERP and SAP brought about a decline in inflation rate from three digits (123 per cent) in 1983 to two digits (18 per cent) in the 1990s. There have also been modest economic growth rates of around 5 per cent per annum between 1985 and 1992 (Ghana, 1994). The health sector has also had certain improvements such as the introduction of Primary Health Care and decentralisation of management. However, the introduction of cost recovery (cash and carry) to raise revenue to maintain the health sector led to a decline in nutrition and service utilisation. Thus diseases that were virtually eradicated by campaigns in the 1950s and 1960s such as yaws and yellow fever reappeared during the SAP period (Creese, 1991; Vickers, 1991).

In the social realm of affairs, attempts have been made at improving the status of women through activities such as improved access for female education and the enactment of laws banning obnoxious customs such as trokosi, female circumcision and widowhood rites. The appointment of women for leadership and managerial jobs such as

Parliamentary and Ministerial positions has also made some contribution towards the improvement of women's status in the society. The National Council on Women and Development, Federation of Women Lawyers (FIDA), United Nations Population Fund and the 31st December Women's Movement have through workshops, seminars and symposia addressed vital issues affecting women. These have changed people's perception about women considerably and improved upon the status of women to some extent (Dolphyne, 1997).

What is not clear, however, is whether these changes have had positive effects on the general welfare of women, particularly those in rural areas in a wide range of areas including reproductive health. This study examines the issues. Specifically, it examines women's decision-making and its implications for their health particularly those relating to maternal health within the context of socio-cultural and economic transformation that has taken place over the years. The study is limited to women in selected communities in the Ga District of the Greater Accra Region.

1.2. Objectives

The general objective of the study is to examine the implications of socio-economic and cultural transformation on the status of women and the relationship between the present status of women and maternal health in the study area. This would be done using the safe motherhood framework by Tinker and Koblinsky, 1993).

The specific objectives of the study were:

i. To find out the state of maternal health in the Ga District;

ii. To examine the attitudes of women towards their reproductive health rights

iii. To examine their awareness of their basic human rights and the extent to which they have exercised these rights; and

vi. To assess the link (if any) between perceived rights and maternal health.

1.3. Hypotheses

The study tested the following hypotheses:

1. The reproductive health of women is not positively related to their level of decision-making on their sexuality.
2. There is no significant relationship between maternal health on the one hand and the socio-economic circumstances of women such as educational achievement, employment status and type of residence on the other hand. (In other words, maternal health does not depend on the socio-economic and cultural conditions of women).

1.4. Rationale of the Study

Since the 1980s, issues concerning women have taken new forms and received varying treatments by researchers, development planners and professionals. Two of the main reasons for the change are the recognition of the contribution of women towards development and the fact that the health status of women have implications for the

health of their children and the well being of the family (Richters, 1992). Since then, governments and NGOs have made several efforts to address problems affecting women and instituted programmes that would make them more efficient and effective in their contribution to national development. From this perspective women are seen to constitute a stock of human potential for development which is currently under-utilised

One of the strategies for Ghana to achieve a middle income status by the year 2020 is the development of its human resource. One of the main aims of the programme is the "improvement of health status, life expectancy, and capabilities of all individuals, to eliminate extremes of deprivation, reduce poverty and ensure an equitable distribution of the benefits of development"(Ghana, 1995: 32). Women have been targeted as one of the potential human resources whose contribution has been overlooked for a long time. To be able to harness the full potentials of women, it is necessary to address certain pertinent issues that affect their lives among them being their reproductive health and rights.

Consequently, much attention has been given to issues relating to women's reproductive health and rights and have become integral components of Ghana's population policy. Also, the importance of these variables and their implications for the socio-economic and demographic characteristics of the country make it imperative to incorporate them into any development programme so as to ensure the full development of the country's potential human and physical resources.

In order to harness the full potential of women for development, serious research needs to be done so that solutions could be found to the numerous problems affecting women. Also factors responsible for women's problems are intertwined and vary from one society to another A scientific study particularly at the micro-level is needed for a better understanding of how these factors operate in different social systems so that society-specific programmes could be designed. In this way, funds and other resources can be utilised judiciously.

This study is expected to contribute to the discussion on issues concerning the relationship between women's rights and their health, specifically, the relationship between their status and maternal health. It provides some explanations for the factors responsible for some of the problems affecting women, particularly those issues surrounding their rights and their reproductive health status. It also provides information needed by policy makers and other groups interested in issues affecting women and also act as a basis for further research on women's rights and related issues.

1.5. Study Area

The study was conducted in four settlements (Krokrbite, Kweiman, Dome and Weija) in the Ga District in the Greater Accra Region, the region which contains the national capital, Accra. The District is located between Latitudes 5 34'N and 5° 55'N and Longitudes O° 30'E and O° 05'E (Fig 1.1a.). and shares boundaries with Akwapim South in the Eastern Region in the North, Gomoa District in the Central Region in the West, Tema District in the Northeast and Accra Metropolitan Assembly in the

Southeast. The Southern part lies along the Gulf of Guinea. The District has a total land area of 859km sq.

Except for the Akwapim and Weija hills the rest of the District has an undulating relief. It lies within the Coastal Savannah zone which consists of shrubs, grassland, mangrove and coastal dunes. While the coastal zone comprises wetlands and dunes, the interior is made up of scrub and grassland vegetation. The District lies in the climatic anomalous zone with mean annual rainfall ranging between 790mm on the coast to about 1270mm in the extreme north.

The Ga are the natives of the Ga District but there are now migrants from all over the country and from outside Ghana residing in the district. The major ethnic groups in the District are Ga, Ewe, Akan, Fanti and Guan. The people in the district carry out broad categories of economic activities but the major ones are agriculture (49 per cent), followed by trading (19 per cent), transport and communication (12 per cent), construction (15 per cent) and recreation (5 per cent). The Densu and Nsaki Rivers, Weija Lake, Medie Park and the Beach at Korkrobite provide scenic and natural resources for recreation. There is also a fairly large proportion of the population employed by the government or private sector (Ga District Development Plan Document, 1995).

The predominant residential arrangement of the Ga people is that women live with their female matrilineal relatives and men with their male patrilinear relatives. There are

therefore separate male and female compounds. Food is prepared in the female compound and sent to the male compound by the children (Awusabo-Asare, 1988). This type of arrangement fosters freedom of movement and solidarity among women and enhances the organisation of their business ventures as women. Communication is also more effective within the same sex than between different sexes. The implications are that traditional gender role activities for men and women have been perpetuated (Hafkin and Bay, 1976).

Amasaman, the district capital, is the seventh largest settlement in the Ga District. Population censuses gave the population of the district as 31,303 in 1960, 58,308 in 1970 and 136,358 in 1984. The estimated population for 1996 was 280,656. This gives an annual growth rate of 6.2 per cent, which is twice the national average of 3.1 per cent per annum. This phenomenon is probably due to the expansion of the Accra Metropolitan Assembly (AMA) into the district resulting in a high concentration of population along the border of the district within the AMA.

The largest settlement is Madina with a population of about 40,000. The large towns and some villages have good road network but others have poor roads which become unmotorable during the raining season or heavy down pour. The main (first class) roads in the District are those which form part of the major outlets from Accra to Cape Coast, Kumasi and Koforidua, the regional capitals of the Central, Ashanti and Eastern Regions respectively. Apart from the major roads there are a number of minor roads totaling about 270km. The main Accra-Kumasi/Takoradi Railway line passes through the

District at Dome. These conditions have serious implications on the accessibility of residents of the Ga District to health facilities and other social services.

The health and welfare of the people are provided for by a number of statutory and voluntary institutions as well as by private physicians and midwives. Some of the private practitioners are qualified doctors, midwives, nurses or dispensers. Others are traditional healers and midwives and Traditional Birth Attendants. The District has no District Hospital or Polyclinic. Maternal and Child Health and Family Planning are provided by four health Centres at Amasaman, Danfa and Obom and the Communicable Disease Hospital at Weija and the five purely MCH Clinics at Abokobi, Pantang, Madina, Obom and Amasaman (Table1.1). The District depends largely on health facilities in Accra for all referral cases.

FIG. 1a MAP OF GHANA SHOWING THE POSITION OF GA DISTRICT

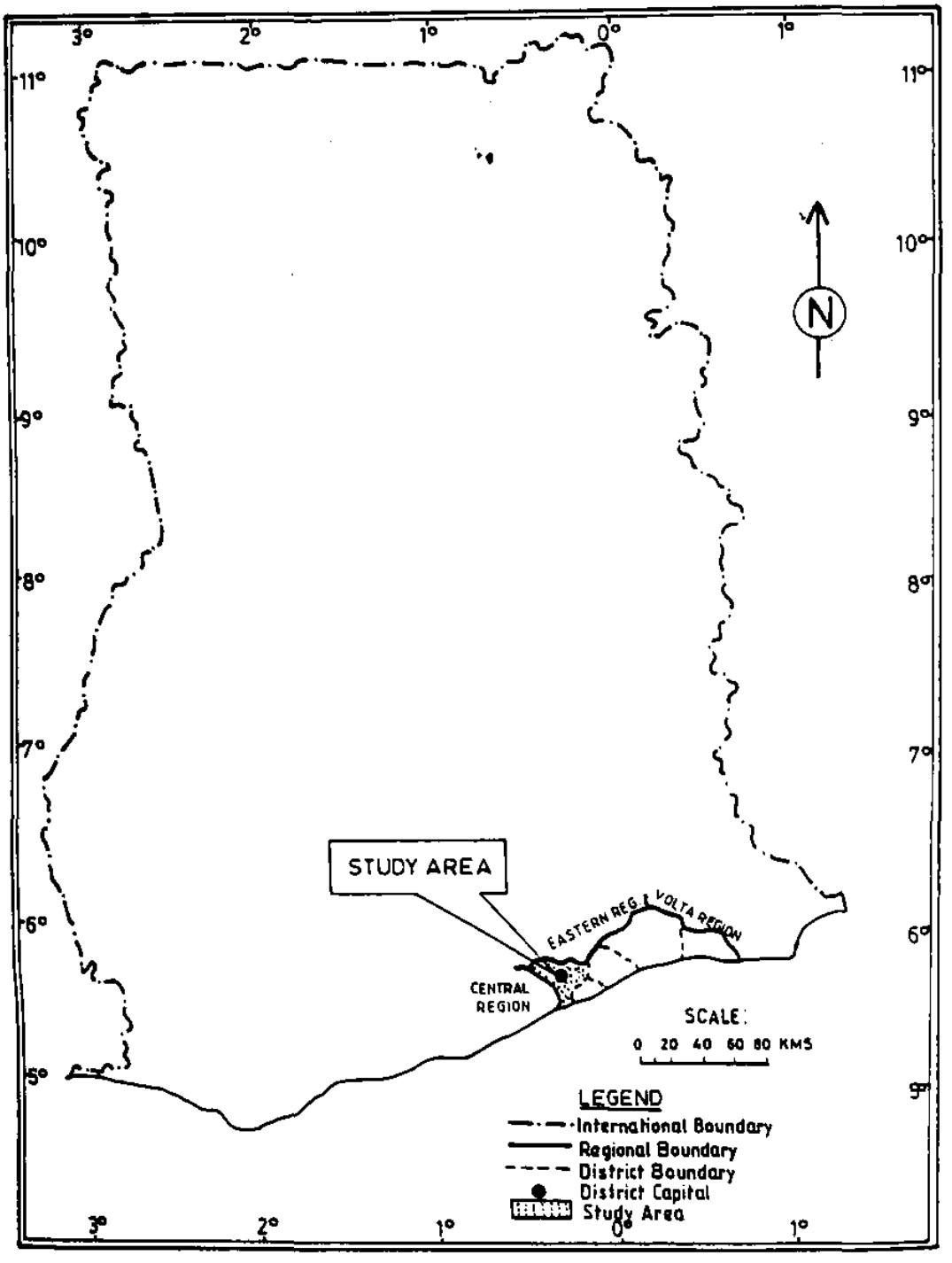


FIG. 1b GA DISTRICT

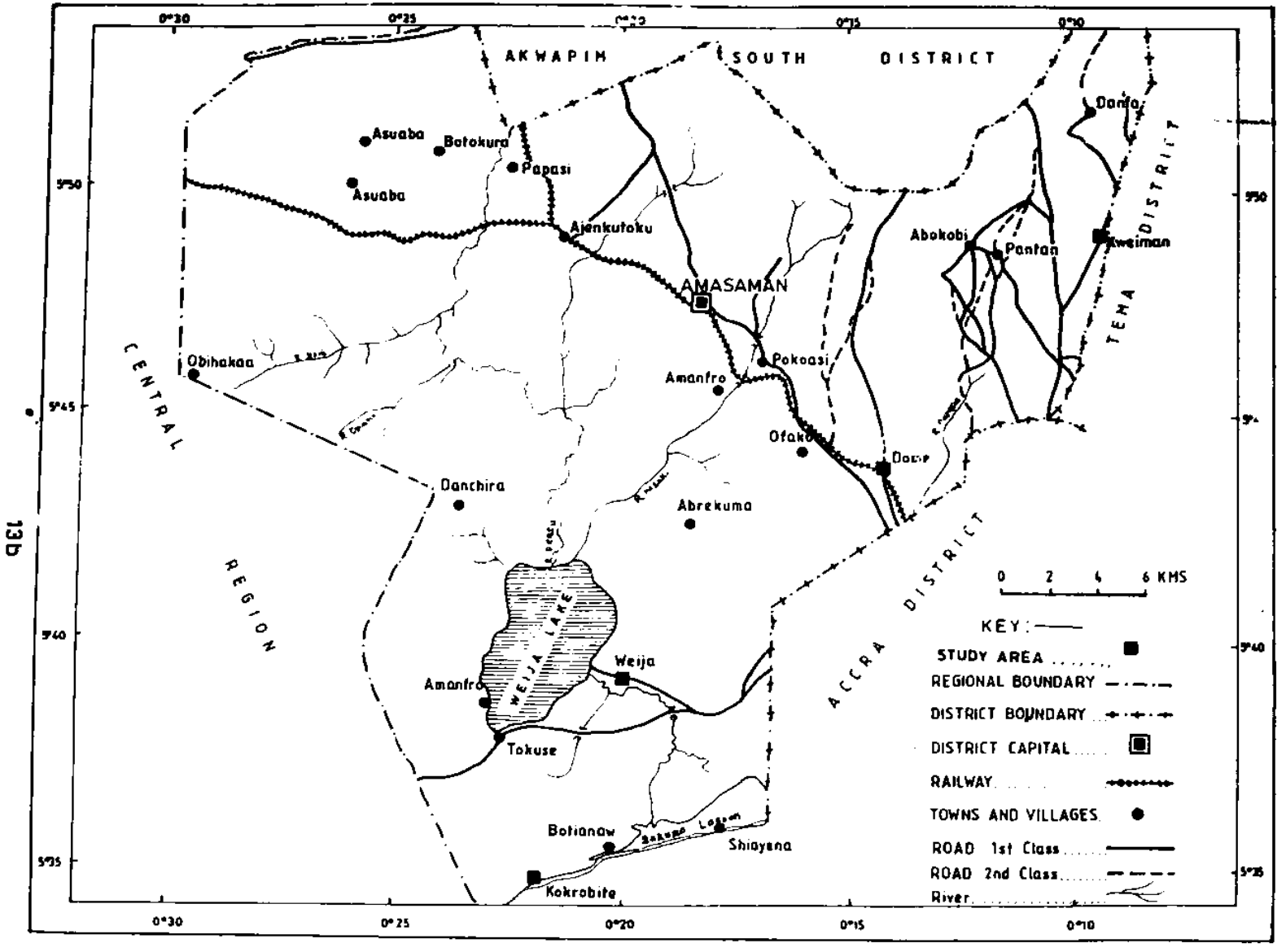


Table 1.1. Public Health Facilities and Population Served.

Sub-District	Health Facility	Population Covered	Remarks
Amasaman	1. Rural Health /Centre, Amasaman	104,000	Nearly all staff live outside the district and start work late in the morning.
Danfa	1. Rural Health Centre, Danfa 2. MCH Clinic, Abokobi 3. MCH Clinic, Pantang Pantang Psychiatric Hospital	27,000	Staff accommodation needs repairs
Madina	1. MCH Clinic, Madina.	51,000	A consultation room is needed immediately for use by a medical officer on part time basis. Madina with its population needs a polyclinic
Obom	1. Rural Health Centre, Obom. 2. MCH Clinic, Obom.	51,000	Buildings need renovation
Weija	1. CDH Communicable Disease Hospital, Weija 2. Public Health, Weija 2. Nursing Demonstration Clinic, Weija	47,000	Structure for admission in poor condition.

Source: Ga District Assembly Development Plan Document, 1995.

The District lacks good water supply and sanitation facilities although it is close to Accra, the national capital where these facilities exist. About 40 per cent of the people depend mainly on ponds and streams/rivers for their water supply. Refuse disposal is mostly by open dumping, creating unsanitary conditions in most of the settlements. In the urban areas for instance, 16 out of the estimated 40 refuse

containers were available. Pit latrine is a major form for disposing human waste. Indiscriminate defecating is however common in many areas. Thus diseases associated with poor environmental sanitation such as buruli ulcer, cholera, and malaria are reported in the area (Ga District Development Plan Document, 1995).

The closeness of the Ga District to the national capital has made it possible for inhabitants of the district to have frequent contact with it for a very long time through trade, education (formal, informal and non-formal) and other socio-cultural activities. There is therefore the possibility that the inhabitants of the district have acquired values, beliefs and innovations associated with urbanisation from Accra. Furthermore, the district has both very urbanised settlements and very remote rural settlements. This socio-economic and cultural diversity coupled with the fact that there is the likelihood for the District to experience some socio-economic and cultural transformation over a long period of time make it ideal for this study. Also, studies such as those by Robertson, (1976) as well as Mullings Leith (1976) have been carried out in the district because of its proximity to the national capital. It would therefore be relatively easier to obtain data for the study. These features have largely influenced the researcher's choice of the district for this particular study.

1.6. Chapter Organisation

The study is organised into six chapters. Following the present chapter is Chapter two which gives an overview of conceptual issues and views on maternal health and women's rights and status. The third chapter is on the research methods, issues and background characteristics of respondents. Chapter four is about rights, decision-making and fertility whilst chapter five examines the link between sexual rights and maternal health. The last chapter, comprises the summary and implications of the study for methodology, theory, further research and policy-making.

CHAPTER TWO

ISSUES AND CONCEPTS ON WOMEN'S RIGHTS AND MATERNAL HEALTH.

2.0. Introduction

Previous concern on women's health has most commonly been on their reproductive process and organs, and on the childbearing period, which is generally defined as between the ages of 15 and 44 years. Most discussions of women's health especially with respect to developing countries have referred briefly, if at all, to health problems apart from reproduction or post-menopause. This has had continuous implications on health policies and planning, especially in an era of limited resources and global recession. The consequences of the low status of women in the society and discrimination against them on their health were not recognised. The implications are that various aspects of development ignored the health of women, as well as their economic and social needs (WHO 1992).

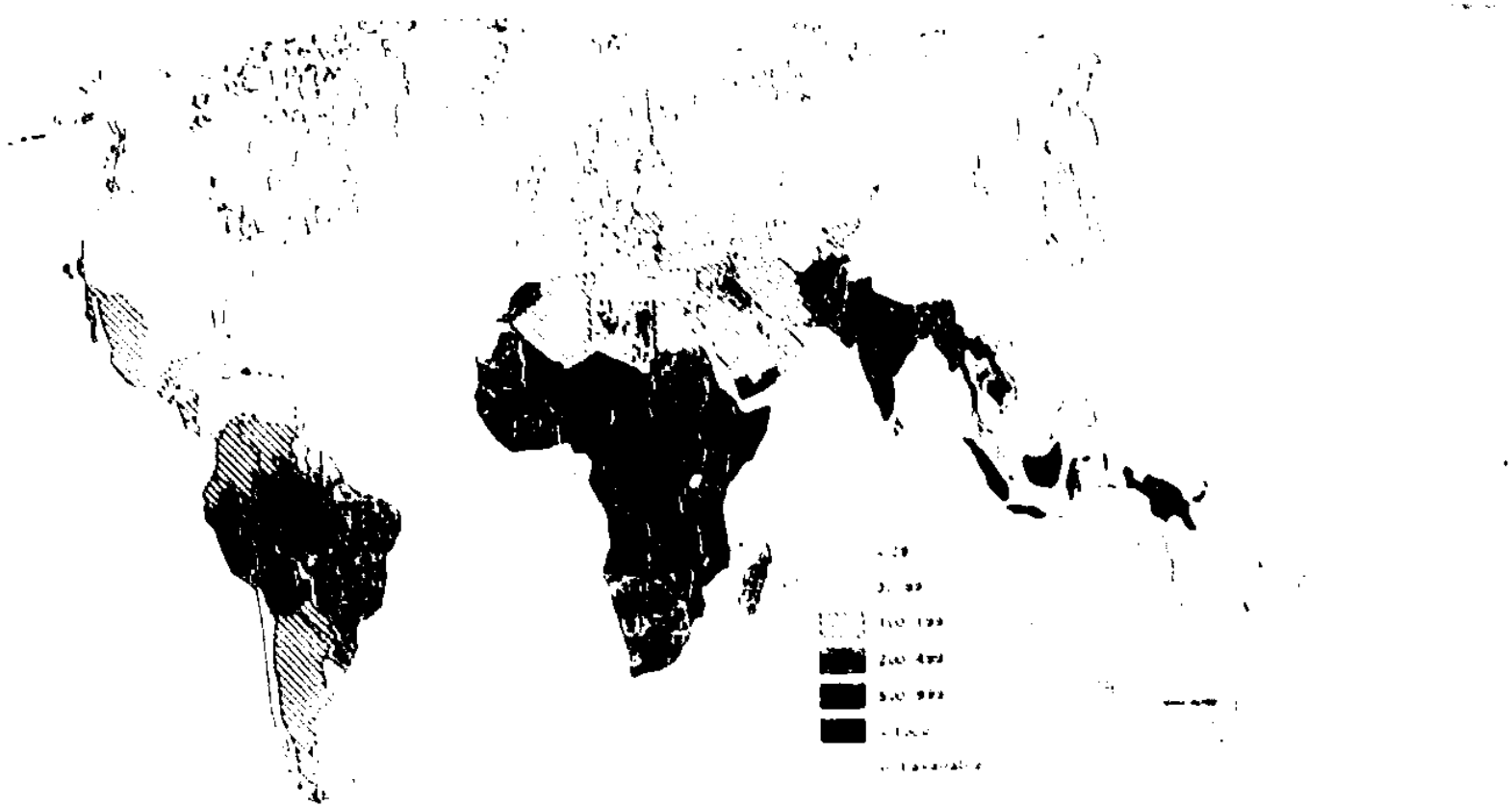
This chapter deals with some of the relevant issues and the conceptual framework on maternal health and women's rights. It examines the various perspectives, conceptions and misconceptions on maternal health and women's rights. It also discusses the applicability of the conceptual framework adopted for the study. The main aim is to provide a general overview on issues and views on maternal health and women's rights to serve as a basis for a better understanding of the problem under investigation.

2.1. Maternity and Motherhood

The concept *maternity* is derived from the Latin word *mater* (mother). In the ordinary usage of the word a mother is a woman who has had children. This is synonymous with the medical understanding of the concept which associates it with a pregnant woman or an early puerperal woman (Bergstron, 1994). *Maternal* in everyday usage also means a childbearing woman. For the purpose of this study, maternal health is defined as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to pregnancy, labour and conditions within forty-two days of the postpartum period (Basu, 1992). Maternal health care in medical parlance is usually taken to mean pregnancy-related health care or care in pregnancy and the immediate postpartum period. That is, the period of time during which maternal deaths are registered (Winikoff, 1992).

The experience of motherhood is a highly complex issue and also central to the lives of many women. Motherhood is not just the experience of looking after and caring for a child but it also shapes women's relationship with other people, their opportunities for paid employment, their leisure activities, and identities for adulthood. Childbirth is thus rewarded with social approval and acceptance whereas barrenness is viewed with scorn (World Bank, 1993).

Figure 2·1 Maternal mortality ratios (global estimates) 1990 (maternal deaths per 100,000 live births)



Source United Nations, 1999

In patriarchal societies such as Ghana, the principal duty of women historically was to bear men's children, particularly, sons, and to serve as the foundation of families. Pregnancy is therefore cherished and it is the target of many sexual relations in marriage because childlessness is socially unacceptable (Cook, 1995). The cost to women's health of discharging this duty therefore went unrecognised. Ill-health, influenced by early and excessive childbearing, and women's premature deaths were explained through fate, destiny, and divine will rather than through societal and governmental neglect of reproductive health services (Cook, 1995).

All over the world myths surround pregnancy and some of these myths have resulted in the subjection of pregnant women in the past to various forms of restrictions and care, believed to ensure good foetal development and easy childbirth. In some parts of the country, pregnant women use herbs as antenatal drugs and protect themselves against witches, magicians, sorcerers and other evil spirits by putting themselves under the guardianship of a deity. They may also wear talismans or amulets to ward off evil spirits. They observe many prohibitions such as abstaining from eating certain foods and drinking certain liquids. Direct contacts with monsters and ugly persons must be avoided in order that the baby to be born will not look like what the mother had been in contact with (Harrison, 1991). In some societies, sexual intercourse during pregnancy is encouraged because it is believed to ensure easy labour. However, sex with a woman impregnated by another man is prohibited because it is believed that such an act could lead to prolong labour and in extreme cases death, if the woman fails to confess (Clover, 1995).

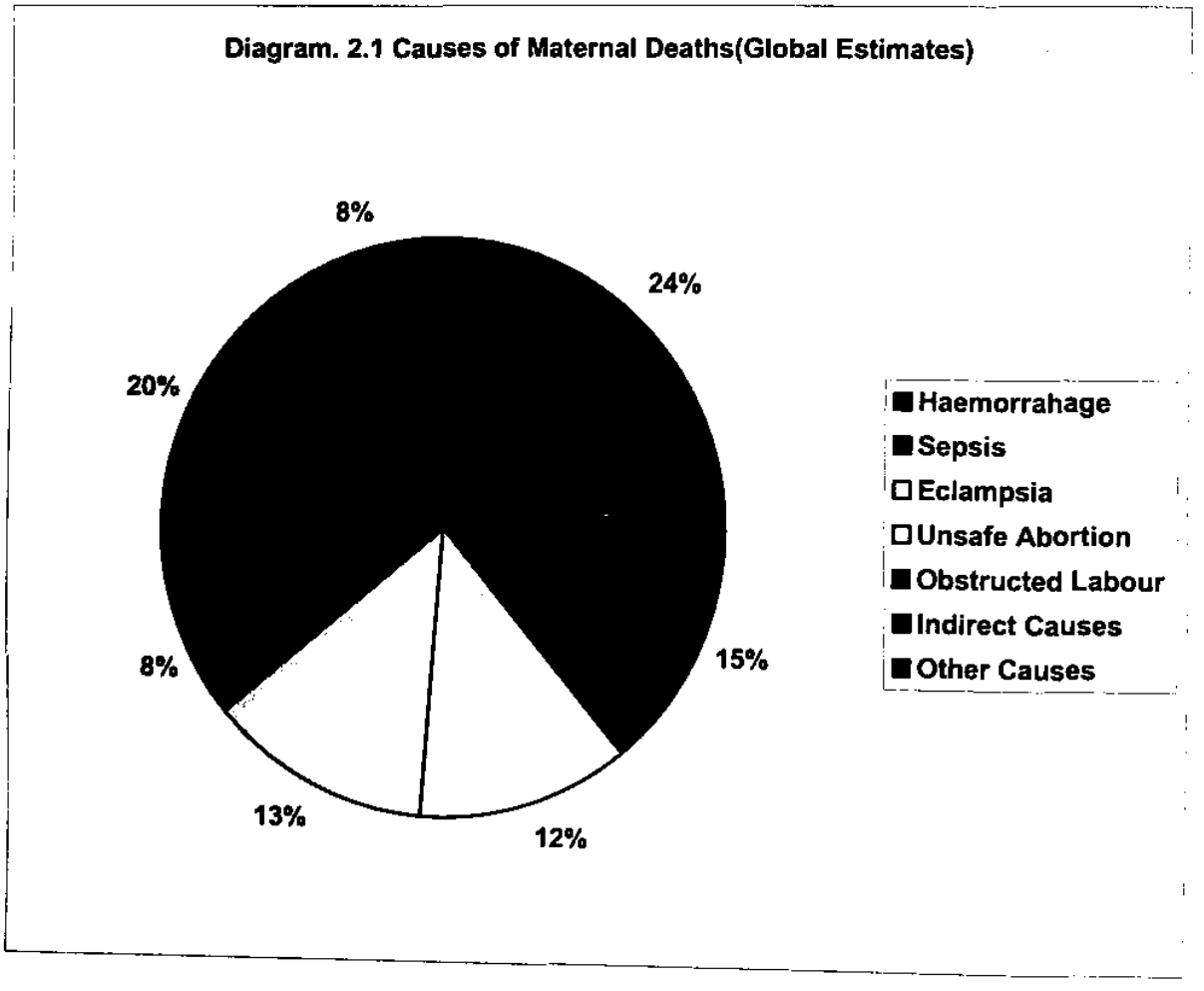
Although much progress has been made to change people's perception on maternity and to reduce maternal mortality in many industrialised countries, the performance of the developing countries is still far below standard. For example, whereas Sweden and USA had maternal mortality rates as low as 6 and 12 per 100,000 births respectively between 1990-97, Sierra Leone and Guinea have as high as 1,800 and 880 per 100,000 births respectively within the same preiod (Table 2.1). Maternal mortality and morbidity, still high in some countries, are mostly associated with anaemia, eclampsia, haemorrhage, obstructed labour, bacterial infections and complications arising from unsafe abortion (Diagram 2.1). Figure 2.1 gives the global estimates of maternal mortality ratios.

Table 2.1. Maternal Mortality Rates for Selected Countries Over Time

	1980-87	1990-97
Ghana	1,000	740
Kenya	170	650
Sierra Leone	450	1,800
Mali	--	58(
Guinea	--	880
Singapore	5	10
Philippines	93	210
Kuwait	6	20
Cuba	34	36
Viet Nam	148	105
Sweden	--	6
USA	--	12

Source: United Nations, 1991; World Bank, 1999.

Diagram. 2.1 Causes of Maternal Deaths(Global Estimates)



Source: United Nations, 1999.

Bergstron (1991) has suggested that female empowerment through education is a crucial starting point to reverse the situation in developing countries. She further suggested community involvement in maternal health care along the lines of the Primary Health Care (PHC) concept which is essentially, a system of health care which is practical, scientifically sound and socially acceptable. It also involves a technology which is universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maitain. This must be made in the spirit of sel-reliance and self-determination as advocated for under the Alma Ata Declaration of 1978.

Maternal mortality and morbidity can also be reduced, to some extent, through improved access to family planning, simple hygienic practices by trained birth attendants and appropriate strategies to deal with unsafe abortion. There should also be an effective obstetric management through continuous active medical interventions. The health delivery system must be able to use potent drugs, provide blood transfusions, perform obstetric surgery, and handle life-threatening complications. Because life-threatening obstetric complications are often unpredictable, it has been suggested that maternal health services must be widely and rapidly accessible. To make motherhood safe requires an ordered development and rational management of an appropriate health infrastructure. Most of all to reduce maternal mortality will involve behavioural changes and informed choices in society in general and for women in particular. It also involves improving the status of women so that they can exercise their rights in decision-making and changes in the perception of people regarding pregnancy (Bergstron, 1994).

2.2 . Theoretical Perspectives on the Determinants of Health Status

This section examines the theoretical perspectives and their respective proponents on the determinants of health status. It focuses on the health transition, epidemiological transition, material well-being, public health, technologically-based and cultural-behavioural perspectives. It also discusses the weakness or the shortcomings of each of these theoretical perspectives.

The health transition is one of the models which has been used to explain changes in health status of a society. It describes the health status of a society as it undergoes socio-economic and political changes. That is, it seeks to explain the relationship between socio-economic and political developments on the one hand, and the health status of a society on the other.

The health transition is made up of two components. These are the mortality transition and epidemiological transition. The mortality transition states that life expectancy at birth increases as a society undergoes socio-economic and political development. That is as a society undergoes positive social, economic and political change, life expectancy at birth, which predicts the number of years a child born today will live before dying, also increases (Caldwell, 1990).

The epidemiological transition, on the other hand, describes changes in the composition of causes of ill-health and death as a society undergoes socio-economic and political transformation. It states that, as a society undergoes socio-economic and political transformation, the proportion of ill-health arising from infectious, parasitic, and respiratory diseases such as Malaria, Tuberculosis, Whooping Cough, and Cholera decline considerably while ill-health arising from cardiovascular diseases and cancer-related increase (Phillips and Verhasselt, 1994).

The epidemiological transition as propounded by Omran in 1971 explains the complex changes in patterns of health and diseases, and the interaction between these patterns and their demographic, economic and sociological determinants and consequences. Omran suggested that improvements in health status were engineered by socio-economic and political transformation; and that the shifts in health and diseases that characterise the transition have positive impacts on infant and child mortality due the decline in infectious, parasitic and respiratory diseases. Omran's theory was criticised on the basis that it fails to explain the socio-economic and behavioural factors that determine health and rather stresses more on outcome measures such as death (Phillips and Verhasselt, 1994; Agyei-Mensah, 1997).

Other viewpoints have been used to explain the health transition. These are the material well-being viewpoint, public health, technology-based viewpoint and cultural-behavioural viewpoint. These viewpoints, which have been used to explain the secular

improvement in health and nutrition observed in the developed and parts of the developing world, are examined in the next sections.

2.2.1. The Material Well-Being Viewpoint on the Health Transition

This view attributes improved health outcome principally to improvement in food consumption made possible by general expansion in prosperity and in agricultural productivity. This view has been used to explain the vast improvement in life expectancy that occurred in the Western World in the late ninetieth and twentieth centuries. This explanation was given precedence over other views such as the technology-based explanation on the grounds that it was not until the twentieth century that major advances occurred in medical technology capable of fighting infectious diseases responsible for high mortality (Mckeown, 1976). For instance, Rogel (1994) argued that it was improved nutritional intake, made possible by material prosperity, that mainly accounted for the secular improvement in physical status experienced by western populations. Mckeown, Record and Turner, (1975) observed a link between better diet and health status and concluded that increase in real incomes and the availability of nutritious food were the main causes of the substantial fall in mortality from tuberculosis particularly, in England and Wales. This viewpoint relates the health status of people to the Gross Domestic Product (GDP) or Gross National Product (GNP) of a country. This straightforward relationship between GDP or GNP and health, measured in terms of life expectancy is, however, debatable because of the remarkable performance of some less developed countries such as Sri Lanka, Cuba and China in mortality reduction. The

failure of this theory to explain the relatively better health status attained by these countries led to the search for other variables and the development of other views (Osmani, 1997).

2.2.2. The Public health Viewpoint on the Health Transition

This view was introduced as a result of weaknesses in the material well-being perspective. It attributes improvements in health to socio-cultural, economic and political conditions such as improvements in sanitation, housing, nutrition, water, personal hygiene, education and technology. It was realised that improvement in the health status of some countries took place under conditions, which the material well-being view could not explain. Relating GDP for instance to health status could not explain the health status of certain regions and countries with low GDP such as Kerala state in India, Sri Lanka and Costa Rica (Table 2.2). Proponents of this view recognised the fact that the most important breakthroughs in medical technology did occur after and not before the most important advances in human health were made in the West. This view suggested that the sharp decline in mortality observed in the developing world in the second half of the twentieth century could be attributed to technologies that made mass access to safe water, sanitation, vaccination and other public health facilities possible (Szreter, 1988). Caldwell (1993) however, observed that this view only drew attention to the achievements of public health in improving health status at local levels, but could not explain broader social and behavioural change. This led to the development of the cultural behavioural viewpoint.

2.2.3. The Technological-based Perspective on the Health Transition

This viewpoint attributes advances in technology and medical research, coupled with the emergence of the germ theory as the main causes of mortality decline. Although Mckeown and Record (1976) associated reduction in mortality levels to better nutrition, he also identified changes in medical science and technology as possible causes of improvement in life expectancy in Britain. The perspective is that the invention of drugs, vaccines and disinfectants brought about through technological advancement helped to improve upon the cure and reduced the occurrence of many diseases such as small pox, meseales, leprosy, sheep anthrax, hydrophobia, diphtheria and cholera. Furthermore, various technologies for foetal monitoring, blood transfusion, the use of antibiotics and caesarean section have helped to improve maternal care and thus, reduced maternal mortality. Also the introduction of aseptic and antiseptic surgery, and the availability of heavy and better clothen have made it possible to combat evere weather conditions. However, towards the 1980s, a strong reaction against the unnecessary over-reliance on interventions and technology led to the re-examination of the technological-based viewpoint. For instance, it was observed that the over-reliance on medical technology for health care carried with it the risk of neglecting the psychological and emotional aspect of health care and for that matter reduced attention on the socio-economic factors that are very important in determining health status.

Table 2.2. Relationship between GNP and Health Status of Selected Countries.

COUNTRY	GNP PER CAPITA, (1997).	LIFE EXPECTANCY (1997).	MATERNAL MORTALITY RATE
DR CONGO	110	51	890
MALAWI	210	43	95
GHANA	390	60	740
KENYA	340	63	650
COTE d 'IVOIRE	710	47	810
ZIMBABWE	720	52	280
SRI LANKA	800	73	30
CHINA	860	70	95
SAUDI ARABIA	7,150	71	18
IRAN	1,780	69	120
UNITED KINGDOM	20870	77	9
CANADA	19640	79	6

Source: World Bank, 1999.

2.2.4. The Cultural-behavioural Viewpoint of the Health Transition

The emergence of the cultural-behavioural model was a reaction to the failure of the Public Health model to offer explanations for disparities in health status especially in poor countries. This model attempted to explain the disparities in health status among developing countries. Poor countries such as Sri Lanka, Costa Rica, China, Cuba and Kerala State in India, with low levels of per capita income, have achieved levels of life expectancy that are close to levels achieved by the richest countries in the world. On the other hand countries such as Ghana, Nigeria, India and Pakistan have very low life expectancy rates. It has been observed that factors responsible for the achievements of the former group of countries go beyond material prosperity and public health technology. Factors, which have been identified for this phenomenon, include the

educational levels of women, their level of autonomy, good gender policies and a system of good governance. It was observed that a comprehensive and accessible health programmes with community involvement and female education as well as good nutrition are important determinants of health. Education and literacy have been associated with improved health status through improved nutrition and hygiene. For example, Kerala's health achievements have been linked more to the educational attainment of women of maternal age followed closely by the practice of family planning and education of men than the density of doctors and per capita income (Caldwell, 1993; Bergstrom, 1994).

Although these theories represent different viewpoints, they are interdependent and must not be treated in isolation. That is, the health status of a society should be viewed in a socio-cultural and economic context as well as the quality of the medical system. These views together offer a better understanding of factors that affect the health status of a society and give insights into intervention measures needed to tackle health issues. Table 2.3 shows the theoretical perspectives and the period within which these views were articulated.

The next section would discuss issues concerning women's health. Specifically, it would address issues relating to safe motherhood, management of STDs and violence against women.

Table 2.3. Theoretical Perspectives of the Determinants of Health.

Theory	Proponents	Time	Main Issues
Material Well Being	Thomas Mckeown	1970s	Medical interventions and improvements in food consumption made possible by expansion in material prosperity as the main determinants of health status.
Public-Health	Simon Szreter Rogel	1980s 1990s	Mass access to safe water, sanitation, vaccination as the main determinants of health status
Technology-based Theory	Thomas Mckeown	1970s	Improvement in medical technology led to the cure and eradication of certain diseases. Eg, the introduction of drugs, vaccines and the use of modern and better medical equipment
Cultural Behavioural Theory	Caldwell, J. C Caldwell, P Indra Gajanayake Orubuloye I O Indrani Pieries	1990s 1990s 1990s 1990s 1990s 1990s	Socio-cultural and behavioural change such as increase in female education, improvement in gender relations and good governance
Epidemiological Transition.	Omran	1970s	Improvements in health status as a result of changes in the composition of diseases as a society undergoes socio-economic and political change

2.3. Issues on Women's Health

The overall global health needs of women could be considered under three main headings. These are safe motherhood and control over ones body including prevention and management of STDs such as HIV/AIDS, midlife and ageing health concerns and reduction of violence (McElmuerry et al, 1993).

2.3.1. Safe Motherhood, Control over Sexuality and Violence Against Women.

Safe motherhood is perhaps the clearest priority in women's health. It is well established that relatively low cost and simple measures can dramatically improve survival rates and reduce morbidity and mortality for mothers and their infants. However, this is not the case in many countries. Not even the highly developed countries have adequate health care for women. Lack of adequate care for children or family leave opportunities make it difficult for women to combine motherhood with work. This has physical and psychological effects on the welfare of mothers, children and families (Rowbotham, 1992). A World Bank report in a number of developing countries has indicated that during reproductive period, the most important causes of mortality and morbidity among women are high fertility and abortion rates, vulnerability to sexually transmitted diseases, genital mutilation, and gender violence (World Bank, 1997). Also as women's life span increases, they experience specific health problems. These problems include understanding and normalising the menopause experience, prevention and early treatment of the most prevalent women's cancers, especially breast and cervical cancer and more attention to the physical, psychological, social and economic aspects of ageing (McEmurry, et al, 1993; Macfarlane, 1990).

Violence against women which occurs in many cultures and countries is a means used to control and to assert men's dominance over women. Gender-based violence including physical, sexual, psychological or emotional abuses affect women's health adversely and

limits their control over their sexuality. Wife battering for instance creates fear in women and thus limits their ability to negotiate for safer sex from men. The implications are that women do not only suffer from physiological problems such as broken bones, bleeding and sometimes death but also psychological or emotional problems. These could create adverse consequences on women's health and negatively influence their reproductive behaviour. Victims could also be depressed and demoralised as a result of humiliation and loss of dignity which could also adversely affect the victim's sense of self-esteem (Correa, 1994; Abane, 1999). It has however been observed that rates of detection and referral for treatment fall behind prevalence due to the sensitive nature of these issues (Jaising Bernstein, 1996).

To unravel issues surrounding violence against women would involve painstakingly studying what women do as well as where, when and why they do what they do. This is important because different socio-economic and cultural conditions impact differently on women's status and health. Therefore it is important to know how women at different places interact with the environment in their daily chores and the implications of these conditions on their health. Furthermore, it is necessary to assess how these activities expose women to various health risks. Variables such as age, level of education, the degree of autonomy and gender relations affect women's health. The availability of resources to promote health and to treat ill-health, the control of these resources, decisions made concerning their utilisation and benefits to be derived are important issues of geographic interest. This is due to the fact that these issues affect the

accessibility and utilisation of health services by the individual (Phillips and Verhersselt, 1994).

Equally important is the risk women go through as they move through space to perform their many roles. Roundy (1987) observed that working population groups, especially adult females and working children, are exposed to numerous health hazards not only in terms of time spent in spheres identified as individual household, compound, settlement, production but also movements outside these spheres. For example, migrant women, especially refugees, are vulnerable to sexual exploitation and abuse. Such experiences are also common among migrant women both in domestic and public employment. They lack access to reproductive health services and so, are often confronted with unwanted pregnancies which disrupt their employment. Pregnant women on the move may also face serious health crisis as a result of precarious living and health conditions as well as strains they may go through (Lane and Malaise, 1991).

Apart from the above problems, there is also the issue of how women allocate their time among their multiple roles. That is, how women balance their time between their biological, economic and social roles (Phillips and Verharsselt, 1994). Defining women's roles both at home and outside the home can help to explain the complex factors which affect their health spatially and temporally. These are important for policy-making and implementation because they provide an opportunity for women's health issues to be viewed in a broader perspective.

2.4. Women's Rights and Status

Human rights are related to health in that any violations of one's human rights impact negatively on ones health status. That is all human rights violations have an adverse effect on the physical, mental or emotional and/or social well being and dignity of the individual. Conditions such as cultural norms and practices, policies and programmes that influence health status are also closely related to set human rights-based parameters. It is therefore important to link issues in human rights with health in order to have a broader perspective of the complex relationships that exist between rights and health and tackle them in a holistic manner.

2.4.1. Human Rights and Rights of Women.

Rights are moral and legal claims and/or entitlements. *Legal human rights* are those that can be found in the positive law while *moral human rights* are claims which ought to be in the positive law. 'Human rights are universal moral rights, things which all human beings, everywhere at all times ought to have, and things which no one may be deprived of without grave affront to justice, things which are due to everybody simply because they are human' (Shiviji, 1989; 21). Human rights are quite often related to human dignity and concerned with asserting and protecting human dignity. The Human rights

system is thus the basis of the fundamental and universal values of human dignity and social justice as declared by the United Nations (Freedman, 1995).

The Universal Declaration of Human Rights adopted by the General Assembly in 1948 emphasised the fundamental human rights, dignity and equal right for both men and women. This was reinforced by the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), otherwise called the Women's Convention. The convention prohibits discrimination on the basis of sex in the political, economic, social, cultural, civil or any other field and calls for the respect for the individual dignity and freedom (Freedman, 1995). The section on women's health states that " *States should take appropriate measures to eliminate discrimination against women in the field of health care, in order to ensure, on the basis of equality of men and women, access to health services, including those relating to family planning. Also states must undertake to ensure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Gruskin, 2000; P 38).* In the 1992 constitution of Ghana, provision was made for equality and freedom from discrimination. It states that "all persons shall be equal before the law. A person shall not be discriminated against on grounds of race, colour, ethnic origin, religion, creed or social or economic status...". The provision on women advocates for special attention for women during maternity, and pay for working mothers. This means that, the right to exercise one's rights without discrimination and the realisation of one's freedom and dignity is a pre-condition to the right of one's health.

The right to health, therefore, encompasses all issues that will enable an individual to realise *a state of complete physical, mental and social well being.* This includes the full realisation of the fundamental human rights and freedom as spelt out in the Universal Declaration on Human Right. Consequently, women's right to health represents an array of interrelated rights that may either be constituent elements of rights to health or other enabling rights that create the necessary conditions for the realisation of these rights. This implies the elimination of all forms of discrimination against women as provided for by CEDAW, so as to enable women to achieve *a state of complete physical, mental and social well being.* The relevant issues needed for the realisation and protection of women's rights are "the protection of women's employment and granting them equal pay for work of equal value, the right to education, to information, and to political participation, influence, and democratic power within legislature" (Mann, 1997, p 361)

Such values and principles according to Freedman (1995), are the foundations on which to build an understanding of women's reproductive and sexual rights. Freedman defines reproductive rights to be "the constellation of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make and implement decisions about her reproduction and sexuality"(p5). This definition does not focus only on women's choices, but on the relationship between women's ability to make and carry out these choices, and their ability to maintain a sense of control over what happens in their life.

This implies that reproductive and sexual rights link the sense of control and dignity with protection of a woman's decision-making in reproduction and sexuality. That ability involves both a right to make decisions, and a right to implement decisions (Freedman 1995). However, the abstract right to make decisions is meaningless if the conditions needed to carry out this right does not exist. Therefore, to enable women to make decisions about themselves and implement such decisions, states must provide the necessary basis on which the equality of both men and women would be ensured. An environment (social, economic and political) which would ensure that both men and women have the same right to make and implement decisions concerning themselves should be provided (Coomaraswamy, 1994). This requires the empowerment of women through the improvement of their social, economic and political status.

Status is usually the position or positions a person or group hold in the structure of a society. To these various positions – a number of which may be occupied by a single individual simultaneously in his or her capacity as a member of several social groups– are ascribed varying degrees of power, privileges and prestige (Dooley, 1995).

The status of women, then, is the conjuncture of positions a woman occupies at any one point in time, as worker, student, wife, mother, church member, or political worker, and of the rights and duties she is expected to exercise in her active role as occupant of these positions. It is generally accepted that women are discriminated against, and that men have more prestige, power and privileges in almost all societies but the direct measurement of status is a difficult and complex problem which hinders investigations

of the causes and consequences of this particular form of discrimination (Lewis and Edie, 1994).

It has been argued that the best method of assessing the status of women is to determine the extent to which women as compared to men have access to knowledge, to economic resources, to political power and the degree of personal autonomy these resources permit. Another approach is to assess the range of choices or options available to women as compared to men in the same society (or to women in different societies or sub-groups) in the areas of education, employment, political life, family life and other relevant areas. Both approaches are based on the assumption that low status derives from a lack of control over material or social resources and a lack of choice in the unfolding of one's destiny (Plata, 1994).

Thus, the lack of equal access of women to economic, social and political resources has contributed to the low status of women in the society and their inability to make changes to imbalances in the system. For example, in Ghana and other African countries, women are marginalised in politics and education, and do not have equal opportunities for exercising power in traditional institutions as their male counterparts. For instance in 1995, the adult literacy rate was 52.1 per cent for females and 75.1 per cent for males in Ghana, 70.0 per cent for females and 86.3 per cent for males in Kenya and 99.0 per cent for both female and males in Canada and Norway. In the case of school enrolments into primary schools in Ghana, the ratio was 82.0 and 68.0 for males and females respectively in rural areas, and 94.0 and 77.0 for males and females respectively in urban

areas in 1989. In 1992, the ratio increased to 88.0 for males and 79.0 for females in rural areas and 103.0 and 92.0 for males and females respectively in urban areas. At the secondary level, the ratio was 42.0 for males and 28.0 for females in rural areas whiles in the urban areas it was 44 for males and 28 for females in 1989. This increased to 44.0 and 29.0 for males and females respectively in rural areas and 48.0 and 38.0 for males and females respectively in urban areas in 1992. The situation is not different from other Africa countries such as Liberia, Namabia, Sierra Leone and Tunisia where the level of female enrolments in primary and secondary schools are still lower than their male counterparts. In the political realm, there are only 2 female Cabinet Ministers out of 18, 4 female members of the Council of State out of 24, 6 female Ministers out of 37, 4 Deputy Ministers out of 34 and 18 members of parliament out of a total of 200 (Ghana, 1997). (See Tables 2.4- 2.7).

Table 2.4. Adult Literacy for Selected Countries, 1995

COUNTRY	FEMALE	MALE
Ghana	52.1	75.1
Kenya	70.0	86.3
Cote d'voire	30.0	49.9
Zambia	71.3	85.6
Canada	99.0	99.0
Norway	99.0	99.0
Italy	97.6	98.6

Source: United Nations.

Table 2.5. Ratio of Enrolment of Males and Females into Primary and Secondary Schools in Ghana.

	RURAL		URBAN		GHANA (TOTAL)	
PRIMARY	**M**	**F**	**M**	**F**	**M**	**F**
1989	82.0	68.0	94	77.0	86.0	72.0
1992	88.0	79.0	103	92.0	93.0	83.0
SECONDARY						
1989	42.0	28.0	44.0	28.0	44.0	29.0
1992	40.0	29.0	48.0	38.0	44.0	33.0

Note: Ratios exceeding 100 per cent imply a serious mismatch in the age/class interface, indicating the presence of significant numbers of over-age children in some primary schools.

Source: Ghana, 1997.

Table 2.6. Level of Female Enrolment in Primary and Secondary Education in Selected Countries in Africa

COUNTRY	PRIMARY EDUCATION RATIO (F/M)			SECONDARY EDUCATION RATIO (F/M)		
	1980	1990	1996	1980	1990	1996
GHANA	0.81	0.83	0.85	0.63	0.64	0.63
MALI	0.55	0.59	0.64	0.42	0.43	0.51
NAMABIA	1.10	1.10	1.01	1.26	1.26	1.18
SIERRA LEONE	0.70	0.69	0.69	0.41	0.57	0.58
TUNISIA	0.74	0.89	0.95	0.59	0.80	0.97

SOURCE: African Development Bank, 1999.

Table 2.7. Women in Policy Influencing Positions in Ghana.

POLICY-INFLUENCING POSITION	PROPORTION OF WOMEN (%)	TOTAL (N)
Ministers	16	37
Deputy Ministers	12	34
Regional Ministers	20	10
Council of States	17	24
Parliament	9	200
Carbinet Ministers	11	18

Source: Ghana, 1997

2.4.2. Women's Subordination and Exclusion.

Negative perceptions about women and their role as mothers have their origin in social and religious institutions. For instance, in the Christian Religion Eve was made out of Adam's rib, a part, not a whole and a man's vital organ, unconnected to the heart or brain. She was not only a part and dependent on man but also dangerous, because her moral inadequacies led her to fall under the sway of the serpent, causing human kind to be expelled from the Garden of Eden and to be denied access to the tree of knowledge (Weisner, 1993; Sai, 1994).

These aspects of the female persona, incompleteness and threat have been the basis of the psychology of women and have been perpetuated by traditional psychosocial and psychoanalytic theory.

The discrimination against women and their alienation from public life is also due to the belief that they are a threat to men and the society. First, the female power of sexuality makes them "dangerous" to man. In patrilineal societies, the society is ruled by

"dualism" of reason, justice and logic, the forces of good represented by the male and the so-called pagan feminine power of sexual and emotional drive, which must be resisted at all cost (Creese, 1991). For instance, Oedipus and Sampson were said to have suffered at the hands of women and Eve was responsible for the fall of Adam (Ehrenrich and English, 1979). In Ghanaian history it was a woman who caused the fall of Ntim Gyakari, the Denkyira Chief, which resulted in the fall of the Denkyira Kingdom (Safo, 1976).

Finally, women are considered unclean in most societies. Blood spilled in war and violence is somewhat acceptable, but blood from women through the natural process of menstruation and childbirth is despised. At the same time a woman's blood is considered to be so potent that it is often used for rituals and juju (Crawford, 1981;Rai 1992). For instance, among the Ga of Ghana, some of the reasons given for the separation of the sexes into different houses are mistrust and the uncleanness of women. The belief is that medicines procured for war and buried in the compounds could be contaminated and rendered impotent through menstruation. Another belief is that women are gossips and quarrelsome and so they should not be allowed to know the secrets and plans of the lineage. Also to ensure that women do not draw men into their petty quarrels, it is recommended they should be separated from one another (Azu, 1974).

These myths and beliefs have become deeply entrenched in the social system of most society such that everywhere women face some form of discrimination, abuse and neglect. These forms of human rights abuses vary from country to country and from

society to society, but in all cases, the adverse effects are a deterioration of the status of women in the society.

Although evidence exists that women are systematically oppressed in society on the basis of their gender, until quite recently little had been done to address the situation beyond rhetoric. For instance, violations women suffer have been the subject of various treaties, resolutions of inter-governmental organisation (IGOs), studieš and debates at the international level yet actions taken are minimal (Mastroionni, et. al, 1994; Fitzpatrick 1994).

Two main obstacles have been identified. One is the separation of international law into "public" and "private" and the other is the tendency to view intimate violence as not violence (Bunche, 1995). Intimate violence is seen as private or domestic or a family matter. Its goals and consequences are obscured, and is justified either as a form of "chastisement or discipline" (p. 117). Thus violations of the domestic rights of women such as intimate violence have, in many cases been defended as part of culture or religion and gone unpunished (Cook, 1994).

But gender-based violence has various negative impacts on women's ability to control their sexuality. For example, threat of violence ensures that women comply with men's decisions on sexuality and limit women's control over their fertility. This limits women's reproductive freedoms, and reduce their ability to protect themselves against

unwanted pregnancy and sexually transmitted infections such as HIV/AIDS (Hesse, 1995).

Also, when women are denied their democratic and human rights in private, it is difficult for them to exercise their human rights in public because what happens in their private lives affect their participation in the public arena. Where women have to obtain permission from their male counterparts or partners before taking part in public activities, their freedom of association will be curtailed for fear of being beaten or locked up by their partners (Dooley, 1995).

The discussion has shown that there is an intersection between health and human rights and this has provided a framework for understanding women's issues in a broader perspective. Perhaps the link between health and human rights has become more urgent in the area of women's reproductive health and reproductive rights. This is because it has drawn attention to the need to understand women's reproductive health and reproductive rights across different cultures and political systems, and to finding the social structures and cultural arrangements that will promote and support these issues.

2.5. Conceptual Framework

The World Health Organisation (WHO) defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (Evans and Stoddart, 1990 p. 23). This means that being healthy involves much more

than simply determining if a person is ill or injured. It also means experiencing a sense of wellbeing. Health is not merely the absence of disease or injury, but also an absence of distress or an impaired capacity to carry out one's daily activities. It also implies the existence of the social, economic, cultural and political rights for the individual to accomplish a state of socially and economically satisfactory life. This involves the provision of an appropriate environment (social, economic, physical and political) that will make it possible for the individual to interact and enjoy a meaningful life.

To feel healthy or sick is a personal experience which is learnt by drawing on the accumulated knowledge of the relevant culture. In every society, there are accepted standards of 'normal' health and fitness that govern the thinking of its members about their condition. How these norms develop, how they are learnt and applied and what are regarded as deviations are deeply rooted in the culture of the society. Again, notions of health and meanings attached to health by individuals reflect the individual's social position and material circumstance. Thus, one's socio-economic standing is a major factor which influences the state of health and volume of ill health. For instance, the type of job people do, the degree of control they are able to exercise over their jobs, their daily schedules and their relationships are reflected in their perception of health and ill-health (Miles 1991).

It can be deduced from the above definitions that the domain of health includes an entire range of issues, which touch on illness, disease, well-being, as well as prevention of diseases, healing, curing and caring. It embodies almost the crucial elements necessary

to achieve an understanding of the society itself: life and death, rights and empowerment, strength and weakness, fear and suffering, production and reproduction, work and play, separation and unification (Oslesen and Ellen, 1985).

Various models have been used to provide insights into relationships that exist between social, cultural, economic and demographic variables and health. In this study, the maternal mortality and morbidity framework (Safe motherhood framework) has been used to explain the relationship between maternal health and women's rights. This framework explains the multiple socio-economic, cultural and political determinants of maternal health by taking into consideration various perceptions of health.

2.5.1. Maternal Morbidity and Mortality Determinants Framework

To understand the mechanism affecting maternal health, and to predict possible outcomes, requires the use of a framework, which gives an in-depth explanation of these factors. The choice of the maternal morbidity and mortality framework for this study was influenced by the need to satisfy these requirements. The framework which was originally developed by McCarthy and Maine (1992) and revised by Tinker and Koblinsky, (1993), explains the actual mechanisms which determine maternal health. This model uses a pictorial causal flow graph to explain factors responsible for maternal morbidity and mortality. In its original form, the framework is classified into two-distant determinants and intermediate determinants (Figure.2.2). However, Tinker and Koblinsky, (1993), have identified issues affecting maternal health as the outcome of

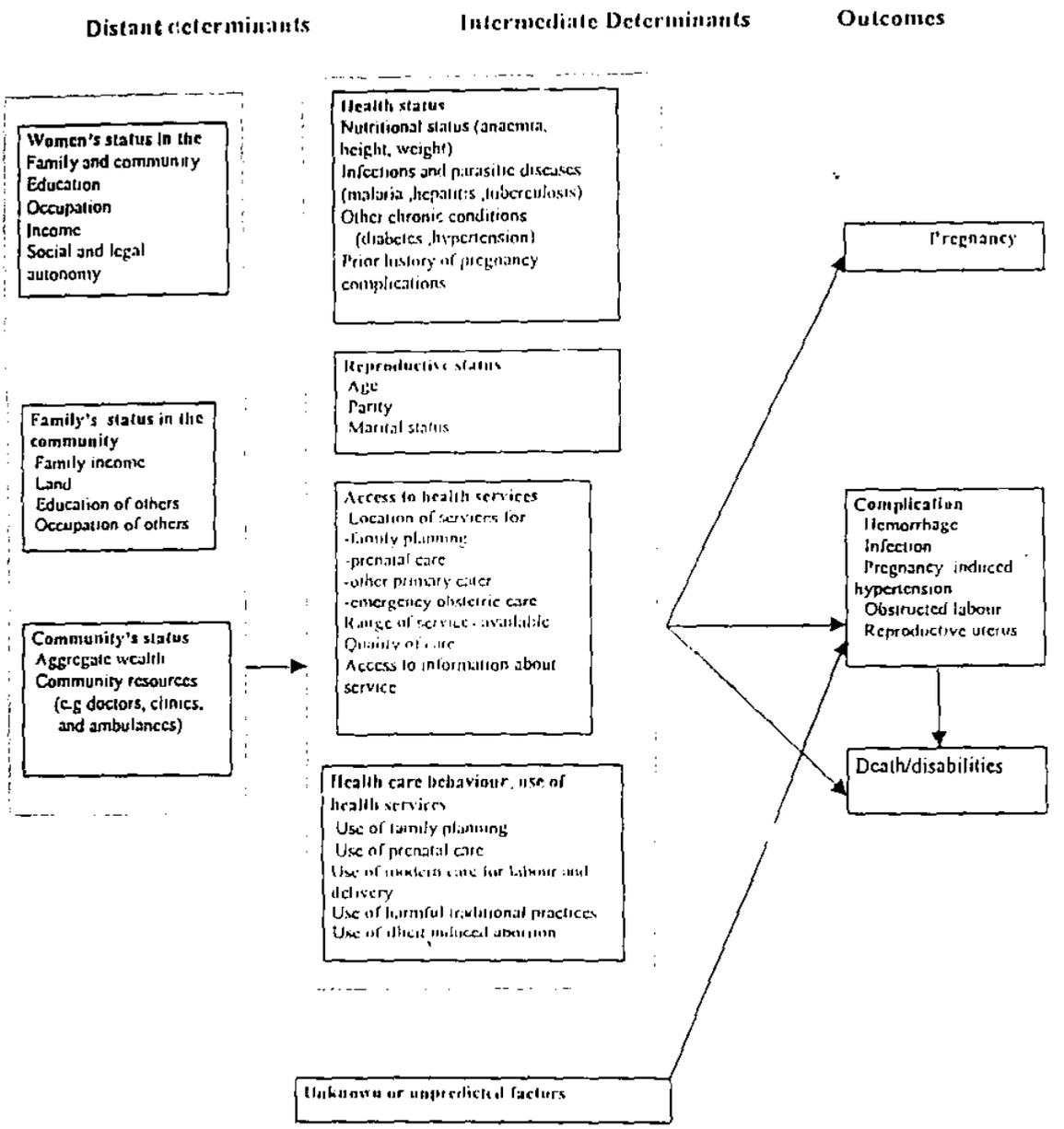
interactions between a number of factors classified as proximate determinants, intermediate determinants, and contextual determinants (figure.2.3 below).

In the McCarthy and Maine model, the distant determinants are those factors which indirectly influence the outcomes of conception. That is whether there will be a successful conception outcome or not depends indirectly on the distant variables. These include women's status in the family and community, family's status in the community, and community's status. At the individual level, ones background, occupation, income level, and social and legal autonomy influence status in the community. Family income, land ownership, education and occupation of other members of the family have influence on the relative status of a person, including her perception of her health and ability to utilise available resources. Aggregate wealth and community resources (e.g. doctors, clinics, and ambulances) constitute the common wealth available to the individual. Thus, even though the focus of safe motherhood is on pregnancy and birth, many conditions that affect the outcomes occur before pregnancy. Formal education for instance, has significant effects on women's health and reproductive behaviour through its influence on age at marriage, conception and health care use, and awareness of risks and dangers. Women who are impoverished and have no formal education normally suffer from chronic malnutrition and usually experience poor prenatal care. They also tend to experience high infant mortality rates and a rapid succession of pregnancies which often expose them to complications in childbirth. The status of women in the society (education, access to and control of income, and resources, and the level of

isolation), political commitment, general resource availability and existing infrastructure are therefore factors which remotely influence pregnancy outcomes.

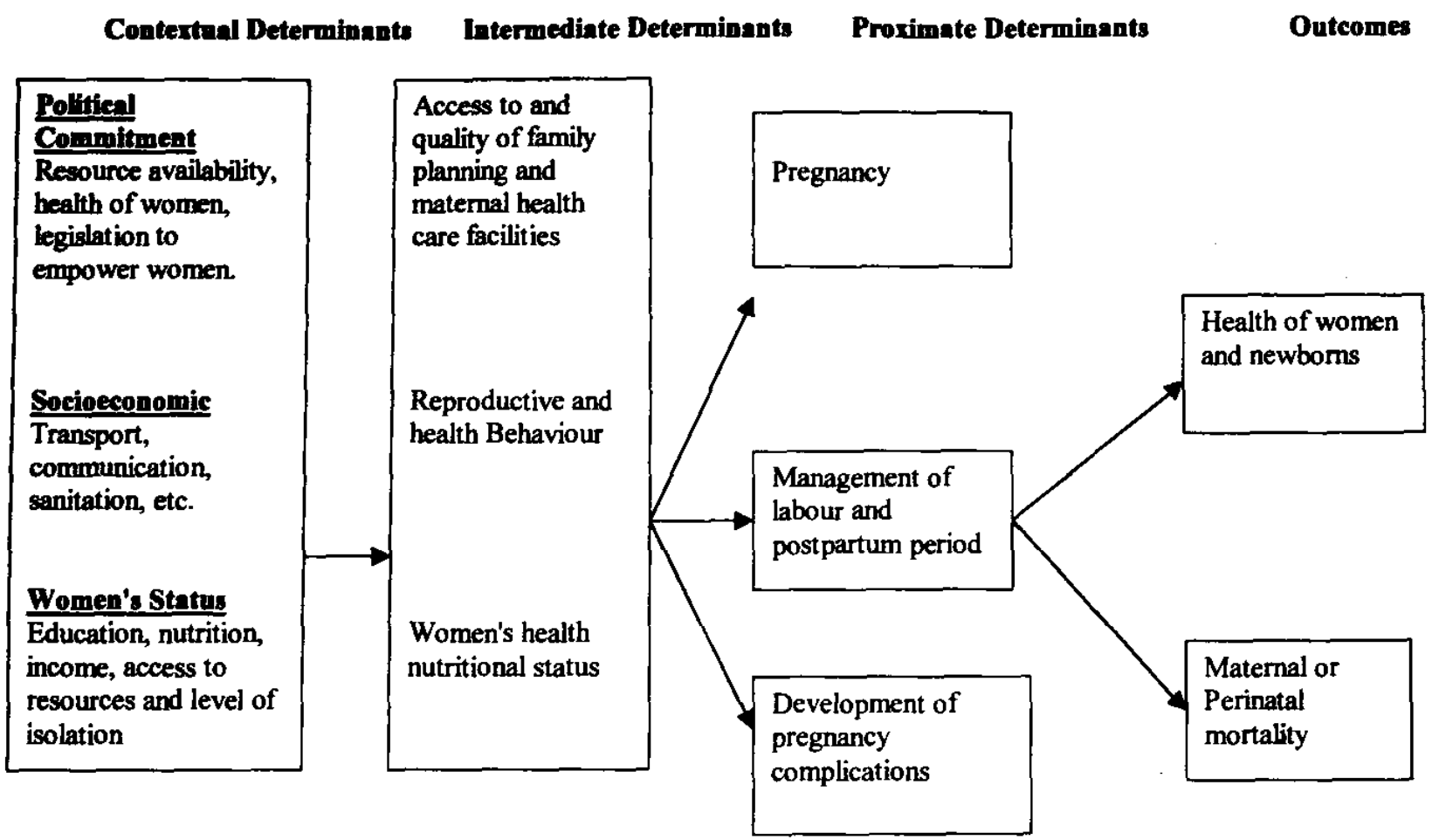
The intermediate determinants are those factors, which influence conception directly and determine whether there will be successful pregnancy outcome or complications or death or disabilities. The intermediate determinants are the health status of women, reproductive status, access to health services and health care behaviour or use of health services. The health status of a woman is influenced by her nutritional status, infectious and parasitic diseases, other chronic conditions and prior history of pregnancy complications. The reproductive status according to the model are determined by the age, parity and marital status of women while access to health is also determined by location of services, range of services available, quality of care and access to information. For example, the reproductive and health behaviour of women which include age at which a woman becomes pregnant, whether the pregnancy is planned, and the kind of health care she seeks largely influence pregnancy outcomes

Fig. 2.2. Framework for Analysing the Determinants of Maternal Mortality and Morbidity



Source: McCarthy and Maine (1992)

Fig.2.3. Safe Motherhood Conceptual Framework



Source; Adapted from Tinker and Koblinsky, (1993)

In the extended model by Tinker and Koblinsky (1993) which the present study is based on, the proximate determinants include factors that influence pregnancy, before, during and after delivery. They include the state of the pregnant woman, the perception of people around her towards pregnancy and the readiness of the health delivery system to attend emergencies. That is, whether or not a woman develops complications at birth, depends on the health status of the woman during pregnancy, the management of labour which include place of delivery, attitude of health personnel and family members and care received during the postpartum period. Poor antenatal care and assistance during pregnancy and labour, poor referral system, little understanding and knowledge of symptoms which indicate risk during pregnancy and labour could lead to complication and maternal death.

The ability and the right to make decisions and the right to implement those decisions influence the extent to which one is able to control one's life including the area of reproductive health. Secondly, the socio-cultural and economic conditions under which one lives have implications for access to and quality of reproductive services. Thus, women's income, access to household resources, and power to make decisions influence their ability to seek health services and to exercise their rights to these when need be.

The framework discusses the complex interrelated factors which operate through a series of complex intermediate and proximate variables to influence pregnancy outcomes. That is, it shows the linkage between the socio-economic status of women, such as education and income and maternal health. However, in as much as findings in the literature about the association between socio-economic status and maternal health are consistent, it is important to note that such an association is not direct and may not operate the same way in all societies (Tinker and Koblinsky, 1993; Dixon –Mueller, 1993). Thus, the fact that a woman has attained a higher level of formal education and comes from an affluent class does not imply that she would not experience complications associated with pregnancy. A combination of factors operate conjointly to influence maternal morbidity and mortality and the health of the new-born baby. Also, although all factors in the framework are likely to influence maternal morbidity and mortality as well as the new-borns and all women, some have greater impact in the short term, particularly on the incidence of maternal health than others. For example, it has been observed that maternal care and family planning services have greater effects on maternal mortality reduction than broad-based socio-economic development (Tinker and Koblinsky, 1993). Thus, there is the need to assess the relative importance of each factor at each stage of the pregnancy so that appropriate intervention measures can be adopted.

Again, the framework does not offer an elaborate explanation of how these factors work to influence maternal mortality. It does not provide the precise mechanisms of how different variable operate in each of the concepts. For example, the framework does not consider how the variables operate at each stage of the sequence of events through pregnancy to death or disability. The framework assumes that complications may arise only during labour but complications can arise at each stage of the pregnancy--early stages of pregnancy, the period immediately surrounding labour and delivery, and the postpartum period. The framework however, generally provides suggestions on the determinants of maternal mortality in some or all societies. These suggestions will therefore act as a general outline on which the relationship between women's rights and maternal health in the Ga District will be discussed. Since the framework provides an integrated analyses of issues concerning the status of women and maternal health it will serve as a guide in the preparation of the research instruments and in the collection of data for the study. Although the framework may not be able to address all issues affecting women's health and status in the Ga District, the outline it provided has discussed the major issues that affect women in general and so can be adopted for the study of women in the Ga District.

2.5.2. Conclusion

The views and opinions on maternal health and women's status show that issues affecting women are global. These views also show that factors affecting women's health and rights as well as status vary in different societies but discrimination against women is universal and need to be tackled at the global level to ensure the total development of women and society. Approaches to the elimination of discrimination against women may vary due to different perspectives and socio-economic and cultural background under which these discriminations operate. What is important, however, is that women need to be empowered through the elimination of obnoxious customs and traditions.

CHAPTER THREE.

RESEARCH METHODS, ISSUES FROM THE FIELD AND BACKGROUND CHARACTERISTICS OF RESPONDENTS

3.0. Introduction.

A major objective of this work was to examine some of the factors influencing women's reproductive rights and health in Ghana. Therefore, the methodology for the study is situated within their domestic arena. It should involve data collection from both males and females and observation of interaction between the sexes.

This chapter describes the approaches and methods used to collect data and some of the problems encountered in the field as well as the background characteristics of respondents. The chapter is divided into two sections. The first section outlines the data collection procedures including design of questionnaires and guides for in-depth interviews, observations and focus group discussions (FGDs), choice of sampling area and the sampling techniques used. The second section describes the background characteristics of the respondents.

3.1. Research Methods.

3.1.1. Source of Data.

Since reliable data on reproductive health issues have generally been difficult to obtain from a single source, both quantitative and qualitative techniques were used to collect the data for this study. For the quantitative method structured questionnaires were used to elicit information from respondents. The qualitative data technique made use of in-depth interviews, FGDs and observations. Qualitative techniques have become important in reproductive research because they enhance data obtained from the quantitative sources as well as elicit sensitive information on determinants of behaviour such as attitudes and social norms and the cultural context within which these behaviours occur (Helitzer- Allen et al, 1994).

Secondary sources consisted of data from libraries, hospitals, clinics and other institutions concerned with women's welfare such as the NCWD, the 31st December Women's Movement and Federation of Women lawyers (FIDA). These data, complemented the data obtained from the primary sources.

Table 3.1. Electoral Areas/Settlements where opinion leaders were chosen.

ELECRORAL AREAS/SETTLEMENTS	ASSEMBLYMEN	31ST DEC. WOMEN'S MOVEMENT
AMASAMAN (U)	1	
MADINA (U)	1	
PAPASI (F)	1	
DANFA (F)		1
BORTIANO (FF)	1	
AMANFRO-TOKUSE (FF)	1	1
KOKROBITE (FF)		1
ABOKOBI (F)	1	1
AJENKUTOKU (F)	1	
SHIAYENA (FF)	1	
WEIJA(U)	1	1
DOME (U)	1	1
TOTAL	**10**	**6**

Source: Fieldwork, GA District, 1999.Note: **U**= Urban communities, **F**= Farming communities, **FF**= Fishing Communities.

3.1.2. The Choice of Study Areas.

For the study, the settlements in the district were clustered into rural and urban, using population, type of occupation and the type of infrastructure as the basis. The sample frame was from the District Assembly Development Plan Document, which had a list of all settlements in the district with their respective population estimates up to 1997.

The basis for the classification of the settlements into urban and rural was population, type of infrastructural facilities available and the predominant occupation of the people in the settlements. For example, settlements without pipe borne water, electricity, schools and hospitals and where the predominant occupation of the inhabitants is either fishing or farming or both were considered as rural while the urban settlements were those with these facilities and inhabitants depended less on fishing and farming or both. Thus even though the population of some settlements was more than 5000, they were not included in the study because they were either predominantly farming or fishing communities or lacked basic infrastructural facilities such as pipe borne water, electricity, hospitals and schools. They were considered as "overgrown" villages and among them were Abokobi, Amasaman, Mallam, Obom and Ayimensa where respondents were chosen for either in-depth interview or FGDs. Selection of these settlements was mostly based on convenience. Thus data from these settlements were used for qualitative analysis rather than for testing any of the hypotheses.

The rural settlements were stratified according to occupation, mainly farming and fishing. One settlement from each occupational stratum was randomly selected. Thus, Kweiman (3,000) and Kokrobite (4,000) were selected to represent the farming and fishing communities respectively. The selection of settlements from each occupational stratum rested on the

assumption that different economic activities will yield different behavioural patterns, which would be amenable to comparisons. The urban settlements were put together and two [Weija (5,000) and Dome (6,000)] were selected randomly.

For each of the selected settlements, the average and total number of households in the area were estimated by multiplying the number of houses by an estimated average number of households in each house in the study areas. The estimated number of households came to 1500, 1250, 333 and 500 for Dome, Weija, Kokrobite and Kweiman respectively. To avoid the ambiguities associated with the interpretation of ''household'' and cater for the different living and sleeping arrangements among different ethnic groups in Ghana, the definition adopted for the study is ' a group of individuals who share the same living quarters and their principal meals' (IUSSP, 1982, cited in Awusabo-Asare, 1988).

3.1.3. Techniques of data collection

Two broad data collection techniques were used. These were quantitative and qualitative. The questionnaires used to collect the quantitative data were based on those prepared for the *Demographic and Health Survey, Infant, Child and Maternal Mortality Study in Ghana and Female Autonomy, Family Decision Making and Reproductive Behaviour study in*

Africa. There were two sets of questionnaires, one for females and the other for males. The questionnaire for the females was organised under eight sections. These were; background of respondents, marriage, economic status, health and fertility characteristics, knowledge and use of contraceptives, health facilities, housing and environmental sanitation and gender roles and women's rights. The questionnaire males was also organised under background of respondents, marriage, type of residence, pregnancy and childbearing, contraceptive use, communication, decision making, economic status and gender relations. These were administered to the 400 females and 300 males

For the qualitative data collection, forty-six respondents comprising opinion leaders and medical personnel were interviewed. These comprised 10 midwives (trained and TBAs) from the five health sub-districts, five doctors from the five health sub-districts, 10 nurses from the five health sub-districts, and 10 Assemblymen randomly selected from the Electoral Areas in the district. Out of the 10 Assemblymen, 2 were selected from 2 fishing communities, 4 from 4 farming communities and 4 from the urban communities. Also 6 local representatives of the 31st December Women's Movement (2 from fishing communities, 2 from farming communities and two from urban areas) were interviewed. Interview guides were prepared for all these categories of people to elicit their views on various issues concerning women in relation to their respective professions and positions.

The FGDs were organised in two series. The first series was incorporated into a workshop organised by UNFPA in collaboration with the 31st December Women's Movement for five communities in the District between 23rd and 25th April 1999. The programme which took three days treated topics such as violence against women, the intestate succession law, teenage pregnancy, sexually transmitted diseases, family planning and reproductive health for men and women at Kyekyerewere, Kwaku Panfo, Honi Oblikwa, Oyarifa and Kokrobite. The second series was organised for another five communities: four of these for women and one for men. It was found during the first series that women were not active participants. This is because both sexes were put together for the FGDs and this affected women's contribution in the discussions. They only reacted to contributions made by men through hooting. It was therefore considered appropriate to organise FGDs solely for women so that they could express themselves freely.

3.1.4 Sampling Techniques

It was estimated that at least one woman who has ever experienced pregnancy or childbirth would be found in a household in the study area. Given the total number of estimated households of 3583, 500 households were arbitrarily chosen to yield a required sample size of 400 female and 300 male respondents. The 500 allowed for households without eligible

females (females who had never experienced pregnancy or childbirth), absenteeism and households with only males. A proportional representation based on the population and households in the settlements selected was used to allocate sample sizes of respondents and households respectively for each selected settlement (see Tables 3.2)

3. 2 Houses and Sampled Household for the Survey.

Settlement	No. of houses (estimated)	No. of households (estimated)	No. of household per house (estimate)	Sampled households (Selected)
Kweman	227	500	2.2	70
Kokrobite	167	333	3.2	47
Dome	468	1250	2.0	174
Wieja	520	1500	2.2	209
Total	1382	3583		500

Source: Ga District Assembly

A systematic sampling technique was used to select houses from which one household in which one eligible person was selected for interview. Where there were more than one household in a selected house a simple random technique was used to select a household from which one eligible woman was also selected randomly. The same procedure was adopted to select the 300 male respondents who were not necessarily husbands of women selected.

Seven hundred respondents made up of 400 females and 300 males were targeted for the study. Males were also included in the study in order to obtain information on their background characteristics and views that

could be of relevance in explaining the relationships. The 700 respondents constituted 0.25 per cent of the population. Considering the nature of the study, time, logistics and budgetary constraints the number was deemed appropriate for the study. More women than men were chosen for the study because the focus was on women. Women are more likely to describe their own health situation and for that matter in a position to give more accurate information on their health than men. They are also easier to contact and more likely to co-operate than men (Agyei-Mensah, 1997).

3.1.5. Evaluation of Data.

Data from retrospective events and sensitive issues such as gender relations and reproductive health are often prone to inconsistencies. For example, obtaining reliable retrospective information assumes that there is proper record keeping of vital demographic events and experiences. In this section, some of the problems relating to the quality of data and how they were dealt with to make the data useable are outlined below.

3.1.5.1. Age Misreporting.

The distribution of respondent's age revealed some level of age heaping on digits ending in 1, 2, 0 and 5. This phenomenon may have been due to either digit preference or using some national events such as the 31st

December Revolution in 1981 and the 1992 Presidential and Parliamentary Elections as reference points. The age misreporting was cross-checked and corrected by comparing the age at first birth with age of first child or comparing age at last birth with current age. There were cases of husbands having lower ages than their wives. It was observed that this was due to the levirate system whereby some of the men inherited older wives from their brothers. Also, some respondents used 'plenty' and 'so many times' to indicated the number of times they consulted health personnel during pregnancy; thus, making it difficult to quantify the frequency with which women visited antenatal care during pregnancy.

3.1.5.2. Attitude of Respondents.

Another issue that affected the data quality and collection was the general attitude of respondents toward the study. Some respondents wanted gifts before they would respond to the questionnaires. They did not understand why they were given gifts for a research that took place prior to this one but were not given anything for this. They, therefore, suspected a deal between the Assemblyman who assisted in the survey and the researcher. They later co-operated with the research assistant after I had explained to them that, I am a student and so had no money to buy gifts for them. Many respondents also complained of time because they felt the questionnaire was too long. In fact, it took three to four days to complete questionnaires

for some respondents because they did not have enough time to complete the questionnaires in a day. These greatly affected the response rate and delayed the work by an additional month.

3.1.5.3. Concepts and Language Barrier.

Demographic concepts have different meanings in different socio-economic and cultural settings. One must therefore have adequate knowledge of the concepts and be able to interpret them to give the meaning they intend to carry. Relationships such as sister, brother and uncle were difficult to define because of the extended family system. To avoid ambiguities associated with relationships such as sister or brother in the area a sister or bother was defined as "someone born to the same mother or father". The qualification ''sisters born to the same mother'' also helped to reduce confusion enshrined in the term 'sister' which in Ghanaian context, can refer to cousins, that is daughters from paternal and maternal Uncles and Aunts. These minimised the problems that would have arisen in trying to collect data on households and sisters.

Related to the above was a language barrier between the researcher and the population. Ga was the major medium of communication in the study area. This requires that one understands and is able to speak the Ga language fluently to make communication effective. However, the

researcher did not understand the Ga language. Thus, a direct communication between respondents and the researcher was somewhat hindered, particularly among respondents who also could not understand Twi. An interpreter had to be employed for the FGDs since most people spoke in Ga. The use of research assistants from the localities greatly minimised the problem that would have been encountered with regard to this issue.

3.1.5.4. Partner's Interference.

The presence of the partner of a respondent during interview seems to have influenced some of the answers given by the respondents on issues considered as sensitive. Men, in particular, often attempted to influence the answers provided by their wives, especially, when they felt that the answers were not in their favour. On certain occasions arguments between spouses disrupted interviews when husbands interrupted to correct what they considered false accusations. Some respondents were therefore cautious of the answers they gave when their partners were present. In some cases, respondents refused to answer questions they considered sensitive to the stability of their marriage in the presence of their partners. To avoid any possible interruption or confrontation between partners, interviews were sometimes rescheduled to take place when the opposite sex was absent.

3.1.5.5. Nature of Questions

The nature of the study demanded asking questions which tended to delve into what was considered by many respondents as private. Thus, some respondents refused to answer those questions which they thought bordered on their sexual behaviour and relationship with spouses. There were instances where respondents were changed because they refused to continue with the interview, perceiving the questions asked to be either against their religious beliefs, customs and traditions or too private for a stranger to know. Those questions, which were not answered during the interview schedules, were discussed at length during the FGDs in a more relaxed atmosphere. This minimised the shortfalls that had occurred in the questionnaire administered. Despite the problems encountered on the field, a response rate of 82.2 per cent (Table 3.3) was achieved.

Table 3.3. Population and Response Rate of Survey Localities.

Settlement	Population (1997) *	Sample Size		Total	Response Rate
		Male	Female		
Keiman	3,000	50	67	117	98 (83.3)
Kokrobite	4,000	67	89	156	130(83.3)
Dome	6,000	100	133	233	172 (73.8)
Weija	5,000		111	194	177 (91.2)
Total	18,000	300	400	700	577(82.2)

*** Projections made by District Planning Office**

Source: From Field Data, 1999.

3.2. Background Characteristics of Respondents.

Knowledge of the background characteristics of respondents is important because of the implications these characteristics have on a wide range of issues including decision-making on demographic factors. Among the critical socio-demographic and economic variables are age, marital status, parity, place of residence, religion, education and occupation. For instance, age and sex influence perception and decision-making on sexuality and reproductive health.

3.2.1. Age Distribution.

Slightly more than half of the female respondents (54.5 per cent) were within the 20-39 age group, a proportion consistent with what exists in the country (Ghana, 1995). The low proportion of females in the 15-19 age group (0.3 per cent) was possibly due to the difficulty in identifying eligible women within this age group. It is also possible that age misreporting might have contributed to this situation; that is, some might have inflated their ages because they did not want to be associated with teenage pregnancy. For the male population, about 69 per cent were in the 20-44 age group, 5.1 per cent in the 15-19 cohort and 26 per cent within the 45-60 and above age group. (Table 3.4). While there were more females (29.3) than males (20.9 per cent) in the 15-29 age group, there were fewer females (11.7 per cent) than males (19.3 per cent) in the 55-

60+ age group. This unexpected situation is probably due to problems associated with the data collection process or age misreporting by respondents.

Table 3.4. Age-Sex Distribution of Respondents.

AGE	FEMALE		MALE		TOTAL	
	FREQ	%	FREQ	%	FREQ	%
15-19	1	.3	13	5.1	14	2.4
20-24	34	10.5	21	8.3	55	9.5
25-29	60	18.5	19	7.5	79	13.7
30-34	38	11.7	56	22.1	94	16.3
35-39	45	13.8	38	15.0	83	14.4
40-44	41	12.6	40	15.8	81	14.0
45-49	45	13.8	6	2.4	51	8.8
50-54	22	6.8	11	4.3	33	5.7
55-59	11	3.4	17	6.7	28	4.9
60+	27	8.3	32	12.6	59	10.2
NO	**324**	**100**	**253**	**100**	**577**	**100**

Source: Field Data, 1999

3.2.2. Marital Characteristics.

Out of the total of 557 respondents, more than two-thirds (72.5 per cent) were married. The rest were either separated, never married, divorced or widowed. The highest proportion of widows (31.9 per cent) was among those aged 60 years and above (Table 3.6). As shown in Table 3.6., almost 80 per cent of those married were 20-49 years while only 0.2% of those in the 15-19 age group were married. More females (83.8 per cent) than males (73 per cent) were currently married. Also there were more widowed men (8.6 per cent) than widowed women (3.3 per cent), contrary to what has been observed from other studies in the country. For instance,

the GDHS result, showed a relatively lower proportion of widowed men (0.6 per cent) than women (1.8 per cent). This situation could probably be either an artifact of the data or most of the women who lost their husbands remarried.

Table .3.5. Marital Status of Respondents by Sex

MARITAL STATUS	FEMALE	MALE	TOTAL
Never Married	4.6	7.3	8.1
Widowed	3.3	8.6	10.7
Married	83.8	73.0	72.8
Divorced	3.3	7.0	5.9
Separated	5.0	4.1	2.4
TOTAL	**100.0**	**100.0**	**100.0**
N	**324**	**253**	**577**

Source: Field Data, 1999

Table 3.6. Marital Status of Respondents by Age

Age	NEVER MARR	WID	MARRIED	DIVOR	SEPARATED	TOTAL	NO
15-19	—	—	100.0	—	—	100.0	1
20-24	27.6	5.2	65.5	1.7	—	100.0	58
25-29	12.3	2.5	64.2	13.6	7.4	100.0	81
30-34	4.7	12.8	77.9	4.6	—	100.0	86
35-39	3.8	1.3	88.5	5.1	1.3	100.0	78
40-44	7.2	14.0	67.7	12	—	100.0	99
45-49	11.8	—	74.5	—	13.7	100.0	51
50-54	—	13.6	86.4	—	—	100.0	22
55-59	—	20.7	79.3	—	—	100.0	29
60+	1.7	31.9	63.9	2.8	—	100.0	72
TOTAL	8.1	10.7	72.5	5.5	2.4	100.0	
NO	47	62	420	34	14	100.0	577

Source; Field Work 199

3.2.3. Place of Residence and Religion.

Table 3.7. Religion of Respondents by Place of Residence.

RELIGION	TOWN/VILLAGE								TOTAL (N)	
	KWEIMAN		KOKROBITE		DOME		WEIJA			
	F	M	F	M	F	M	F	M	M	F
TRADITIONAL	10.3	6.4	6.1	6.3	8.0	6.9	20.5	16.0	20	38
CATHOLIC	20.7	10.6	10.6	9.4	2.0	_	9.3	22.0	22	25
ANGLICAN	_	6.4	_	6.3	23.0	19.4	10.3	12.0	27	34
METHODIST	31.0	17.0	_	15.6	20.0	22.2	20.5	22.0	45	64
PRESBY	31.0	34.0	19.7	40.6	10.0	22.2	15.9	12.0	64	47
PENTECOST	7.0	_	16.7	_	15.0	13.9	5.6	6.0	13	76
MOSLEM	_	25.5	47.0	21.9	21.0	11.1	5.6	4.0	56	27
ASSEMBLIES	_	_	_	_	1.0	4.3	_	6.0	6	1
BAPTIST	_	_	_	_	_	_	11.2	—	—	12
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**		
NO	**29**	**47**	**66**	**64**	**100**	**72**	**107**	**70**	**253**	**324**

Source: Field Data, 1999

The data showed that Christians constituted 75.5 per cent of the respondents. Adherents of orthodox Christian faith constituted the largest Christian sect (56.8 per cent) while others including Pentec stals and Spiritualist formed about 27 per cent. Ten per cent were Traditionalists and 14.4 per cent were Moslems. Table 3.7 shows that the religious practices among the settlements also differed. Weija had the largest proportion of those who profess Traditional Religion (17.5 per cent). At Kokrobite and Kweiman Christianity was the dominant religion, while the highest concentration of Moslems was found at Dome. This is probably due to the fact that Dome had the highest concentration (21 per cent) of people from Northern Ghana (Grushi, Grumah, Hausa and Mole-Dagbani)

who are mostly Moslems. Although about three-quarters of the people, particularly the Ga reported Christianity, the Traditional religion still wields much influence, and many people believe fervently in both.

3.2.4. Ethnicity

The predominant ethnic group in the area was Ga-Adangbe (Table 3.8). About 28.9 per cent of the respondents were Ga-Adangbe and formed more than one-third of the population of Kweiman (44.9 per cent) and Kokrobite (47.1 per cent). The second largest (23.5 per cent) were the Akan ethnic group. Dome and Weija exhibited heterogeneous characteristics in terms of ethnicity, with people from all over the country. This is probably because the two settlements are settled areas that have attracted people from all over the country.

Table 3.8. Ethnicity of Respondents by Area of Residence

ETHNICITY	TOWN/VILLAGE				
	KWEIMAN	KOKROBITE	DOME	WEIJA	TOTAL
	%	%	%	%	(%)
GUAN	31.6	32.1	6.2	19.6	17.4
GA-ADANGBE	44.9	47.1	24.2	12.2	28.9
EWE	15.3	13.5	15.5	24.8	16.4
AKAN	4.1	3.8	34.2	23.4	23.9
MOLE-DAGBANE	4.1	3.5	19.9	20.0	13.4
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
NO	**98**	**130**	**172**	**177**	**577**

Source: Field Data, 1999

3.2.5. Education

The data from the study revealed striking differences in educational attainment between sexes and among settlements. Generally, the educational level of males was higher than their female counterparts (Table 3.9). Whereas about 13 per cent of the males had not had any formal education, the proportion for the females was about 20 per cent. Also, males who had attained tertiary level education were 9 per cent but only 4 per cent of the females said they had attained that level. Females and males with Middle/JSS and Senior Secondary/Vocational/Technical School education constituted 64 and 58.5 per cent respectively. At the residential level, 22.8 per cent of those from Kweiman and 25.4 per cent of those from Kokrobite had no formal education compared to 6.6 per cent for both Dome and Weija (See Tables 3.9 and 3.10). The level of formal education at Dome and Weija was higher than Kweiman and Kokrobite because the former were urban settlements where people are informed about the benefits of education, are able to pay for it and have access to quality education

Table 3.9. Educational Attainment of Respondents by Sex.

EDUCATIONAL LEVEL	FEMALE	MALE
	PERCENTAGE	PERCENTAGE
NO FORMAL EDUCATION	20.4	12.6
PRIMARY	2.5	2.4
MID/ JSS	40.9	41.1
SSS/COM/VOC/TECH	23.1	17.4
TRAINING/NURSING/POLY	9.1	17.4
UNIVERSITY/DIPLOMA	4.0	9.1
TOTAL	**100.0**	**100.0**
NO	**324**	**253**

Source: Field Data, 1999

Table 3.10. Educational Attainment of Respondents by Residence

EDUCATIONAL LEVEL	TOWN/VILLAGE								TOTAL	
	KWEI		KOKROB		DOME		WEIJA			
	M	F	M	F	M	F	M	F	M	F
NO FORMAL EDUCATION	31.9	13.8	26.7	24.2	4.2	9.0	--	10.3	12.6	19.4
PRIMARY	--	5.9	--	6.1	6.9	5.0	--	1.9	2.4	6.5
MID/JSS	46.9	27.4	50.0	12.1	22.2	22.0	45.7	10.3	41.1	41.0
SS/CO/VOC/TEC	14.8	--	9.4	--	34.7	18.0	11.4	23.4	17.4	23.1
TR./NURG/POLY	4.3	5.9	9.4	6.1	27.8	--	22.9	6.5	17.4	5.9
UNIV/DIPLOMA	2.1	47.0	4.5	51.5	4.2	46.0	20.0	47.6	9.1	4.0
TOTAL	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
NO	**47**	**51**	**64**	**66**	**72**	**100**	**70**	**107**	**324**	**253**

Source: Field Data, 1999

3.2.6. Economic Activity

The economic activities in the area can be broadly classified into trading/business, salary earners/government employees, farmers, fishermen/fishmongers, food sellers, artisans and the unemployed.

Farming and fishing were the major occupations of the people in the area. About two- thirds (61.5 per cent) of both males (35.6 per cent) and females (25.9 per cent) population were engaged in these occupations. There were however more females (23.8 per cent) engaged in trading/business than males (11.5 per cent). The proportion of unemployed females (15.3 per cent) was more than that of the males (10 per cent). This is probably due to the fact that females have no access to resources to enable them to enter into productive ventures. Contrary to expectations, the percentage of women engaged in paid employment (22.3 per cent) as compared to males (28.2 percent) was quite high. However the female paid workers constituted mainly teachers, secretaries and messengers whilst males were in what may be termed as more lucrative occupations such as managerial positions, in financial and public institutions (Table 3.11).

Table 3.11. Occupational Status of Respondents by Sex.

OCCUPATION	MALE	FEMALE	TOTALS
	PERCENTAGE	PERCENTAGE	
FAMERS	17.5	11.4	14.4
FISHERMEN/FISHMONGERS	18.2	14.5	16.5
TRADERS/BUSINESSMEN	11.5	23.8	17.6
SALARYEARNERS/GOV'T EMPLYEES	28.2	22.3	25.3
ARTISANS	13.8	9.0	11.4
FOOD SELLERS	0.8	3.7	2.3
UNEMPLOYED	10.0	15.3	12.6
TOTAL	**100.0**	**100.0**	**100.0**
NUMBER	324	253	577

Source: Ga District Survey, 1999

3.2.7. Summary

The data revealed that about 55 per cent of the females and 70 per cent of the males were within the reproductive age group. The proportion of respondents who were married was about 73 per cent and those who had divorced was 5.9 per cent. Education for males was observed to be higher than that of the females as 12.6 per cent of the males compared with 19.4 per cent of the females had not had any formal education. Farming and fishing were the most prominent occupations in the area as about a third of the respondents were engaged in these occupations.

3.3. Accessibility and Utilisation of Health Care Services by Respondents.

As indicated earlier, there is no District Hospital or Polyclinic in the Ga District. Maternal and Child Health and Family Planning are provided by the three health centres in the District, at the Communicable Disease Hospital at Weija and the five purely MCH Clinics at Amasaman, Danfa, Madina, Obom and Weija.

Table. 3.12. Average Distance from Respondents to Health Centre.

Distance	Frequency	Percentage
Half a Kilometre	76	30.3
One Kilomtre	41	16.3
1.5 Kilometres	19	7.6
2.0 Kilometres	29	11.6
2.5 Kilometres	53	21.1
3 Kilometres	31	12.4
4.5 Kilometres	1	0.4
6 Kilometres	1	0.4
Total	**251**	**100.0**

Source: Field Data, 1999.

Although the Ga District has no hospital or polyclinic, residents living near the border with AMA such as Dome, Madina and Weija have access to health and other facilities in Accra than those situated in the District.

The estimated average distance travelled by respondents to these health facilities in the District was 3.2kms. The distances however, ranged

between half a kilometre and six kilometres. While about 87.0 per cent of the women lived between half to 2.5 kilometres away from health facilities the rest (14.1 per cent) were more than 3 kilometres away (Table 3.12). However, periodic outreach programmes for monitoring and immunisation services by the District Health Management Team have to reduce the effect of distance for the rural population. For example, in 1998, 265 communities covering 83 per cent of the rural population were served through 257 Outreach Points (Ga District Health Department, 1998). This has made it possible for most rural communities who are far away from a health centre to have access to health care. Table. 3.13 shows the mean distance to health centres by type of residence.

Table 3.13. Mean Distance to Health Centre by type of Residence.

SETTLEMENT	MEAN DISTANCE (KM)
KWEMAN	4.13
KOKROBITE	4.10
DOME	1.5
WEIJA	3.48
AVERAGE	**3.2**

Source: Field Data, 1999.

3.3.1. Antenatal Consultations

About an average of 76.2 per cent of the women interviewed had visited an antenatal clinic during their first pregnancy (Table 3.14). The table

below shows that more women in Dome and Weija than Kweiman and Kokrobite had received antenatal care during their first pregnancies.

Table. 3.14. Antenatal Consultations During First Pregnancy by Type of Residence.

TOWN/VILLAGE	YES	NO	TOTAL	NUNMBER
KWEIMAN	68.8	31.2	100.0	51
KOKROBOTE	65.6	34.4	100.0	66
DOME	91.5	8.5	100.0	100
WEIJA	78.7	21.3	100.0	107
AVERAGE	**76.2**	**23.8**	**100.0**	**324**

Source: Field Work, 1999.

The percentage of women who had had antenatal consultations during their first pregnancies at Kweiman and Kokrobite areas was 68.8 per cent and 65.6 per cent respectively, while the proportions were 91 per cent and 78.7 per cent for women in Dome and Weija respectively.

About 51 per cent of women who attended antenatal care consulted medical doctors, 30 per cent visited midwives and nurses, 13.4 per cent visited TBAs and 4.5 per cent consulted traditional priests/priestesses. The percentage of women who consulted doctors were Dome, 54.2 per cent, Weija, 61.5 per cent Kweiman 43.1 per cent and Kokrobite, 46 per cent. However, the percentage of women who consulted Traditional priests/priestesses were 13.8 per cent and 8.6 per cent for Kweiman and Kokrobite respectively, but none of the women at Dome and Weija had

consulted these sources for antenatal care. These rural-urban differentials in antenatal health seeking behaviour of women is probably due to differences in their perception of health, and disparities in their ability to pay for health care.

Table 3.15. Visits to Antenatal Care by Women by Residence and Educational status

	MEDICAL DOCTOR.	NURSE/ MIDWIFE	TBA	TRAD.PRIEST PRIESTESS
RESIDENCE				
Kweiman	43.1	18.6	24.4	13.8
Kokrobite	46.0	20.7	24.8	8.6
Dome	54.1	46.3	0.0	0.0
Weija	61.5	34.0	4.5	0.0
Average	**51.0**	**30.0**	**13.4**	**5.6**
EDUCATIONAL STATUS.				
No Education	27.2	22.3	36.8	21.5
Primary	26.3	44.2	27.8	0.0
Middle/JSS	48.4	30.9	15.6	12.0
SSS/Com/Voc/Tec	49.5	44.5	0.0	0.0
Tr./Nur./Poly	55.2	37.5	0.0	0.0
Univ./Diploma	100.0	0.0	0.0	0.0
Average	**51.0**	**30.0**	**13.4**	**5.6**

Source: Field Data, 1999

It appears educational attainment also influenced women's choice of antenatal care because none of the women who had attained Post Secondary education and above had consulted either TBAs or traditional priests/priestesses. However, 11.5 per cent and 32.8 per cent of those who had no formal education had consulted traditional priests/priestesses and

TBAs. It is therefore likely for women with higher formal education to receive better health care than those with lower or no formal education.

Since the time and number of consultations made during pregnancy are important for the welfare of the mother and child, respondents were asked to state the number of times and the stage of the pregnancy when the first consultation was made. About 11 per of the women in the area started their first antenatal consultations during the first month of pregnancy. The percentage increased to about 26 per cent in the fourth month and started declining to about 4.1 per cent in the 10^{th} month. It should be noted that normal pregnancy does not go beyond ten months. The 4.1 per cent who indicated that they had attended antenatal care in their tenth month may have wrongly calculated the duration of their pregnancies or were probably the few cases that went beyond nine months. At the residential level, about 2 per cent of rural women and 3.5 per cent of urban women had attended antenatal care in the first month. In the third month, however, the percentage rose to 6.4 per cent for rural women and 5.3 per cent for urban women. Antenatal consultations started declining from the fourth month for rural women and in the fifth month for urban. For instance, there were no consultations in the sixth and seventh months for rural women while only 0.6 per cent and 2.6 per cent of the urban women had made antenatal consultations in the sixth and seventh months respectively. There were no antenatal consultations in the eighth and ninth

months for women in all the settlements (Table 3.16). The modal number of visits made was 5 times although about 60 per cent of the women visited antenatal care for more than ten times.

Table 3.16. Time of Antenatal Consultations by Place of Residence

No. of Months of pregnancy.	Kweiman	Kokrobite	Dome	Weija	Total
One	1.8	2.3	3.5	3.5	11.1
Two	1.8	1.8	6.4	3.5	13.5
Three	5.3	7.6	4.1	7.6	24.0
Four	3.5	4.1	12.3	5.4	26.3
Five	3.5	4.1	3.5	3.5	14.6
Six	--	--	1.2	--	1.2
Seven	--	--	5.3	--	5.3
Eight	--	--	--	--	--
Nine	---	--	---	--	--
Ten	1.8	2.3	---	--	--
Total	**17.5**	**22.2**	**36.3**	**24.0**	**100.0**
Number	**30**	**38**	**62**	**41**	**171**

Source: Ga, District Survey, 1999.

Traditional Birth Attendance (TBAs) were the most popular personnel who assisted with deliveries. At all parity levels, TBAs were the dominant personnel who assisted with deliveries because more than 50 per cent of the deliveries were supervised by them. This was followed by medical doctors, while trained midwives/nurses were the least utilised personnel

(Table 3.17). This is probably because TBAs are most accessible socially, economically, and in terms of distance.

Table 3.17. Personnel Assisted Deliveries by Parity

PERSONNEL	PERCENTAGE DELIVERIES BY PARITY					
	First	Second	Third	Fourth	Fifth	Sixth
TBA	52.7	64.6	68.3	61.0	56.9	77.1
MED. DOC.	29.9	22.2	19.2	20.0	30.8	20.8
TR.MIDWIFE	17.4	13.3	12.5	18.3	12.3	2.1

Source: Field Data, 1999.

3.3.2. Postnatal Care

Postnatal care which include visits to health care centres within six weeks after delivery are also important for both mother and child. Responses to questions on postnatal visits indicate that about 40 per cent of mothers had received postnatal care of which trained TBAs attended to about 50 per cent (Table 3.18). These figures were higher than the district average for 1998, which put the average percentage of those who had received postnatal care at 31.5 per cent out of which 41.4 per cent consulted trained TBAs.

The reported likelihood to seek postnatal care was about the same for the women in rural (49.8 per cent) and urban (50.2 per cent) areas. However, the women in rural areas (60.7 per cent) were more likely to consult TBAs for postnatal care than urban women (39.2 per cent) (Table 3.18). The educational attainment of women also influenced their decision to consult

or not to consult someone for postnatal care. About 60 per cent of women who had had University/Diploma education sought postnatal care from Doctors. Women who had not had any formal education and those with education below Senior Secondary/Technical/Vocational/Commercial level constituted about 35 per cent of the total postnatal consultations made but formed about 75 per cent of the total TBA consultations (Table 3.19).

Table. 3.18. Postnatal Consultations by Place of Residence and Type of Personnel.

SETTLEMENT	TYPE OF PERSONNEL CONSULTED.		
	TBA	MEDICAL DOCTOR	TRAINED NURSE
KWEIMAN	60.9	29.1	10.0
KOKROBITE	60.5	28.3	11.2
DOME	40.2	49.5	10.3
WEIJA	38.0	50.3	11.7

Source: Field Data, 1999

Table 3.19 Postnatal Attendance by Educational Attainment

EDU. LEVEL	TYPE OF PERSONNEL CONSULTED			
	MED. DOC	MIDWIVE	TBA	TOTAL
NO FORMAL EDUCATION	32.6	27.2	40.2	100.0
PRIMARY	35.0	30.9	34.4	100.0
MID/JSS	37.2	31.9	30.9	100.0
SSS/COM/TEC	32.5	30.8	36.7	100.0
TR./NUR/POLY	35.2	28.9	53.9	100.0
UNIVERSITY	39.2	20.6	40.0	100.0

Source; Field Surve

3.4. Summary and Conclusion.

The fieldwork, which started on the 11th July, 1999, lasted three months instead of two months due to the process of data collection.

Two sets of questionnaires designed separately for males and females were used to collect data. The questionnaires relied heavily on the 1993 Ghana Demographic and Health Survey Data (GDHS). Other methods used to collect primary data were FGDs and in-depth interviews. Secondary data from the District Health Centre, Women Organisation and the District Planning Office were used to complement these methods.

The FGDs provided good data on social norms but not very good data on deviations from these norms. An in-depth interview was therefore necessary for eliciting data on knowledge and experiences of women.

Fifty-five per cent of the females and 69 per cent of the males were in the reproductive age group, out of which 80 per cent were married. Christianity was the main religion in the area, constituting about 76 per cent of the respondents, whiles, traditionalists accounted for 10 per cent. The most predominant ethnic group in the area were the Ga-Adangbe. They constituted about 46 per cent of the population of Kweiman and Kokrobite which are indigenous Ga settlements.

Generally, more males had had formal education than females in the area. For example, whereas about 13 per cent of the males had not had any formal education, the figure for the females was about 20 per cent. Also there were more people in rural areas who had not had formal education than in urban areas. Farming and fishing were found to be the major economic activities in the area. About one-third of the population were engaged in these activities.

Medical doctors were the main form of antenatal consultation for women. For instance, 51 per cent of the women consulted medical doctors. Educational attainment seems to have influenced choice of antenatal care. Whereas doctors and nurses were the only health personnel who were consulted by those who had attained post-secondary education and above, 36.8 per cent and 21.8 per cent of those without any formal education had consulted TBAs and traditional priests/priestesses.

In the next chapter, attempts would be made to explore how the issues discussed affect women's decision-making on sexuality and reproductive health.

CHAPTER FOUR

RGHTS, DECISION MAKING AND FERTILITY

4.0. Introduction

In every society the different roles performed by men and women, and the associated rights and responsibilities greatly influence gender relations. Men are the primary decision-makers on sexual activity, fertility and contraceptive use. Thus, females have been excluded from decision-making at all levels of public and domestic affairs. While men have the right to decide freely and exercise control over their lives, the reverse is true for women. Patriarchal social structures have deepened women's economic dependence on men and increased their vulnerability and have thus contributed to their inability to assert control over their reproductive rights and sexual lives. The traditional gender subordination, for instance, leading to inequalities in power often make women vulnerable to men's risky sexual behaviour.

This chapter discusses the position of women vis-à-vis men in the society by examining their level of participation in decision making, ownership of property, control over their lives and the extent to which they communicate with their husbands. It also examines factors, which influence women's decision making on maternal health care.

4.1. Gender Roles.

Gender roles are the expectation of society regarding the behaviour of men and women. These are activities, behavioural patterns and responsibilities which male and females are expected to exhibit (Oheneba-Sakyi and Awusabo-Asare, 1999). Any contradictions to these expectations may be regarded as a deviation from the norm. Gender roles are culturally specific and do influence reproductive decision making and behaviour. This section explores the attitude of men and women toward gender role activities and assesses the individual's perception on what is considered the appropriate gender roles and activities for men and women: how the rights and responsibilities associated with gender roles affect men and women's decision-making on reproduction and sexuality.

4.1.1 Ideal Household Chores and Family Responsibilities for Men and Women.

Both men and women were asked to state what they considered to be the appropriate household chores, the family responsibilities, and the ideal occupation for men and women. Respondents' views on the appropriate household chores for women and men are presented in Table 4.1 and 4.2.

Table 4.1. Appropriate Household Chores for women by Place of Residence.

HOUSEHOLD CHORES FOR WOMEN.	URBAN (%)		RURAL (%)		URBAN (N)		RURAL(N)	
	M	F	M	F	M	F	M	F
COOKING	38.9	40.1	39.2	41.5	71	98	61	49
WASHING CLOTHES	20.3	23.1	20.2	22.4	37	56	31	26
SWEEPING THE HOUSE	10.5	11.2	11.0	12.3	19	27	17	14
WEEDING AROUND THE HOUSE.	5.1	3.2	5.5	3.3	9	8	8	4
FETCH WATER	9.0	9.2	12.3	11.5	16	22	19	13
CARE FOR CHILDREN	11.4	11.3	5.7	4.0	21	28	9	5
IRONING	4.1	1.4	3.0	0.9	8	3	5	1
OTHERS	0.7	.5	4.1	4.1	2	2	6	5
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**183**	**244**	**156**	**117**

Source: Field Data, 1999.

Table 4.2. Appropriate Household Chores for men by Type of Residence.

HOUSEHOLD CHORES FOR MEN.	URBAN(%)		RURAL(%)		URBAN (N)		RURAL (N)	
	M	F	M	F	M	F	M	F
COOKING	8.9	10.1	5.2	4.3	16	25	8	5
WASHING CLOTHES	19.5	23.0	2.2	1.2	38	56	3	1
SWEEPING THE HOUSE	3.0	2.3	.9	.5	5	6	4	1
WEEDING AROUND THE HOUSE	20.6	22.4	35.5	39.0	37	54	55	46
FETCH WATER	8.2	10.2	12.3	8.3	15	24	19	10
CARE FOR CHILDREN	11.0	14.3	21.2	25.0	20	35	33	29
TEACH CHILDREN	8.0	11.1	10.6	9.4	15	27	16	11
IRONING	15.1	5.6	8.0	10.2	27	14	12	12
OTHERS	5.7	1.3	4.1	2.1	10	3	6	2
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**183**	**244**	**156**	**117**

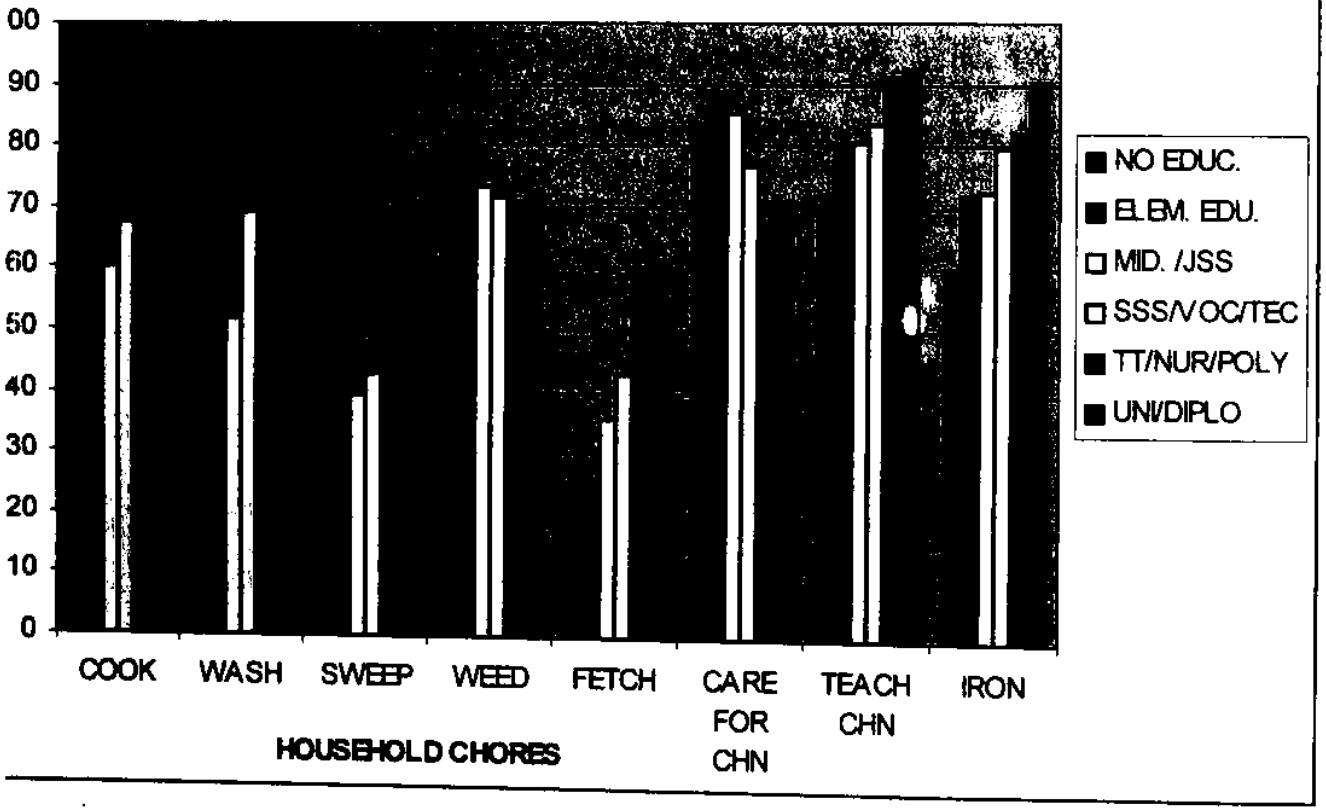
Source: Field Data, 1999.

The main reported household chores for women in both urban and rural areas were cooking, washing clothes, sweeping the house, fetching water, caring for children, weeding around the house and ironing. More than one-third of women in both urban and rural areas mentioned cooking as the most appropriate household chore for women. In addition, more women than men, regardless of place of residence, saw cooking, washing clothes and sweeping as their major household chore. For instance, 34.3 per cent of women and 30.8 per cent of men in urban areas felt washing clothes and sweeping were household chores for women. About 12 per cent of respondents in rural areas and only 9 per cent in urban areas regarded fetching water in the house as a household chore for women. The relatively low importance attached to this activity in urban areas may be due to the presence of pipe-borne water in many houses, thus reducing its importance as an activity needing much time and effort. On the other hand, reliance on ponds, streams and wells sited away from homes makes fetching water in rural communities an important household activity for women.

The main household chores for men (Table 4.2) were weeding around the house, washing clothes, ironing and caring for children. Sweeping, fetching water and cooking were not regarded as important household chores for men in both rural and urban areas. Only 3.0 and 2.3 per cent of the urban males and females respectively and 0.9 and 0.5 per cent of the

rural male and females respectively considered sweeping as an appropriate household chore for men. Also, only about 10 per cent of the urban residents and about 5 per cent of rural residents felt cooking was appropriate for men. About 22 per cent of urban residents and 37.3 per cent of rural residents felt that weeding around the house was the most appropriate household activity for men, and a higher percentage of rural women (39.0 per cent) than urban women (22.4 per cent) mentioned this activity.

DIAGRAM 4.1. HOUSE CHORES FOR MEN BY EDUCATIONAL ATTAINMENT



Source; Field Data, 1999.

Diagram 4.1 shows appropriate household chores by educational background of respondents. It indicated that those who had attained post-secondary level were more likely to perceive it as normal for men to perform household chores generally considered a preserve for females. For instance, while over 70 per cent of those who had attained education beyond post-secondary level considered cooking and washing clothes as appropriate household chores for males, about two-thirds of those with education below post-secondary level and 80.7 per cent of those without any formal education felt these were not appropriate household chores for males. However, 59.0 per cent of those who had had post-secondary education and below and resident in urban areas compared to 12.6 per cent of their rural counterparts thought it was appropriate for men to cook and sweep the house. Thus, although there is evidence that people still consider many household chores as the preserve of females, this perception is more predominant in rural than in urban areas. While higher attainments in formal education and modernisation might have influenced males in urban areas to help their wives, traditional norms and living arrangements in rural areas may not encourage males to perform roles that were traditionally the preserve of females.

Respondents were further asked to give reasons why they felt men should or should not perform household chores preserved for women. Whereas the women in urban areas felt it was a responsibility for men to take part

in household chores so as to reduce the burden of women, the women in rural area felt that men should help in order to prepare them for emergencies and to indicate their love for the women (Table 4.3). For example, about three-quarters of the women from urban areas thought men should partake in household chores because it was a responsibility for men to reduce the burden on women, and as a right of equality which should be given to women. For rural women, it was a sign of love (31.9 per cent) and in the interest of men (during emergencies, 18.2 per cent) to perform certain household chores. With respect to why men should not take part in household chores, the major reasons given by women from urban areas were that, "the man is head of the family" (20.3 per cent), "men do not stay home" (17.2 per cent), "it is the women's duty" (16.6 per cent) and "men will never do it" (10. 6 per cent). Forty-seven per cent could not assign any reasons why men should not take part in household chores. Rural women felt one of the reasons for being married was to perform these functions and so there was no need for men to take part in household chores.

Table 4.3. Respondents' Views on Performance of Household Chores.

REASONS TO PERFORM	RURAL(%)	URBAN(%)
1. It is a responsibility of men to help	9.2	30.2
2. To reduce the burden of women	12.3	20.3
3. Helps during emergencies	18.2	12.3
4. Equality	9.2	20.2
5.Men can also do them so they should help	12.4	9.1
6. It shows love.	31.9	5.7
7. No reason	6.8	2.2
REASONS NOT TO PERFORM		
1. Men have no time	12.3	6.3
2. Men do not stay in the house	4.5	17.2
3. Women's duty	42.1	16.6
4 Man will never help	15.1	10.6
5. Against tradition (is not force)	10.2	1.2
6. Men are expected to provide household needs.	11.2	0.8
7. It is not proper for the head of the family to do that	14.6	20.3
8. No reason	--	47.0

Source: Field Data 1999.

Both men and women regardless of place of residence considered the upbringing of children and preparing food for the family as a responsibility for women. As indicated in Table 4.4 more than one-third of the respondents in urban areas considered rearing of children and preparing food for the family as the major responsibility of women.

Table 4.4 Appropriate Family Responsibilities of Men and Women by Place of Residence.

RESPONSIBILITIES FOR WOMEN	URBAN(%)		RURAL(%)	
	WOMEN	MEN	WOMEN	MEN
Caring for children	20.2	23.6	25.2	25.6
Prepare food for family	20.4	19.9	22.7	23.8
Cleaning the house	13.5	12.6	17.5	16.6
Help husband	22.2	23.2	16.6	14.6
Others	23.7	20.7	18.0	19.4
RESPONSIBILITIES FOR MEN				
Provide money for household needs	26.7	30.2	39.6	40.2
Pay hospital bills	10.2	16.2	16.9	18.3
Pay children school fees	20.2	23.3	21.0	21.7
Protect the family	16.7	17.6	11.3	13.3
Manage the family	18.4	10.5	9.2	5.1
Others	7.8	2.2	2.0	1.4

Source: Field Data, 1999.

Reported household responsibilities for men were general maintenance and management of the family. These included provision of money for household needs, bearing expenditure on hospital and children's education, and protecting and managing the family. The most important household responsibility for men was the provision of household needs: about 40 per cent of residents in rural areas and 28.5 per cent in urban areas.

The results indicated that people still adhere to the traditional responsibilities assigned to men and women. This is particularly the case for respondents in rural areas where about 50 per cent compared to 40 per cent in urban. considered cooking and caring for children as the responsibility of women.

Beyond expectations, it was considered useful to find out if the men had actually helped their wives to do household chores. From Table 4.5, more men in urban areas (53.7 per cent) than in rural areas (46.3 per cent) had helped their wives to perform household chores such as cooking, washing of clothes and caring for children. On the other hand, about 56 per cent and 42 per cent of urban and rural women respectively had received some help from their husbands. However, more urban women reported receiving support from their husbands than the men who reported giving such support to their wives. Conversely, rural women said they had been helped by their husbands to perform their household chores than the men who reported to have given such support to their wives.

Table 4.5. Respondents Who Helped Their Wives or Were Helped by their Husbands by Type of Residence

URBAN		RURAL	
MALE	FEMALE	MALE	FEMALE
YES	YES	YES	YES
53.7	56.4	45.7	42.0

Source: Field Data, 1999.

4.1.2. Ideal Occupation for Men and Women.

Responses on ideal occupation for men and women are given in Table 4.6. Regardless of place of residence, both men and women considered trading, hairdressing, sewing, nursing/midwifery, teaching, and sales as the ideal occupations for women. For example, while about three-quarters of the respondents in rural areas perceived trading, sewing and hairdressing as ideal for women, about two-thirds of the respondents from urban areas mentioned these occupations as ideal for women. Only 3 per cent of the women in the urban areas mentioned armed forces and medicine as ideal occupations for women and only 1.0 per cent of men in urban areas and 0.9 per cent of the total rural respondents thought these occupations were ideal for women.

The occupations, which respondents thought were ideal for men, were being artisans, driving, engineering, business, medical doctors, military, university lecturing, teaching and legal practice. About 19 per cent of

urban residents thought the most ideal occupation for men was being a medical doctor while for the rural residents the major one was driving (17.3 per cent). The urban residents also mentioned engineering (17.4. per cent) as one of the most important occupations for men while the rural populace rated it as eighth (7.5 per cent). Responses from rural areas indicated that teaching was regarded as the most important paid work. About 16 per cent of the rural residents as compared to 8.8 per cent of the urban residents recommended it for men (Table 4.6). This is probably due to the fact that teachers are among the paid workers who frequently interact with the rural people.

Apart from teaching, the ideal occupation recommended by rural residents for men were those that required little or no formal education. Conspicuously missing were farming and fishing. Nobody mentioned these two occupations as ideal for either men or women. This is probably because these two occupations are loosing their importance as major occupations in the country.

The persistence of the gender-based occupations for males and females does not augur well for women's empowerment. Given the results, there is the need to ensure equal opportunities for both sexes, as one of the strategies to improve upon the status of women.

Table 4.6. Appropriate Occupation for Men and Women by Place of Residence

IDEAL OCCUPATION FOR WOMEN	URBAN		RURAL		Average	
	M	F	M	F	M	F
TRADING	20.5	18.5	30.2	29.5	25.1	24.0
HAIRDRESSING	16.3	16.0	20.6	24.2	18.3	20.1
SEAMSTRESS	13.2	14.2	22.3	19.5	17.7	16.8
NURSING/MIDWIFERY	10.2	11.2	8.3	7.2	9.3	10.2
SCHOOL TEACHER	9.5	11.3	6.4	9.2	7.8	10.3
ARMED FORCES	1.3	0.5	--	--	0.7	0.3
MEDICAL DOCTOR	1.7	0.5	0.3	0.6	1.0	0.5
ACCOUNTANT/BANKER	3.2	2.3	1.6	2.1	2.7	2.2
SALESGIRL	3.5	3.6	3.4	4.6	3.8	4.2
OTHERS	20.6	21.9	6.9	3.1	13.8	11.4
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
IDEAL OCCUPATION FOR MEN						
DRIVER	12.2	10.2	18.2	16.3	15.2	13.3
ENGINEER	15.6	19.2	6.5	8.5	11.1	13.9
BUSINESSMAN	10.3	10.2	12.7	13.2	11.5	11.7
MEDICAL DOCTOR	17.6	19.3	13.2	15.2	15.4	17.3
ARMED FORCES	6.2	6.3	3.6	4.2	4.9	5.5
UNIV. LECTURER	10.2	5.7	2.3	5.3	6.3	5.5
ARTISAN	8.0	6.2	10.6	14.2	9.3	10.2
SCHOOLTEACHER	8.0	9.5	16.7	14.2	12.4	11.4
LAWYER	9.6	11.6	82	8.6	8.9	10.1
OTHERS	2.3	1.8	8.0	0.3	5.0	1.1
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Field Data, 1999. Male=300, Female=400, Urban=427, Rural=273

4.1.3. Ideal Level of Formal Education for men and Women.

Respondents were asked to indicate the ideal level of educational attainment appropriate for men and women mindful of the fact that educational attainment of women has generally been lower than that of men, and that the educational attainment of both men and women in urban areas has also been higher than their counterparts in rural areas. Table 4.7 gives the responses by place of residence on the ideal educational attainment for men and women.

About 43 per cent of the men and 37 per cent of the women mentioned university education as the highest level of education for men and women respectively. However, among the rural population 31 per cent of men and 31.3 per cent of women mentioned teaching and nursing training colleges as the appropriate education for women. Those who still thought that women should not have any formal education were 18.9 per cent for men and 15.3 per cent women in the rural areas while it was 2.3 per cent and 1.2 per cent for urban men and women respectively. As much as 34.5 per cent of the males and 25.4 per cent of females in urban areas indicated that the highest level of education women should attain is Secondary/Vocational/Technical/Commercial. However, about 31 per cent of males and females in rural areas recommended Teacher/Nursing Training and Polytechnic education for females. It is unexpected for such a large proportion of urban residents compared to rural residents to

suggest Secondary/Vocational/Commercial/Technical for women since they are more informed about the importance of education. It is likely that some urban dwellers still consider vocational training as best for women hence that recommendation. Among the reasons given by those who thought women should not be given formal education were the tendency for girls to dropout from school as a result of pregnancy, the need for women to stay at home and take care of the children and the need to preserve men's hegemony.

Thirty-nine per cent of the women and 63 per cent of the men recommended university education for males. In the rural areas however, more women (28.4 per cent) had recommended university education for men than they did for women (26.8 per cent). Only about 4 per cent of the males and 5 per cent of the females said education was not necessary for men. Comparing this with views on female education, it was observed that a higher proportion of both males (11 per cent) and females (per cent) indicated that female education was not necessary. At the residential level, only 1.2 per cent of the respondents reported that men should not be educated compared to 7.6 per cent for the rural residents. This is an indication that urban residents have higher self-esteem in terms of educational attainment than their rural counterparts. Also, women in urban areas were more likely to demand equal educational opportunities for males and females than those in rural areas because women in urban areas

are more informed about the importance of education to women and so have a positive attitude towards female education.

Table 4.7. Respondents' Views on the Appropriate Level of Education Attainment for Men and Women by Place of Residence.

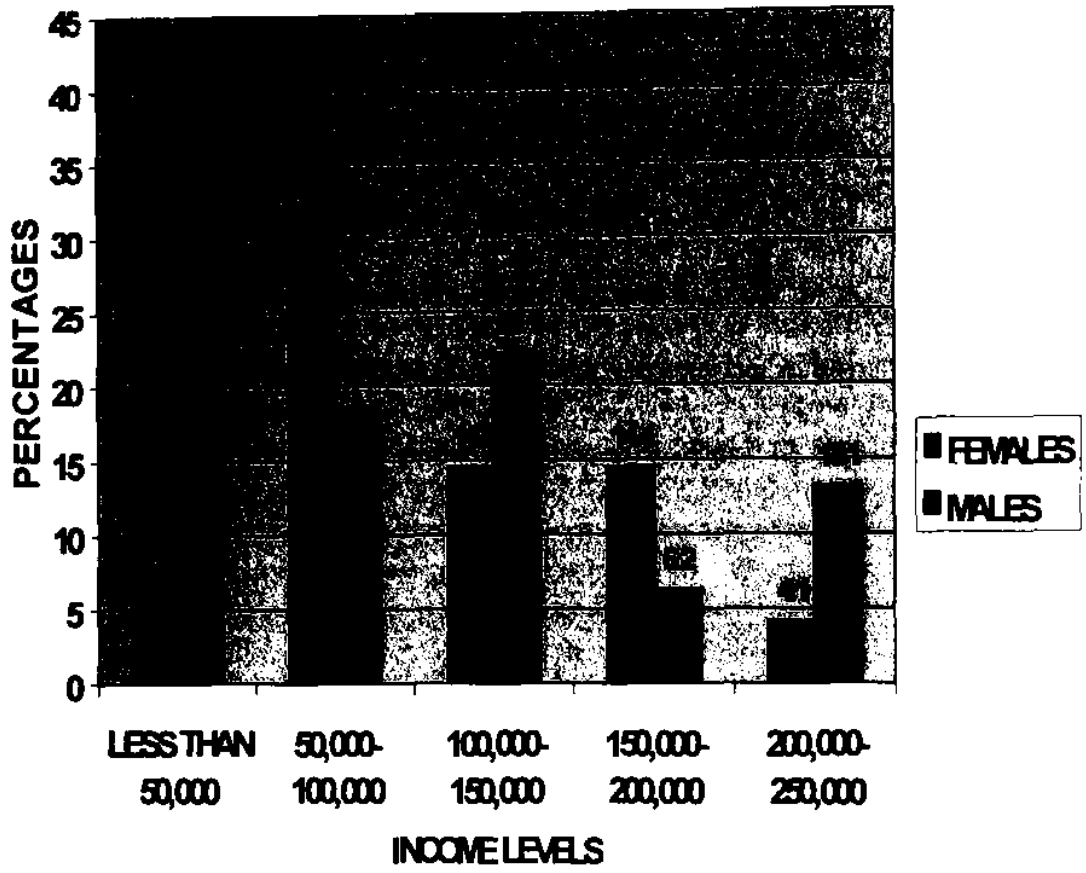
LEVEL OF EDUCATIONAL ATTAINMENT FOR WOMEN	**URBAN**		**RURAL**		**TOTAL**	
	M	F	M	F	M	F
NO EDUCATION	2.3	1.2	18.9	15.3	10.6	8.5
ELEMENTARY	6.5	2.2	7.6	5.9	8.8	4.2
SSS/VOC/COM/TECH	34.6	25.4	11.6	14.0	23.1	19.7
TEACHER\NURSING TRAINING	12.2	15.6	30.6	31.3	19.7	23.5
POLYTECHNIC EDUCATION	6.3	7.9	1.3	5.2	3.8	6.6
UNIVERSITY	36.7	42.5	26.3	26.8	31.5	34.7
ANY LEVEL SHE CAN ATTAIN	1.4	5.2	3.7	1.5	2.5	3.7
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
LEVEL OF EDUCATIONAL ATTAINMENT FOR MEN.						
NO EDUCATION	1.1	3.7	6.7	8.6	3.9	5.0
ELEMENTARY EDUCATION	0.9	1.2	7.9	9.5	4.4	5.1
SSS/VOC/COMM/TECH	22.4	21.7	24.8	24.1	19.4	21.9
TEACHER/NURSING TRAINING	5.2	11.3	24.3	26.5	13.7	16.9
POLYTECHNIC	5.1	16.5	18.3	10.5	11.7	15.5
UNIVERSITY EDUCATION	63.4	6.2	3.6	1.2	30.5	3.7
ANY LEVEL OF EDUCATION	1.9	39.4	14.4	19.6	16.4	31.9
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Field Data, 1999.

4.1.3. Property/Resources

Traditionally, women do not own physical assets because they do not have property rights. In the rural areas none of the women had no any fixed assets such as houses, land or vehicles compared to one-third of the men who had at least one of these items. Whereas about 21 per cent and 2.5 per cent of the women owned shops/stores and fishing nets respectively, 54 per cent of their male counterparts owned shops and about 60 per cent had fishing nets.

DIAGRAM 4.2 MONTHLY INCOMES LEVELS OF RESPONDENTS BY SEX



Source: Field Data, 1999.

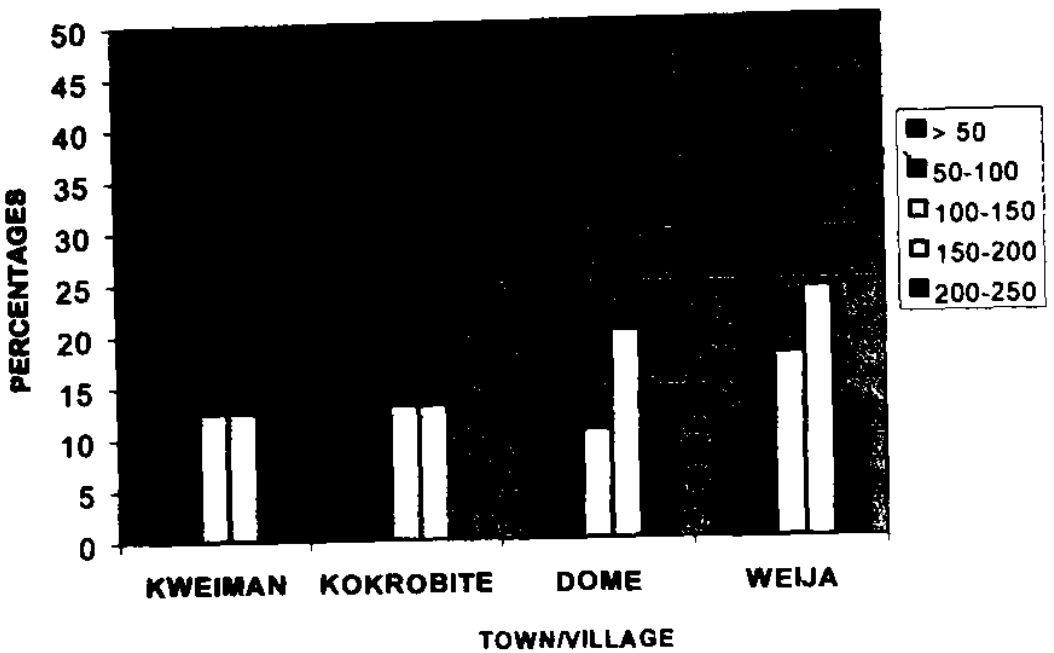
Income levels were generally lower among females than males and among rural residents than urban residents. Diagram 2.2 shows that 13 per cent of males, compared to 4.7 per cent of the females, were earning monthly incomes of between ¢200,000 and ¢250,000. On the other hand, 40 per cent of the males and about 35 per cent of the females were earning below ¢50,000 a month. Apart from the fact that income levels are generally low

in the area, women's position in the society regarding employment and access to resources may have aggravated their financial situation.

As indicated in Diagram 4.3, urban residents (Weija and Dome) earned the highest monthly income. About one-third of the respondents in these two urban areas reported earnings of between ¢150,000 and ¢2500,000 but only about 13 per cent of the respondents in the two rural areas were earning between ¢150,000 and ¢200,000. None of the respondents in the rural areas earned above ¢200,000 per month compared to about 12 per cent in urban areas.

Fifty- seven per cent of the women said they had personal savings while the rest (43.0 per cent) had no saving. About 80 per cent of those without any personal savings (43.0 per cent) said they had hardly enough money to save. On what they would depend on during their old age, their responses were: children (47 per cent), investment (25.6 per cent), social security (21 per cent), husbands (2.8 per cent), relatives (2.4 per cent), and no plans (1.2 per cent).

DIGRAM 4.3. APPROXIMATE INCOME LEVELS BY TYPE OF RESIDENCE



Source: Field Data

4.1.4. Inheritance Rights

Traditionally, women do not have the right to inherit communal or family property because if they were allowed to have such rights it would imply a transfer of such rights to the husband after marriage and thus transferring her lineage or family property to another lineage or family. Where such rights exist, women's rights in property have always been less than that of men because men tend to be given priority in inheriting lineage property.

In the study, about 53.3 per cent of the respondents agreed that females should have equal rights as males to inherit their father's property mainly because they are equal (Table 4.8). However, only 35.1 per cent of the respondents agreed that men should have equal rights as women to inherit their mother's property. Those who did not agree that females should have equal rights as men to inherit their father contended that, ''women belong to mothers and men belong to their fathers''. It emerged that, about 12 per cent of the women had inherited vehicles and houses from their parents but none had indicated that she owned some of these items. This is probably due to the fact that property belonging to women are under the custody of the men - brothers and family heads.

It was observed that land had never been vested in women although they could have usufruct rights over land inherited by their brothers. Secondly, women do not benefit from the sale of land vested in family heads and elders.

Table 4.8. Right of Females to Inherit Parents

Right to Inherit from Father			
Agree:	Male	Female	
Percentage	Number	Percentage	Number
42.5	96	53.3	113
The Right to Inherit from mother			
Agree:	Male	Female	
Percentage	Number	Percentage	Number
35.1	102	58.1	129

Source: Field Data.

4.2. Decision Making on Choice of Partner.

One fundamental human right of women, which is often violated and has adversely affected the decision-making of women is the right to choose their spouse. The level of freedom of one to choose one's partner affects power relations and the extent to which one can make independent decisions in marriage. Questions were asked to determine how both men and women contracted their marriages. Table 4.9 and 4.10 present responses from both men and women on how they contracted their marriages.

Table 4.9. Respondents Mode of Choosing Spouse by Residence

TOWN/ VILLAGE	ENTIRELY BY MYSELF		WITH HELP OF FAMILY		WITH THE CONSENT OF FAMILY		ENTIRELY BY FAMILY	
	F (%)	M(%)	F(%)	M(%)	F(%)	M(%)	F(%)	M(%)
KWEIMAN	48.2	69.5	20.5	12.3	25.2	17.8	12.1	12.4
KOKROB	39.8	64.7	25.3	15.3	26.3	18.9	11.6	10.1
DOME	58.2	72.2	20.2	10.2	10.4	15.4	15.2	14.2
WEIJA	62.1	75.6	19.5	9.1	15.3	14.2	14.1	15.1
AVERAGE	**52.1**	**70.5**	**21.4**	**11.7**	**19.3**	**16.6**	**13.3**	**12.9**

Source: Field Data, 1999.

Whereas about 52 per cent of the women contracted their marriages entirely by themselves, about 71 per cent of their male counterparts had done so. Moreover, about 13 per cent of both females and males had their marriages entirely arranged by their families.

Table 4.10. Level of Education and Mode of Choice of Spouse

EDU. STATUS	ENTIRELY BY MYSELF	WITH FAMILY HELP	FAMILY CONSENT	ENTIRELY BY FAMILY	N
	%	%	%	%	
NO EDU.	22.4	23.8	2.9	50.9	93
PRIMARY	80.2	7.8	12.0	0.0	22
MID/JSS	71.5	7.8	14.8	5.9	232
SSS/COM/VOC	53.3	21.8	5.9	19.0	116
TR./NUR./POLY	51.4	36.2	5.3	8.1	58
UNIV/ DIP.	96.0	0.0	4.0	0.0	32
AVERAGE	63.2	16.1	7.5	13.9	553

Source; Field Data 1999.

Differences by educational status show about 6.0 per cent of marriages of those with Middle and Junior Secondary School education were arranged entirely by their families. This was followed by 19 per cent of those with Senior Secondary/Vocational/Commercial/Technical. Ninety-six per cent of those with University/Diploma education had their marriages contracted independently. Those who reported that their marriages were entirely arranged by themselves were in marriages they themselves took the initiative to cultivate before it was brought to the notice of other family members. With education, women's socio-economic status improves and they are more likely to reject traditional norms that tend to inhibit their ability to exercise their rights because they are better informed about issues affecting their lives. Their leverage in household decision-making also increases and thus are able to make independent decisions about their lives.

4.3. Decision Making on Childbearing

Reproductive health was defined at the International Conference on Population and Development (ICPD) in Cairo "as 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 health system and its functions and processes" (United Nations, 1994 p 30). This implies the ability of women to make informed decisions and have access

to safe effective, affordable and acceptable methods of family planning of their choice to regulate their fertility. The decision making power of women such as those regarding the freedom to decide on how many children to have and when (or whether) is influenced by many factors. This section explores sources of influence on respondents' decision-making on childbearing such as the right of women to make decision on the number of children to have.

Table 4.11. Source of Influence in Decision-Making on Childbearing by Type of Residence.

SOURCE OF INFLUENCE	TOWN/VILLAGE								TOTAL (%)	
	KWEI		KOKRO		DOME		WEIJA			
	F(%)	M(%)	F(%)	M(%)	F(%)	M(%)	F(%)	M(%)	F	M
NOBODY	18.1	32.6	20.9	31.6	35.1	69.8	60.0	77.5	38.1	54.2
HUS/WIFE	9.1	11.2	12.5	15.3	35.1	5.6	6.8	6.3	17.0	12.6
PARENTS	18.4	21.2	18.6	22.8	21.6	15.1	16.4	12.9	18.8	20.5
FRIENDS	27.3	29.9	23.3	21.2	4.1	8.3	0.0	0.7	10.8	3.2
IN-LAWS	27.1	5.1	27.9	9.1	4.1	1.2	16.4	2.6	15.2	9.5
TOTAL	100	100	100	100	100	100	100	100	100	100
N0	**30**	**42**	**60**	**65**	**102**	**71**	**95**	**75**	**287**	**253**

Source: Field Data, 1999.

Respondents were asked whether someone had influenced their decision-making on the number of children to have. Thirty-eight per cent of the women and 54.2 per cent of the men took independent decisions regarding family size. The rest of the women reported influences from in-laws (15.2

to safe effective, affordable and acceptable methods of family planning of their choice to regulate their fertility. The decision making power of women such as those regarding the freedom to decide on how many children to have and when (or whether) is influenced by many factors. This section explores sources of influence on respondents' decision-making on childbearing such as the right of women to make decision on the number of children to have.

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SOURCE OF INFLUENCE	TOWN/VILLAGE								TOTAL (%)	
	KWEI		KOKRO		DOME		WEIJA			
	F(%)	M(%)	F(%)	M(%)	F(%)	M(%)	F(%)	M(%)	F	M
NOBODY	18.1	32.6	20.9	31.6	35.1	69.8	60.0	77.5	38.1	54.2
HUS/WIFE	9.1	11.2	12.5	15.3	35.1	5.6	6.8	6.3	17.0	12.6
PARENTS	18.4	21.2	18.6	22.8	21.6	15.1	16.4	12.9	18.8	20.5
FRIENDS	27.3	29.9	23.3	21.2	4.1	8.3	0.0	0.7	10.8	3.2
IN-LAWS	27.1	5.1	27.9	9.1	4.1	1.2	16.4	2.6	15.2	9.5
TOTAL	100	100	100	100	100	100	100	100	100	100
N0	**30**	**42**	**60**	**65**	**102**	**71**	**95**	**75**	**287**	**253**

Source: Field Data, 1999.

Respondents were asked whether someone had influenced their decision-making on the number of children to have. Thirty-eight per cent of the women and 54.2 per cent of the men took independent decisions regarding family size. The rest of the women reported influences from in-laws (15.2

per cent), husbands (17.0 per cent), parents (18.8 per cent) and friends (10.8 per cent). Influences on the men were from parents (20.5 per cent), wives (12.6 per cent), friends (3.2 per cent) and in-laws (9.5 per cent). Whereas 27.5 per cent and 25.3 per cent of females from rural areas indicated that their in-laws and friends had influenced them respectively, 10.2 per cent and 2.0 per cent of their counterparts in urban areas had been influenced by in-laws and friends respectively.

Sixty per cent of the women at Weija and 35 per cent at Dome reported that they had made independent decisions on childbearing compared to 18.1 per cent and 20.9 per cent at Kweiman and Kokrobite (the rural settlements) respectively. On the other hand, the number of men who had made independent decisions on childbearing was 73.6 per cent in urban areas and 32.1 per cent in rural areas.

Also the degree of influence depended on the level of education and incomes of women. Women who had attained University/Diploma education took independent decisions on when to have a child but none of those who had primary school education made an independent decision.

Thus, decision-making on childbearing in the study area appears to be influenced by the socio-economic background of an individual such as the type of residence, educational background and the sex.

Table 4.12. Source of Influence on Women to Give Birth by Educational Attainment

LEVEL OF EDU.	NOBODY		HUS/WIFE		PARENT		FRIEND		IN-LAWS	
	F	M	F	M	F	M	F	M	F	M
NO EDUC.	0.0	15.6	52.4	13.8	47.4	42.9	0.0	12.3	0.0	15.4
PRIM	48.7	25.6	28.2	25.3	0.0	15.3	0.0	15.6	23.1	19.2
MID/JSS	29.2	36.5	18.0	15.3	12.4	19.3	27.0	16.8	13.8	12.1
SSS/COM/ TEC	50.0	68.7	0.0	10.6	38.9	11.8	0.0	7.2	11.0	1.7
TR/NUR/ POL	53.8	71.6	0.0	4.2	0.0	12.3	0.0	8.3	46.2	3.6
UNIV/DIP	100	90.2	0.0	8.3	0.0	0.5	0.0	.2	0.0	.8
N	**30**	**42**	**60**	**65**	**102**	**71**	**95**	**75**	**287**	**253**

Source: Field Data, 1999.

Husbands who had had only basic education were more likely to be influenced by their wives than those with formal education beyond secondary level. For instance, 36.2 per cent of women who had had basic education reported that they had influenced their husbands on childbirth, but 20.3 per cent of men with basic education had influenced their wives. Also, none of the women with formal education beyond secondary level reported being influenced by their husbands but the men under the same category reported being influenced by their wives. The effects of female education on decision-making appear to be positive in the study area.

About 51 per cent of the women reported that they would have felt insecure in their marriages if they had not given birth. Here too, formal

education had influenced how women perceived childbearing and their security in marriage. For example, all women who had attained University/Diploma education responded negatively to the question. Seventy-four per cent of women with formal education below middle school level thought their marriages would be insecure if they had no children. The reasons they gave were "I would not be comfortable in the marriage without children (33.5 per cent)", "in-law will not entertain me (25.1 per cent)", everybody want children to be happy in the marriage (17.4 per cent)", "the man will not like childlessness (20.5 per cent) and "my husband would divorce me (2.2 per cent)". These suggest that, women perceived children as very important in the stability of their marriages and thus, women from rural areas exerted more influence on their husbands probably because they perceive children as a means of increasing their status and stabilising their marriages.

4.4. Decision Making on Maternal Health.

A woman's decision to seek maternal health care could be influenced by her alone, her husband and to some extent her extended family members. The readiness of her partner to allow the woman to go for antenatal care during pregnancy, arrange for a qualified attendant to be available during delivery, and help the woman to overcome postpartum complications greatly influence the health of the woman. Family members may influence

the woman's decision, particularly when there are complications during delivery. The health care seeking behaviour of women therefore depend on a number of factors some of which may be beyond the control of the woman (Tsui, 1997). This section examines women's control on decision-making on maternal health care.

4.4.1.Decision Making on Antenatal Visits.

The woman's decision to seek antenatal care, the type of care chosen and the number of visits made depends on the distance to the centre, cost of treatment and the level of income. Other factors which may also influence the decision to seek antenatal treatment are the level of formal education attained by both the woman and husband, the presence of health risk indicators during pregnancy, the type of marriage and the age of the woman (Tinker and Koblinsky, 1993; Population Reports, 1995).

Twenty per cent of the women who had attended antenatal clinics more than four times during their first pregnancies had not had any formal education but 21.8 per cent and 27.3 per cent had attended University and Polytechnic/Tr Training/Nursing Training respectively. Out of these women, those whose husbands had not had any formal education were only 7.5 per cent compared to 45.4 per cent of those whose husbands had had tertiary education. A breakdown of these women by residence

indicated that 20 per cent were from rural areas and 30 per cent were from urban areas (Table 4.13). Thus, the level of education of the woman and husband and type of residence are the main factors that have influenced the number of times they attended antenatal clinics during their first pregnancies.

Table 4.13. Women Who Attended Antenatal Care for more than Four Times During First Pregnancies by Selected Socio-economic Background

Variable	Frequency	Percentage
Woman's Education		
No formal Education	11	20.0
Primary	5	9.1
Middle/JSS	6	10.9
SSS/Com/Voc/Tech	6	10.9
Poly/Tr./Nursing Tr.	15	27.3
University/Diploma	12	21.8
TOTAL	**55**	**100**
Husband's Education		
No formal Education	4	7.5
Primary	4	7.5
Middle/JSS	10	18.9
SSS/Com/Voc/Tech	11	20.7
Poly/Tr./Nursing Tr.	12	22.7
University/Diploma	12	22.7
TOTAL	**53**	**100**
Residence		
Rural	25	45.5
Urban	30	54.5
TOTAL	**58**	**100**

Source: Ga District Data, 1999.

Multiple regression analysis has been used to isolate factors, which influenced the maternal health care seeking behaviour of women. The number of times women go for antenatal care represented the dependent variable while the level of formal education attained by both the woman and husband, parity, the type of marriage, the age of the woman, distance to health centre and income level were the independent variables. The multiple regression was chosen for this analysis because it gives the best linear prediction and assesses the strength of relationship between a dependent variable and the independent variables, while holding confounding variables constant. Table 4.14 presents the results of the multiple regression analysis of selected socio-economic variables, which influenced the number of times women surveyed, attended antenatal clinic.

Results from the multiple regression analysis indicated that, level of formal education of the woman and that of husband's; age of woman, parity, distance to health facility and type of marriage (polygyny or monogamy) were found to be significant (at 95 per cent level of confidence) factors that influenced the number of times women attended antenatal clinic. Income level was not a significant variable that influenced the number of times women attended antenatal care. All the variables were positively related to the number of times women went for antenatal visits except the type of marriage. The most significant factors were the

educational attainment of the woman and distance to health centre, followed by age of woman, husband's educational level, parity and type of marriage. A number of possible conclusions can be drawn from the positive relationship between distance and the number of times women go for antenatal care.

Table 4. 14. Multiple Regression Analysis of Women's Decision to Go for Antenatal Care by Selected Socio-economic Variables.

VARIABLE	B	BETA	SIG
EDU. OF WOMAN	1.43130	0.5540	0.0422
HUS.EDUCATION	-1.4130	0.16480	0.0362
INCOME	0.34570	2.69000	0.6822
PARITY	0.84130	0.49940	0.03123
DISTANCE	0.46920	0.20460	0.0415
WOMAN'S AGE	1.62540	1.505600	0.3763
TYPE OF MARRIAGE	-1.5130	-.10266	0.02210

$R^2 = 0.975$. Adjusted $R^2 = 0.971$.

It was observed that communities which were farther away from health centres (such as rural areas) often benefited from outreach Programmes organised by the District Health Management Team (DHMT). The practice reduced the real cost of distance, a major barrier to health care in rural areas. Consequently, the negative effect of distant on attendance to antenatal care centres was not expected to influence attendance. Therefore, distance did not have any negative impact on antenatal attendance.

4.4.2. Decision on Choice of Place of Delivery.

The decision to choose the place of delivery depends on the disposition of the woman, the perception and attitude of the husband and the immediate family members toward pregnancy and the extent to which they can identify signs of delivery and life- threatening complications.

None of the respondents interviewed irrespective of place of residence thought it was necessary to make prior arrangements with trained personnel for delivery. The choice of place of delivery was considered to be dependent on conditions and situations at the time of delivery.

The decision to seek professional assistance for women depended on the perception of the people, even those with complication. Discussion with medical personnel and during the FGDs indicated that professional assistance was sought when people observed bleeding but not obstructed labour, a condition traditionally associated with adultery during pregnancy. Thus, when there is an obstructed labour, confessions and traditional priests/priestess were usually resorted to instead of seeking professional attention.

However, where the level of formal education of the men and women is high, delivery is likely to take place under the supervision of trained

personnel. For instance, 89 per cent of all deliveries under the supervision of trained personnel were women who had attained education beyond Primary school level. None of the women who had attained tertiary education was assisted by TBAs but 89.3 per cent of those who were assisted by TBAs had only basic education. At the residential level, about 52 per cent of women who were supervised by Medical Doctors, 40 per cent of those assisted by TBAs and 56.7 per cent of those supervised by trained midwives/nurses were from rural areas (Table 4.15). However, during the FGDs and in-depth interviews, it was observed that some women confused deliveries in a health centre with deliveries supervised by medical doctors. In fact, some women used the two terms interchangeable and that probably explains the high percentage of deliveries supervised by Medical Doctors in rural areas. It was also observed during the FGDs that, about 50 per cent of women in rural areas and less than 10 per cent from urban areas had home delivery with either the help of relatives or neighbours.

Table 4.15. Personnel Assisted Delivery by Education and Residence

LEVEL Of EDUCATION	PERSONNEL ASSISTED DELIVERY			
	MED. DOC	NUR/MIDWIFE	TBAs	TOTAL**
No Formal Education	1(0.5)	---	33(16.4)	34(16.9)
Primary	7(3.5)	---	11(5.5)	18(9.0)
Middle/JSS	40(19.9)	24(11.9)	39(19.4)	103(51.2)
SSS/Com/Voc/Tec	12(6.0)	5(2.4)	10(5.0)	27(13.4)
Poly/Tr./Nursing	7(3.5)	6(3.0)	--	13(6.5)
Univ./Diploma	6(3.0)	--	---	6(3.0)
TOTAL* **	**73 (36.4)**	**35 (17.1)**	**93 (46.3)**	**201(100)**
SETTLEMENT				
Kokrobite	24(11.9)	15(7.5)	6(3.0)	45(22.4)
Kweiman	31(15.4)	19(9.5)	8(4.0)	58(28.9)
Dome	40(19.9)	125(12.9)	4(2.0)	70(34.8)
Weija	11(5.5)	---	17(8.5)	28(13.9)
TOTAL* **	**106 (52.7)**	**60 (29.9)**	**35 (17.4)**	**201(100)**

Note: *** Proportion of women who were assisted by a particular health personnel during delivery.

** Proportion of women who were assisted by health personnel by educational attaiment and type of residence

Source: Ga District Data, 1999.

Women in rural areas reported during the FGDs that their husbands did not act promptly during delivery particularly, when complications occurred. Ill health or complications during pregnancy were sometimes attributed to fate, destiny, divine will or unfaithfulness of the part of the woman which do not require any medical intervention. Thus, although men do not wish that their wives die while pregnant or during delivery, some find it difficult to sell their property like animals to enable them get money to take the women to hospital. As one woman put it, " our husbands and sometimes relatives play with our lives".

In the rural areas, commercial transport owners were usually unwilling to transport emergency cases to the hospital or charge exorbitant fares to do so. This is because blood discharged during labour or childbirth is considered unclean and some commercial drivers fear their vehicle would be contaminated if they carried a woman in labour. As such, some drivers even demand drinks for purification. Owing to the fact that complications arising from childbirth can endanger the life of the woman, family members often become desperate to send the woman to a health centre. They are therefore unable to negotiate with drivers and transport owners for fair charges. Under this situation drivers and transport owners charge exorbitant fares.

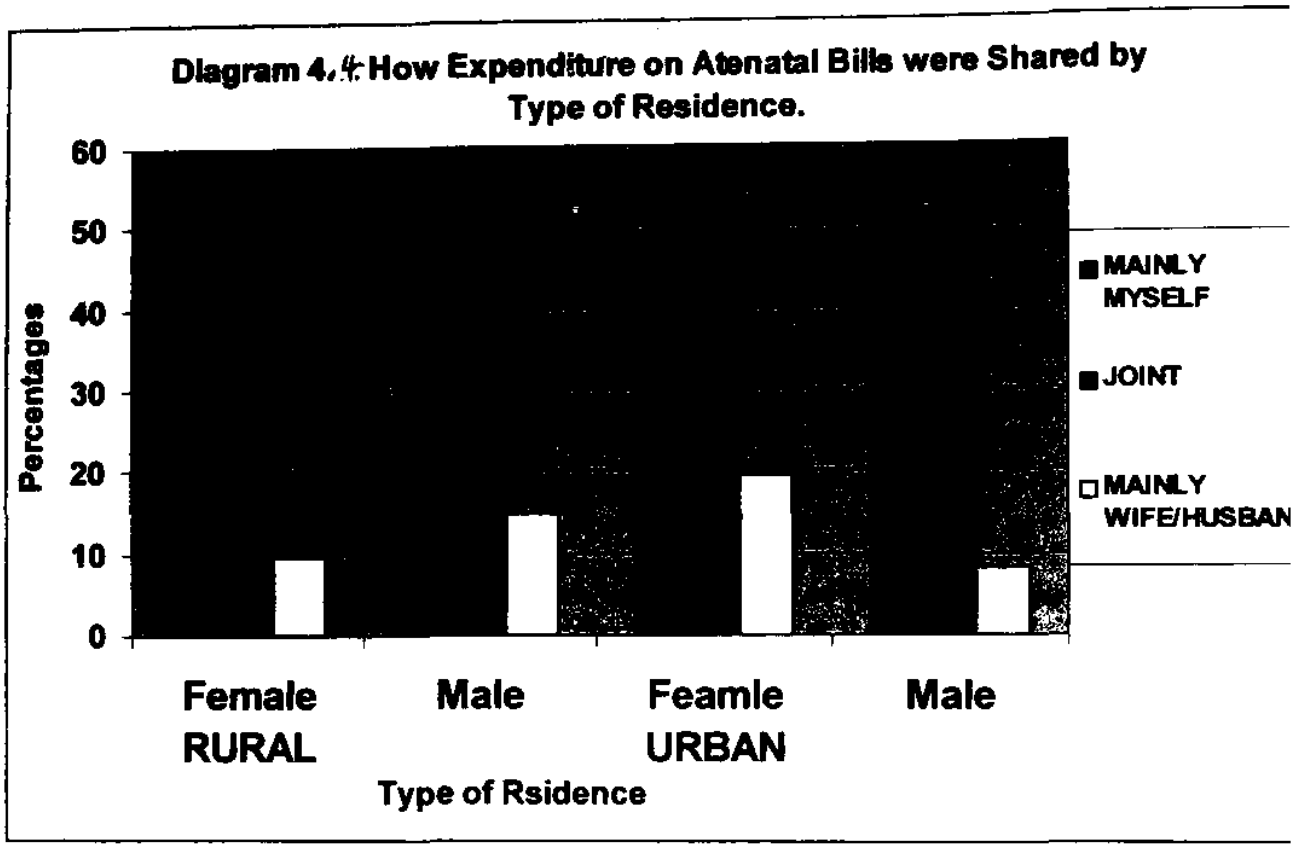
During delivery, therefore, the woman seemed to have little control over the choice of place of delivery. The decision of the man is particularly important because he controls the household resources and his permission is needed before the woman can be taken to a health care facility.

4.4.3. Hospital Expenditure during Maternity

Cost of treatment during pregnancy, delivery and after childbirth may be borne by either the man or women or jointly by both the man and woman.

This section explores the one who bears medical expenses of the woman during maternity in the study area.

In the rural areas more than 40 per cent of both the male and female respondents reported that they bore hospital expenditure on maternal care. On the other hand, 9.7 per cent of men and 14.9 per cent of women in rural areas had reported that their partners alone were responsible for the payment of expenditures on maternal care. Twenty per cent of the women and 8.1 per cent of the men in urban areas also indicated that their partners alone were responsible for the payment of expenditures on maternal care (Diagram 4.4).



Source: Field Data, 1999.

The result indicated that some women rely on their husbands for money to pay for their hospital bills. For such women, their decision to attend antenatal clinic would depend on the readiness of the man to provide her with the money. Also, some women contributed to their own health and therefore an improvement in their income levels would reduce their dependence on men.

4.4.4. Activities during Pregnancy and Childbirth

The attention women receive (physically and emotionally) and the types of work they do when pregnant have implications for their health. For instance, poor nutrition and tedious chores can cause complications such as anaemia, premature births and obstructed labour during childbirth. Respondents were asked to indicate whether pregnant women and women who have given birth need to be given special treatment.

Table 4.16. Respondent's Views on the Treatment of Women During Pregnancy and Postpartum Period by Place of Residence

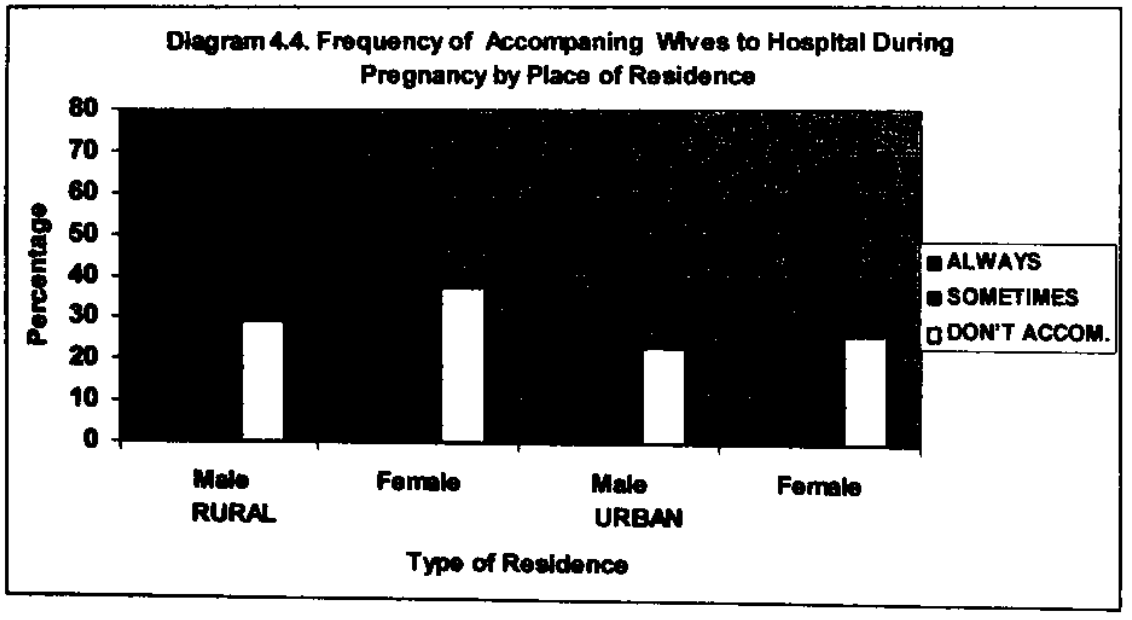
RURAL		URBAN	
MALE	FEMALE	MALE	FEMALE
YES	YES	YES	YES
92.7	97.2	82.1	91.5

Source: Field Data, 1999.

More than 90 per cent of all respondents regardless of sex and place of residence said pregnant women should be given special treatment such as cooking and helping in household chores (Table 4.16). As to where women had received any special treatment during pregnancy and the type of treatment they received depended on their place of residence.

Seventy-five per cent and 55 per cent of urban and rural women respectively said they were given some form of special treatment such as

special foods, husbands helping in household chores and being gentler during pregnancy. About 70 per cent and 60 per cent of men in urban areas and rural areas respectively reported that they gave special treatments to their wives when pregnant. For instance, 23.5 per cent of the men indicated that they gave their wives special food, 22.7 pounded fufu for their wives, 22 per cent washed for their wives, 19.7 per cent conversed with their wives and 12.1 per cent took care of the children. Others also accompanied their wives to hospital during the period (Diagram 4.5). On the other hand, about 10 per cent of women in rural areas and nearly 3 per cent in urban areas reported that their husbands had beaten them when they were pregnant.



Source: Field Data, 1999.

It was observed that approximately 95 per cent of men who had attained University/Diploma education claimed that they always accompanied their wives to hospital during pregnancy and 5 per cent did so occasionally. Accompanying wife to the hospital may mean taking the woman to the health centre with or without any obligation of coming for her later. It may also mean going to the health centre with the woman and assisting her to go through all the procedures and returning to the house with her. It was however not possible to investigate the number of times men had actually accompanied their wives to the hospital each time they were pregnant. About 40 per cent of those without any formal education reported that they had always accompanied their wives to hospital during pregnancy. Almost two-thirds of males in rural and urban areas who had not had any formal education reported that sometimes they accompanied their wives to hospital during pregnancy.

Women in urban and rural areas get more help from their husbands during the first two weeks after childbirth than they get during pregnancy. Almost three-quarters of men from rural and urban areas irrespective of the level of educational attainment reported that they had always helped their wives after childbirth. The help given by men in rural areas included gathering firewood, fetching water and taking care of older children. In the urban areas the men assisted in cooking, fetching water and taking care of older children.

4.5. Spousal Communication

Joint decision making is easier when couples discuss common issues or take part in social activities. On the other hand, where couples do not interact and there is no effective communication between them joint decision-making is normally impeded. Under such situations shared decision-making is discouraged and there is the tendency for one partner to dominate in the decision-making process.

In this study, respondents were asked questions on spousal communication. Respondents were asked to indicate whether they discussed issues such as those relating to fertility, whether they sat at table to eat together, if they attended social functions and visited relations with their spouses. Table 4.17 shows the distribution of respondents who had ever discussed selected fertility-related issues with their spouses and the frequency with which these issues were discussed.

Table 4.17. Respondents who Discussed Selected Fertility-related Issues with Spouse

HOW OFTEN ISUSSES WERE DISCUSSED	FAMILY SIZE.		BREASTFEEDING		CONTRA. USE	
	F(%)	M (%)	F(%)	M(%)	F (%)	M (%)
NOT AT ALL	15.2	22.2	4.3	17.2	15.2	20.9
SELDOM	21.4	13.1	29.9	3.3	25.3	5.9
OFTEN	42.2	32.0	33.5	29.1	33.8	30.1
REGULARLY	21.2	32.0	32.3	50.3	25.8	43.1
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
N	151	145	107	101	164	121

Source: Ga District Survey, 1999.

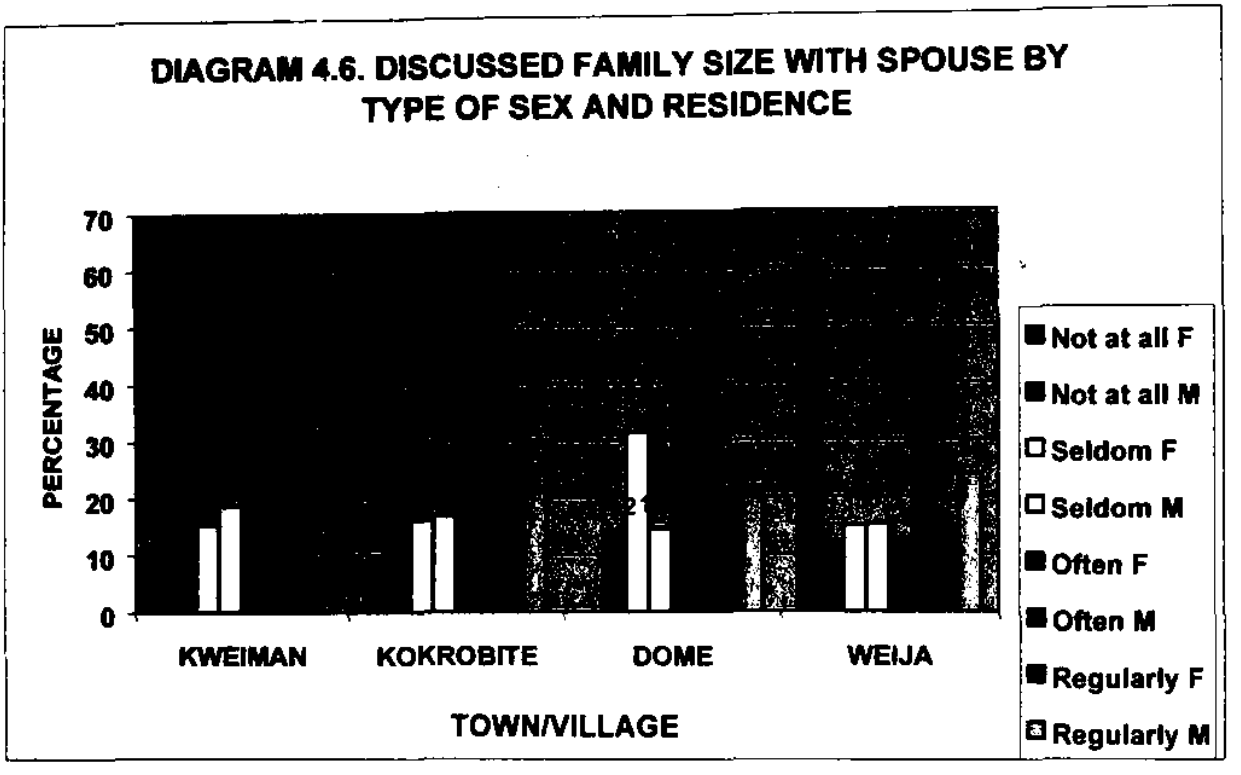
About two-thirds of both women and men reported that they often and regularly discussed family size, breast-feeding and the use of contraceptives with their spouses. About 20 per cent of the males and 16 per cent of the females had not had such discussions with their spouses.

The result indicated that it was women who usually brought up issues on reproductive health for discussion. In the rural areas, 56.5 per cent of he males and 65.3 per cent of the females reported that they initiated discussions on reproductive health issues. In the urban areas 76.5 per cent of the female and 73.2 per cent of the males indicated that they initiated discussions on issues on reproductive health. About 70 per cent and 60.5 per cent of urban and rural men respectively reported that their wives usually brought up the issues for discussion. The responses from the field do not confirm actual situations in traditional Ghanaian societies where

men dominate in decision-making, and traditional and cultural beliefs usually discourage women from starting the discussions. However, the data show some level of changing traditional cultural norms and values which hinder decision-making on family planning and reproductive health issues in the family.

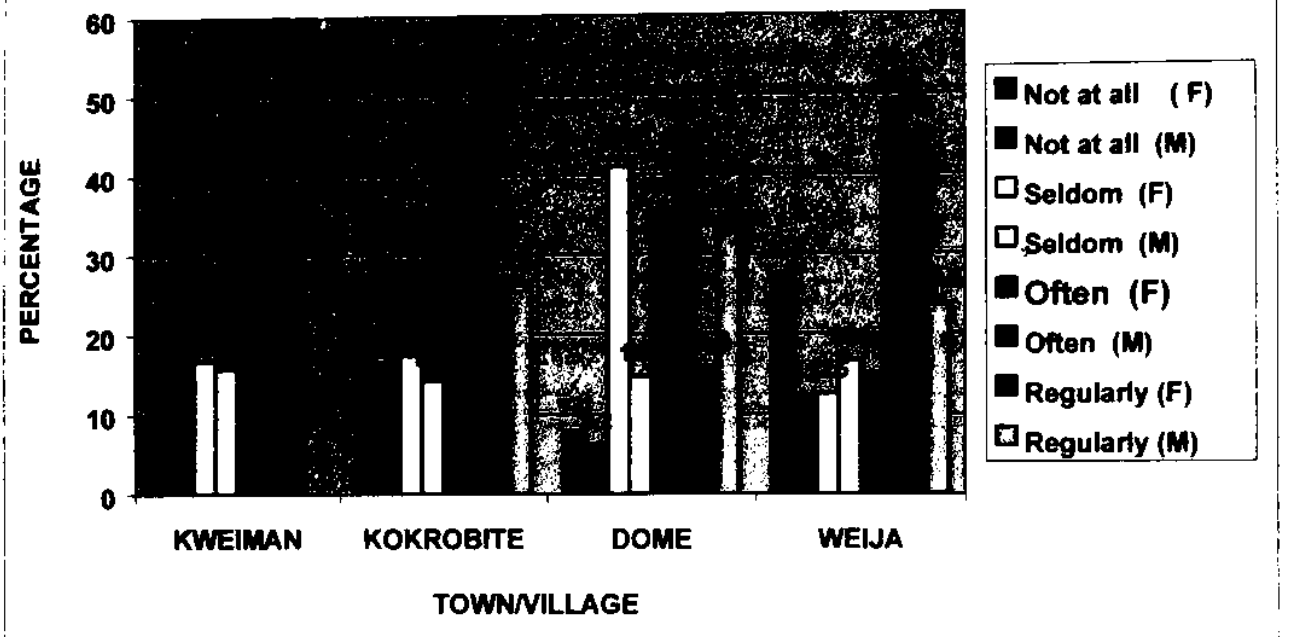
Diagrams 4.6 and 4.7 present how frequently women discussed issues with their husbands. In all the settlements, more males and females in rural areas reported to have discussed issues with their spouses than those in urban areas. For instance, about 54 per cent of women at Kweiman, a rural settlement, frequently discussed reproductive health issues with their spouses compared with 47 per cent of the women at Dome, an urban area. Dome had the highest percentage of women who seldom discuss these issues with their spouses. This is unexpected because people in urban areas are supposed to be more informed on issues concerning family planning and reproductive health. It is likely respondents in rural areas lied in order to give the impression that they are involved in family planning and reproductive issues.

DIAGRAM 4.6. DISCUSSED FAMILY SIZE WITH SPOUSE BY TYPE OF SEX AND RESIDENCE



Source: Field Data, 1999.

DIAGRAM 4.7. RESPONDENTS WHO HAD DISCUSSED BIRTH SPACING WITH SPOUSE BY TYPE OF RESIDENCE



Source: Field Data, 1999.

It is expected that discussions between spouses should encourage or facilitate shared decision-making on sexuality and reproductive health issues. In the study, more than two-thirds of the women said they took joint decisions with their spouses on family size, birth spacing, breast feeding, use of contraceptives, choice of methods and discontinuation of methods. Thirteen per cent of the women took independent decisions as against 11.6 per cent of the men. Apart from family size, more wives than husbands had taken independent decisions on all the issues under consideration.

Table 4.18. How Decisions Were Taken on Selected Reproductive Health Issues

DEC. MAKER	FAM SIZE		BIRTH SPACING		BREAST FEEDING		USE OF CONTR.		CHOICE OF METH.		DISCON METHOD	
	F	M	F	M	F	M	F	M	F	M	F	M
	%	%	%	%	%	%	%	%	%	%	%	%
HUSB. ALONE	17.6	2.)	6.2	3.3	6.8	5.8	7.4	14.2	7.3	13.2	4.4	31.6
WIFE ALONE	6.3	14.7	14.2	15.0	24.4	17.5	10.6	17.0	14.1	19.4	10.9	16.7
JOINT DECIS.	70.6	78.0	73.3	77.8	65.9	65.0	68.5	57.4	62.8	52.7	79.8	39.5
OUT. INFLU.	5.4	5.3	2.8	3.9	2.9	11.7	13.7	11.3	15.7	14.7	4.9	12.3
TOTAL	100	100	100	100	100	100	100	100	100	100	100	100
N	146	133	146	132	142	138	154	128	162	144	141	135

Source: Field Data, 1999.

As shown in Tables 4.19 and 4.20, more than two- thirds of male and female respondents reported joint decision-making as the process for arriving at decisions on the use of contraceptives, choice of method, discontinuation of method, desired family size and birth spacing. Outside influence such as friends and in-laws was low. For instance, Weija was the only settlement which reported some outside influence on decision-making relating to desired family size (20.7 per cent) and birth spacing (10.3 per cent). The results suggest that about half of the rural women had the opportunity to take active part in decision making on important issues with their spouses. This means that husbands and wives are able to discuss issues concerning family planning and reproduction. However, these were inconsistent with expectations especially for the rural populations. It is probable that some women gave answers to favour their spouses to avoid

provocation. Because during the in-depth interview and FGDs it was found that communication between spouses regarding reproduction were sometimes in the form of suggestions, hints and complaints to close friends and relatives in the hope that the opposite sex would get to know. It was observed that, although this never yielded the expected results for the women concerned, it was the only means through which they could communicate to their spouse.

Table 4.19. Decision-Maker on Desired Family Size and Birth Spacing by Type of Residence

TOWN/ VILL	DESIRED FAMILY SIZE (%)				BIRTH SPACING (%)			
	HUSB. ALONE	WIFE ALONE	JOINT DECIS	OUTS. INFL.	HUSB. ALONE	WIFE ALONE	JOINT DECIS	OUTS. INFL.
KWEI	0.0	14.3	85.7	0.0	0.0	21.4	78.6	0.0
KOK	0.0	15.1	84.9	0.0	0.0	22.6	77.7	0.0
DOME	14.7	0.0	85.3	0.0	23.1	6.2	70.5	0.0
WEIJA	50.0	0.0	29.3	20.7	8.6	10.3	70.7	10.3

Source: Field Data, 1999

Table 4.20. Decision-Making on Contraception and Choice of Methods.

TOWN/ VILL	CONTRACEPTIVE USE (%)				CHOICE OF MEHTOD (%)			
	HUSB. ALONE	WIFE ALONE	JOINT DECIS.	OUTS. INFL.	HUSB. ALONE	WIFE ALONE	JOINT DECIS	OUTS. INFL.
KWEI-MAN	0.0	20.0	80.0	0.0	0.0	20.0	80	0.0
KOKR-OBITE	0.0	21.1	78.9	0.0	0.0	12.1	78	0.0
DOME	4.4	0.0	86.8	8.8	4.6	1.5	75.4	18.5
WEIJA	21.2	11.3	32.7	34.6	19	20.7	29.3	31.0

Source: Ga District Survey, 1999.

Table 4.21 Marital Relations of Couple on Selected Household Activities by Place of Residence.

ACTIVITY	URBAN		RURAL	
	FEMALE	MALE	FEMALE	MALE
Sit at table to eat together.	71.3	76.2	35.2	42.1
Visit wife's relations together	70.5	77.5	82.3	85.5
Visit husband's relations	70.6	68.5	75.4	72.3
Visit husband's hometown	75.2	70.2	74.2	60.3
Visit wife's hometown	69.2	69.0	65.6	61.7
Attend religious Services	52.3	59.6	64.5	59.7
Attend funerals	82.3	75.5	66.7	62.8
Attend other social functions	66.2	69.6	42.3	74.4

Source: Ga District Survey, 1999.

The extent to which couples do things together was also examined as a proxy to the conjugality of couples. Irrespective of residence, more than two-thirds of the respondents claimed that they sat at table with their wives, visited each other's relations and hometowns, attended religious services and funerals together and attended all other social functions together (Table 4.21). However, 35.2 per cent of the females and 42.1 per cent of the males in the rural areas and 71.3 per cent of the females and 76.2 males in urban areas indicated that they sat at table to eat together with their spouses. While about 90 per cent of couples, who had had education beyond post-secondary level had engaged in all these activities together, slightly above 70 per cent of those with educational attainment below secondary level had undertaken these activities together. Only about

54 per cent of couples who had no formal education had sat at table to eat together. This shows that formal education influenced couples decision to engage in social activities together. It was also observed from the focus group discussion and in-depth interview that, about 95 per cent of couples whose educational background was the same or almost the same, and 72.6 per cent of discordant couples in education did things together.

4.5. Conclusion.

The different roles that men and women perform in the society have bestowed on them different rights and responsibilities. Consequently, the rights of women to make decisions concerning their lives, to own property and resources, to communicate with their spouses and to seek medical attention have been influenced by gender-based roles. The result from the study showed that traditional beliefs and norms, which have determined the different roles, rights and responsibilities of sexes, still persist in the society. For instance, household chores such as cooking, washing clothes, sweeping the house, fetching water and caring for children were considered the preserve for women. Trading, hairdressing, dressmaking and teaching were also considered to be the ideal occupation for women. However, more strenuous jobs such as driving, engineering, business, medicine, military and lecturing in the university were recommended for men.

It was observed that, the level of formal education and type of residence have influenced people's perception and attitude toward gender-based roles. Urbanisation and formal education do not only change people's perception regarding gender roles but also bridge disparities between men and women. In the study, it was realised that urbanisation and formal education had contributed to attitudinal changes regarding appropriate sex role attitudes. For example, women with higher formal education have economic and social security, are more likely to choose their spouses independently, communicate effectively with their spouses and actively participate in reproductive decisions than those with little or no formal education.

On maternal health care, the general observation was that, women in rural areas preferred home delivery, usually alone or with the help of someone from the neighbourhood. The use of health facilities for delivery in rural areas therefore lags behind use of antenatal care.

The next chapter will assess women's control over their sexuality by examining their ability to resist their husbands' sexual demands, the perceptions of men and women on pre-marital and extra-marital sex and wife battering.

CHAPTER FIVE
WOMEN'S STATUS, SEXUAL RIGHTS AND MATERNAL HEALTH

5.0. Introduction.

In many cultures, the performance of full marriage rites signifies a complete transfer of a woman to the husband. It indicates the right of the man to exercise complete control over the productive, sexual and reproductive rights of the woman (Oheneba-Sakyi and Awusabo-Asare, 1999). In some cases, the woman's decision on whether to practise family planning, choose when and how to have sexual relations, engage in extra-marital relations and breast-feeding is subject to that of the male partner. The woman's reproductive rights within marriage, such as the right to resist sexual relations that are likely to expose her to unwanted pregnancy, infections from STDs and when sexual relations are unwanted due to physical tiredness or emotional problems is curtailed by her inferior position in the household vis-à-vis that of the man. Women's reproductive rights have also been reduced by gender-based violence to the extent that women are unable to exercise control over their sexuality and thus have safer sexual relations with their male partners (Tsui, 1997).

This chapter assesses the reproductive and sexual rights of women. The assumption is that the elimination of gender inequalities and the protection

of women against violence and sexual harassment would enable them to make sound decisions on their reproductive health.

5.1. Background Issues

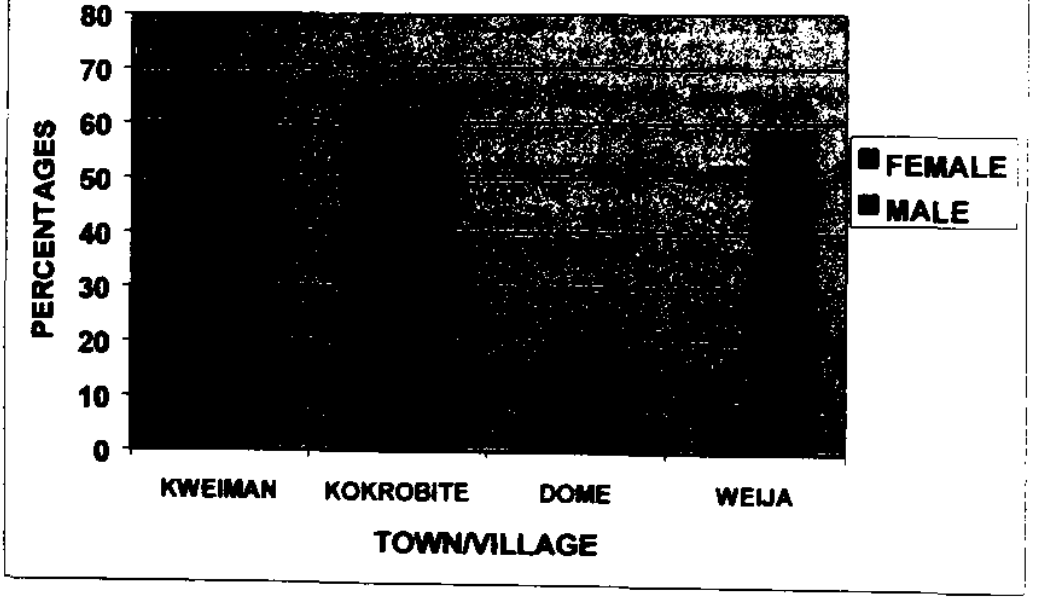
The predominant traditional residential arrangement of the Ga people is that women lived with their female matrilineal relatives and men with their male patrilineal relatives. There were therefore separate male and female compounds. Food was prepared in the female compound and sent to the male compound by the children. This type of arrangement fostered freedom of movement and solidarity among women and enhanced the organisation of their business ventures as women made internal arrangements to cook in turn (Hafkin and Bay, 1976). However, urbanisation and its attendant modifications in social life is creating alterations in this type of residential arrangement.

The data from the study showed a decline in the Ga traditional living and sleeping arrangement as 72.1 per cent of the women and 86.4 per cent of the men live with their spouses. The rest either lived in family houses in the neighbourhood, in another part of the village, in another village or had travelled outside the area. This decline may suggest women no longer enjoy the co-operation they got from each other which facilitated their business ventures. The expected pattern increases conjugality and

intimacy between spouses, which in turn should increased the level of communication between spouses.

Traditionally Ga women processed and marketed fish and farm produce harvested by husbands and used the profit accrued for the upkeep of themselves and the household. This pattern appears in Diagram 5.1 in which about 30 per cent of the females and 51 per cent of the males reported that they were economic co-operation with their partners.

DIAGRAM 5.1. COUPLES WITH ECONOMIC CO-OPERATION BY TYPE OF RESIDENCE.



Source: Field Data, 1999.

It has however been observed that, only 29.9 per cent of women and 51.8 per cent of the men reported that they had some form of economic co-operation with heir spouses. More than 90 per cent of women and about 63 per cent of the men in the urban areas had no economic co-operation with their spouses compared to 58.2 per cent of the women and 56.3 per cent of the men in rural areas. The decline in economic co-operation is possible due to the fact that, women fear they may lose property acquired jointly with the man when he dies. It was also observed during the in-depth interview and FGDs that, women were sceptical about their husbands' faithfulness and so they thought it would be better if they acquired their own property so they have control over it. Also, some women from both urban and rural areas reported during the in-depth interview and FGDs that the men were becoming irresponsible and that the moment they (men) got to know of their financial position, they would stop giving them the daily housekeeping money.

Also, about three-quarters of women said they had not taken any capital from their husbands for their businesses because they did not want their husbands to know the details of their businesses. The main sources of capital for women who wanted to set up their own businesses were "susu" (a traditional form saving) (52.5 per cent), banks (32.5 per cent) and husbands (15.0 per cent) (Table 5.1). However, since some women do not

have collateral security to enable them take loans from banks it has now become difficult for them to get capital for their business from this source.

Table 5.1. Sources of Capital for Women

Sources of Capital	Percentage	Frequency
Susu	52.5	21
Banks	32.5	13
Husbands	15.0	6
TOTAL	**100.0**	**40**

Source: Field Data, 1999.

5.2. Wife Battering.

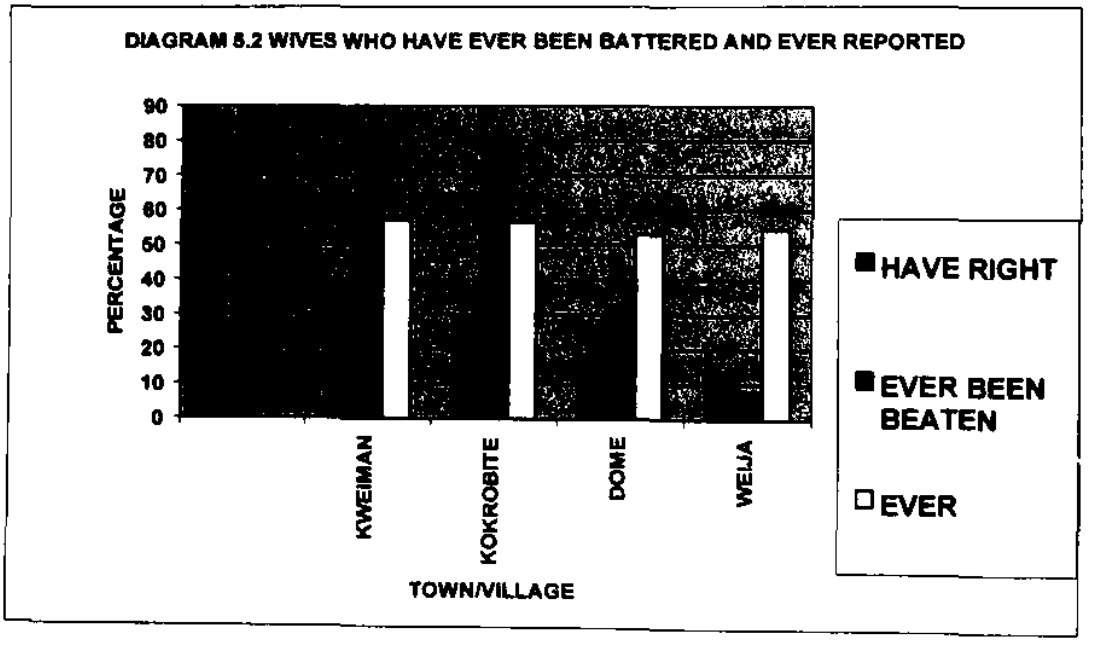
Although violence against women such as wife battering is known to occur both within and outside formal relationships, there is general unwillingness to discuss or report the problem, making it a difficult subject to study (Abane, 1999). Wife battering is not only against women's rights, but also, has serious implications on their reproductive health (Population Reports, 1998). Violence against women is one of the major determinants of women's inability to make reproductive choices. Violence in the form of rape, sexual abuse, or battery affects women's ability to protect themselves from unwanted pregnancies and sexually transmitted diseases, including AIDS. Even where physical violence is not used to control women's behaviour, the possibility of violence helps to

ensure female deference to male decision-making regarding sexual behaviour and contraception use (Hesse, 1995).

Diagram 5.2 shows the perception and attitude of respondents toward wife battering. About 70 per cent and more than 80 per cent of women in rural areas and urban areas respectively said men had no right to beat their wives. About 90 per cent of women and 72 per cent of men with tertiary education also indicated that men should not beat their wives under any circumstance. However, 45.7 per cent of the women and 89.3 per cent of the men with only primary school education reported that it was right for a man to beat their wife when she showed disrespect, engage in extra-marital affairs, refused to have sex with the man, failed to cook or travelled without the knowledge of her husband.

About 57 per cent of the women from rural areas and 54 per cent from urban areas indicated they had ever reported their husbands to an authority when they were beaten by them. This is inconsistent with the expected since women in urban areas are expected to know more about their rights and exercise such rights than their rural counterparts. However, while about 80 per cent of the rural women reported that they had ever been beaten less than 60 per cent had ever reported such incidences to any authority.

The higher the level of education, the more likely it was for a woman to report battering. As shown in Table 5.2 out of the 41 women with no formal educatior who had been beaten, only 19.5 per cent ever reported compared to 83.3 per cent out of 6 of their counterparts with tertiary education. Thus education is one of the major variables which seemed to have influenced women's attitude towards wife battering.



Source: Field Data, 1999

Table .5.2. Percentage of Wives Ever Reporting Battering by Educational Attainment.

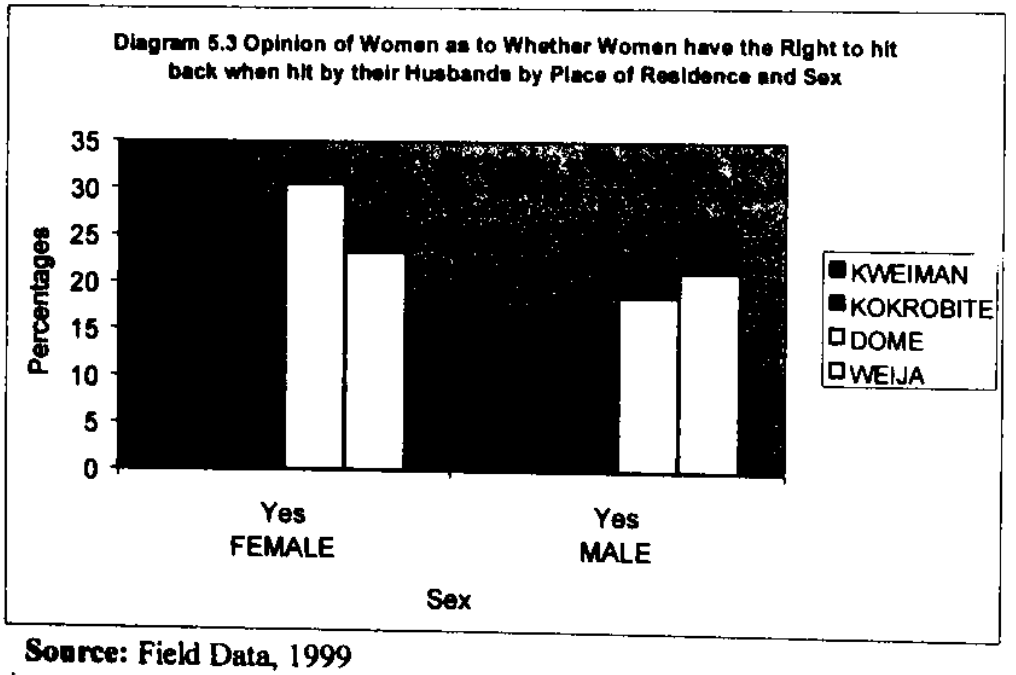
EDUCATIONAL ATTAINMENT	EVER BEATEN (YES)	EVER REPORTED (YES)	N
NO FORMAL EDUCATION	65.0	19.5	41
PRIMARY EDUCATION	85.0	33.3	18
MIDDLE/JSS	72.1	42.9	98
SSS/COMM/VOC/TECH	55.3	67.5	40
TRAINING/NURSING/POLYTECH	52.6	80.0	10
UNIVERSITY/DIPOLMA	46.0	83.3	6
TOTAL			**213**

Source: Field Data, 1999

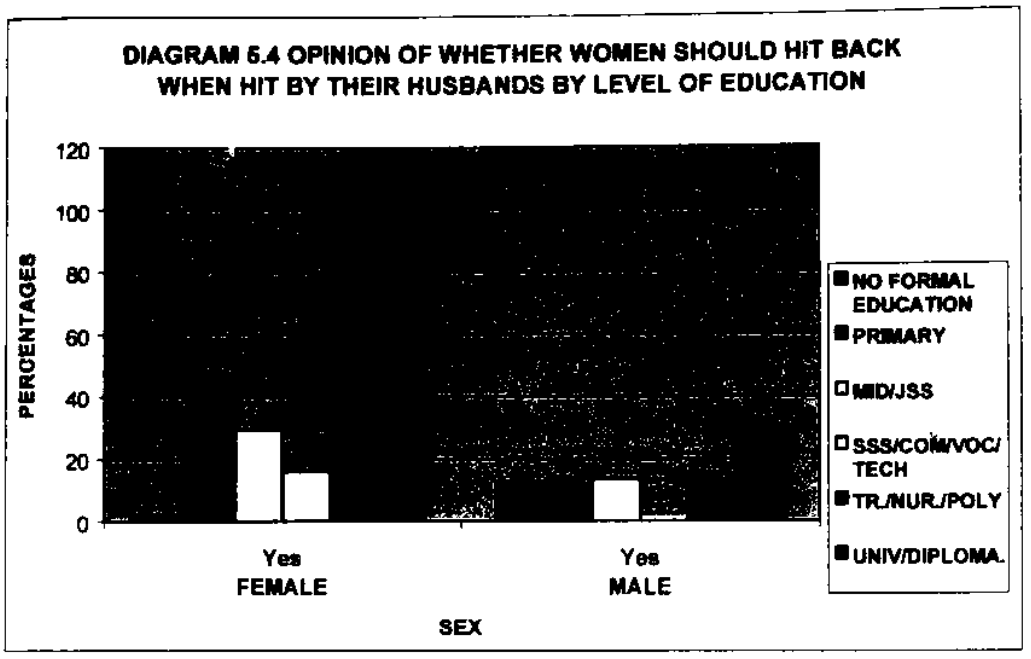
The reasons given by women for not reporting to any authority when they were beaten, were that their husbands accepted their faults and apologised (35.1 per cent), both of them agreed and settled the issue at home (23.1 per cent), they thought they were guilty (11.1 per cent) and they do not want to put the men in trouble (5.1 per cent) (Table 5.3). Only 2 per cent (5) of the men answered the question on the issue and said that it was not right for men to beat their wives. It is probable that most of the men did not answer the question because they did not want to make their views known.

quality of the relationship, her judgement of what the abuse means, her estimation of future threats, and her experience of the man's response following the attack (Neil, 1991).

Nearly 80 per cent of the respondents, consisting of 77 per cent of the females and 85 per cent of the males did not agree that women should have the right to hit back when their husbands strike them. Twenty seven per cent of females from urban areas and 17 per cent of those in rural areas agreed that women should hit back when hit by their husbands. Similarly, more males in urban areas (20 per cent) than in rural areas (14 per cent) agreed that women should have the right to hit back when hit by their husbands (Diagram 5.3).



Source: Field Data, 1999



Source: Field Data, 1999

All the females who had attained post-secondary education felt women have the right to hit back when they were hit by their husbands but only 30 per cent of their male counterparts agreed that women should have such rights. Also only 1.9 per cent of women without any formal education felt the women had the right to retaliate. The effect of education on the perception of men on the issue also increased with education but the increase is less than that which has been observed for the women. For example, 30 per cent of men with tertiary education as compared to less than 14 per cent of their counterparts with education lower than tertiary education agreed that women have the right to retaliate when hit by their husbands. With increase in the level of formal education women are more likely to reject traditional norms which subject them to inferior positions

and this has influenced their perception regarding the right to retaliate when hit by their husbands.

The reasons given for women's failure to fight when hit by their husbands include the fact that it is against tradition for women to hit their husbands because they are considered to be the head of the family and the father of the household. Secondly, the women had learnt from experience, that hitting back often escalated the conflict and increased the physical violence against them. Thus, they avoided hitting back because they feared that it might increase the likelihood and severity of the attack. Under these conditions women become hesitant to challenge their husband's views or question the right of the husband to assume a position they do not approve of, for fear that they might incur the displeasure of their husbands.

Table 5.4. Reason why Women Should or Should not Hit Back When Hit by their Husbands by Sex.

REASONS	URBAN	RURAL
FEMALES		
It is a taboo to hit your husband	11.9	30.9
It does not show respect towards your husband	25.4	11.4
Man will beat you mercilessly	15.4	28.7
It pains so women should hit back	16.7	9.5
It is just not right to hit back	15.7	—
It is against our culture	14.9	19.5
TOTAL	100.0	100.0
N	**90**	**75**
MALES.		
Women are under the man, the head of the family	62.8	62.1
It is a big sin	26.0	23.4
You can't hit someone who is stronger than you	6.6	12.4
It does not show love	4.6	2.1
TOTAL	100.0	100.0
N	**90**	**56**

Source: Field Data, 1999

5.3. Control Over Sexuality.

Control over one's sexuality is an essential precondition for exercising other rights and to fulfil other basic needs. When women have control over their sexuality, they are able to have access to information and make informed decisions about their reproductive health (Coliver, 1995, Awusabo-Asare et al, 1993). To assess women's control over their sexuality, their perception and involvement in pre-marital sex, extra-marital sex and right to refuse sex within marriage were examined.

5.3.1 Pre-marital Sex

Traditionally, sex among girls and to some extent boys, who have not been initiated, is prohibited in any Ghanaian society. A girl or boy who had pre-marital sexual intercourse was severely punished, although punishment for boys was less severe. This was necessary to ensure the virginity of girls before marriage. The degree, to which boys and girls were allowed to engage in pre-marital sex, to some extent, indicated the level of control they had over their sexuality and reproduction.

The data indicated that more than half of the respondents had engaged in sex before marriage. However, about 60 per cent of those who had had pre-marital sex were males and the rest, 40 per cent, were females. About 13 per cent of females who had sexual relationship before marriage indicated that they had been forced. "Force" here did not necessarily mean physical force but was also implied yielding to a man's persistent demands. Of those who were forced, forty-six per cent said the men involved were not those they eventually married.

Table 5.5 shows the percentage distribution of respondents who had had pre-marital sex according to selected characteristics.

Table 5.5. Respondents who had Engaged in Pre-marital Sex by Selected Characteristics

SELECTED CHARATERISTICS	MALES	FEMALES
SETTLEMENT	**YES**	**YES**
KWEIMAN	52.6	32.6
KOKROBITE	53.3	37.7
DOME	65.2	43.8
WEIJA	68.3	52.3
EDUCATIONAL STATUS		
NO FORMAL EDUCATION	55.7	25.8
PRIMARY EDUCATION	49.3	28.3
MIDDLE/JSS	40.3	31.6
SSS/COM/TECH/VOC	59.8	33.7
TRAINING/NUR./POLY	72.4	54.8
UNIVERSITY/DIPLOMA	73.5	67.6
RELIGION		
CATHOLIC	45.8	54.5
PRESBY	55.8	52.0
MOSLEM	86.8	33.2
TRADITIONAL	88.4	23.6
PENTECOSTALS	27.5	41.5
TOTAL	**59.7**	**40.2**

Source: Field Data, 1999

An average of about 53 per cent of males from rural and 67 per cent of those from urban areas reported that they had had pre-marital sex. However, an average of around 35 per cent and 48 per cent of rural (Kweiman, 32.6 per cent and Kokrobite, 37.7 per cent) and urban (Dome, 43.8 per cent and Weija, 52.3 per cent) women respectively reported that they had engaged in pre-marital sex. This shows the societal expectations and differences in male and female sexuality in the area. The difference

between rural and urban areas also indicates that traditional norms still restrict pre-marital sex in rural areas, compared to the urban areas.

Secondly, the higher the level of education, the more likely it was for both men and women to engage in pre-marital sex. While more than 70 per cent of men who had had tertiary education indicated that they had engaged in pre-marital sex, about 40 per cent of those with education lower than tertiary level had done so. Also, about 60 per cent of women with tertiary education said they had engaged in pre-marital sex but around 30 per cent of their counterparts with education lower than tertiary level had done so (Table 5.6). Thus with formal education, people adopt new norms and values such as pre-marital sexual activity and late marriage which may have serious health implications if adequate information on reproductive health services are not available.

Among the men, traditionalists (88.4 per cent) and Moslems (86.8 per cent) had the highest percentage of those that had pre-marital sex. Pentecostals (27.5 per cent) had the least percentage of men who had pre-marital sex. Among the women, Catholics (54.5 per cent) had the highest percentage and traditionalists (23.6 per cent) had the least percentage. Whereas traditional religion had the highest percentage of males who had indulged in pre-marital sex, it also had the least percentage of females who had pre-marital sex. This suggests that traditional religion places more

emphasis on female virginity than male virginity. With urbanisation and education, and the attendant increase in early sexual activity, the elimination of poverty and promotion of safer sex, education and equal access to contraception at an early age are important measures to reduce the exposure of women to infection.

5.3.2. Extra-marital Sex.

Marriage in Ghana as in other parts of the world, is a socio-economic union. It provides a recognised avenue for procreation and the care of children. A woman is traditionally expected to be faithful to and sexually available for her husband. On the other hand, society perceives extra-marital sex as a right of men and a process through which another marriage could be contracted (Neil, 1991).

Table 5.6 shows the perception of respondents on extra-marital sex by selected socio-economic characteristics. The data show that sex, place of residence, educational status and religious affiliation influenced the perception of people on extra-marital sex. A higher percentage of male respondents with lower educational attainment from the rural areas felt that men could engage in extra-marital sex. Regardless of social status, more males (27 per cent) than females (9.7 per cent) thought that men could engage in extra-marital sex.

It was also observed that the higher the level of education the more likely it was for both men and women to reject extra-marital activities. For instance, while about 49.5 per cent and 22.4 per cent of the men and women respectively, who had no formal education thought that married men could engage in extra-marital sex, none of the respondents with tertiary education reported that married men should engage in extra-marital sex. Among the religious sects, those professing to traditional religion and Islam endorsed extra-marital sex. About 50 per cent and 51 per cent of the men in the Traditional and Islamic religions respectively said it was right for men to have sex outside marriage. Also, more females in Traditional (21 per cent) and Islamic (20.7 per cent) religions felt that it was the right of men to have extra-marital sex than females in other religions such as Catholic (7.5 per cent), Anglican (4.2 per cent), Methodist (9.6 per cent), Presbyterian (6.5 per cent) and Pentecostal (4.5 cent). In the traditional society, extra-marital sexual activity by a woman is considered to be adultery. But extra-marital sexual activity of the man with an unmarried woman is not. Also, traditional marriage is a culmination of a series of relationships, including extra-marital relationships which could lead to another marriage. Wives in traditional marriages therefore do not care about their husbands' extra-marital affairs so long as they are able to fulfil their marital obligations to them. Hence, women in traditional marriages are more tolerant of their husband's extra-marital affairs than women in Christian marriages.

On the other hand, only 6 per cent of males and 13 per cent of females indicated that females could engage in extra-marital sex. Men in traditional and Islamic religions, with education lower than the tertiary level and residing in rural areas disagreed that women should have the right to engage in extra-marital sex. Among the women who said wives could engage in extra-marital sex, 86.3 per cent were in urban areas and the rest were in rural areas. About 80 per cent of the women with tertiary education were also more inclined to the view that women should have the right to engage in extra-marital sex, while only 21.2 per cent of their counterparts with secondary, basic and those without any formal education supported this view.

Table 5.6. Respondents' View on Extra-marital Sex by Selected Characteristics

SELECTED CHARATERISTICS	MALES	FEMALES
SETTLEMENT	YES	YES
KWEIMAN	35.3	13.3
KOKROBITE	44.4	15.6
DOME	10.8	6.2
WEIJA	21.0	1.4
EDUCATIONAL STATUS		
NO FORMAL EDUCATION	49.5	22.4
PRIMARY EDUCATION	43.8	19.0
MIDDLE/JSS	38.6	12.3
SSS/COM/TECH/VOC	29.8	4.5
TRAINING/NUR./POLY	–	–
UNIVERSITY/DIPLOMA	–	–
RELIGION		
TRADITIONAL	49.8	21.0
CATHOLIC	25.8	7.5
ANGLICAN	15.8	4.2
METHODIST	18.4	9.6
PRESBY	27.5	6.5
PENTECOST	25.6	4.5
MOSLEM	50.7	20.7
TOTAL	**27**	**9.7**

Source: Field Data, 1999

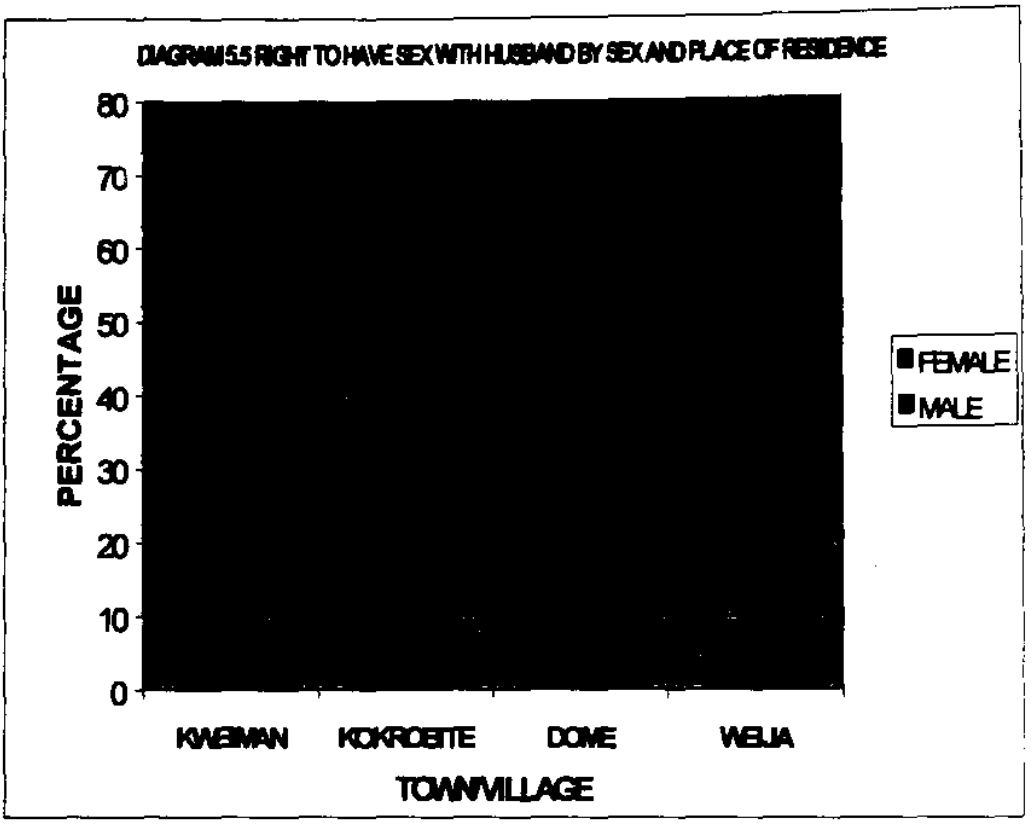
While 54.1 per cent of the men and 41.2 per cent of the women in the study area said men could practise polygyny, only 18.2 per cent of the men and 5.7 per cent of the women agreed that men should engage in extra-marital sex. Some of the reasons advanced for this preference are that extra-marital sex could lead to contracting STDs, husbands likely to spend income on a girlfriend more than on a wife, and marital problems

can arise from extra-marital sex. Thus, for women, polygyny is perceived as an option that will ensure safer sex, maintain marital relationship and ensure the sustenance of economic support from their husbands.

5.3. 3. Right to Refuse Sex within Marriage

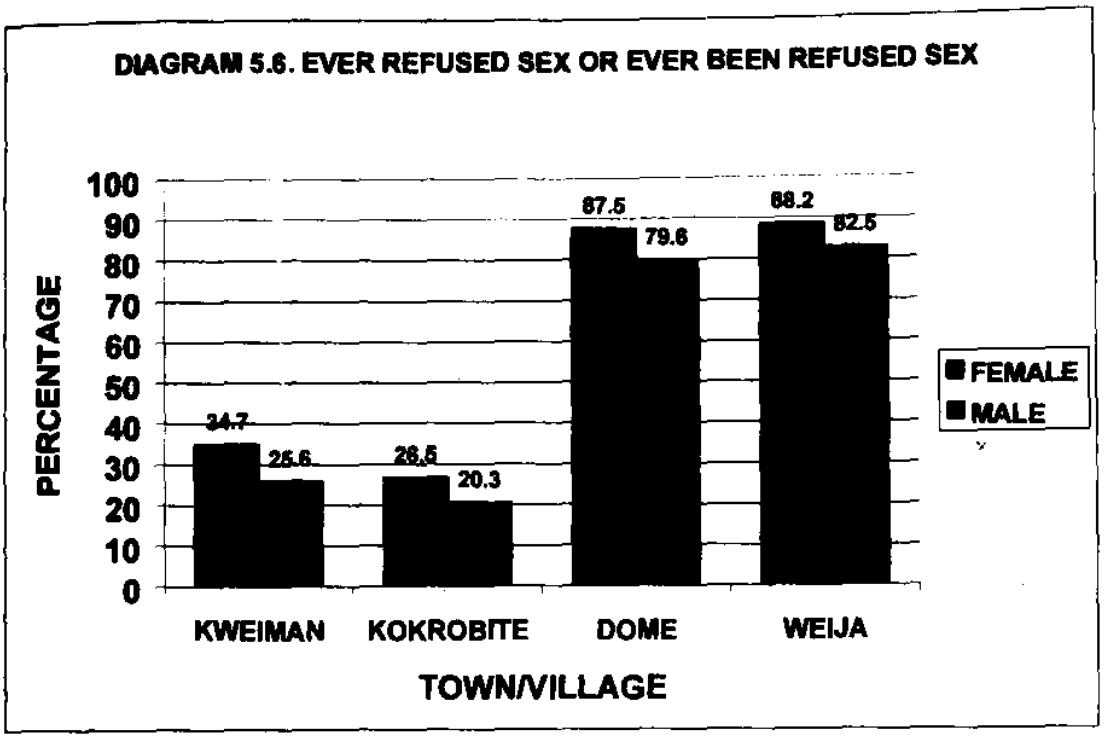
Differences in sexual demands and expectations can lead to misunderstanding and domestic violence. Since the decision making power of women is limited they are often compelled to yield to the sexual demands of their husbands, even if they are not physically and psychologically prepared for it (Neil, 1991).

This section examines responses on the right of women to refuse sex within marriage. About 60 per cent of women and 90 per cent of men from both rural and urban areas (except men from Weija) reported that it was not right for a woman to refuse sex with her husband in any way (Diagram 5.5). Although, the proportion reporting that a woman had no right to refuse sex is high, more females than males indicated that it was right for women to do so.



Source: Field Data, 1999

On average more than 80 per cent of the women in rural areas indicated that they had ever refused sex with their husbands (Diagram 5.6). While 60 per cent of women in rural areas indicated it was not right for women to refuse sex with their husbands, over 80 per cent of the same women claimed they had done so.



Source: Field Data 1999

Table 5.7. Reasons for Refusing Sex with Husband.

TOWN/ VILLAGE	WHEN UNHAPPY	WHEN NOT WELL	WHEN ANNOYED	IMMED AFTER BIRTH	FOR DRINKING	WHEN IN MENSES	N
KWEIM	75.0	12.5	6.3	0.0	0.0	78.4	48
KOKRO	74.2	12.9	6.5	0.0	0.0	85.4	63
DOME	54.3	42.8	0.0	2.9	0.0	67.4	35
WEIJ	50.0	25.0	0.0	0.0	25.0	58.9	29
N	114	35	7	7	6	6	175

Source: Field Data, 1999

The reason given for refusing sex included "being unhappy" (66.9 per cent), "not well" (20.7 per cent), "was annoyed"(9.2 per cent), "when he was drunk"(3.6 per cent) and "immediately after birth" (0.6 per cent) (Table 5.7). As to whether women had actually refused to have sex with

husbands is debatable because sexual activity would normally not take place under the conditions which women claimed they had refused sex with their husbands. These conditions may not favour conjugal union and intimacy and so men would naturally not have sex with their wives. For example, traditionally sexual intercourse with a woman in her menses is not encouraged and so men will not have sex with their wives during menstruation. It is therefore probable that women were able to refuse sex with their husbands only when the men could not resist or become annoyed. Judging from the conditions under which rural women live, the only logical conclusion that can be drawn is that women from rural areas probably lied to favour their husbands.

Table 5.8 shows the reaction of men to the refusal of their wives to have sex with them as reported by women from the study area. From the data, only 5.0 per cent of the women indicated that their husbands understood them when they refused to have sex with them. A quarter said there was no reaction from their husbands and about 70 per cent indicated their husbands were annoyed. These responses point to doubts about the earlier reporting that the women had actually refused to have sex with their husbands.

Table 5.8. Reaction of Husband when Refused Sex.

REACTION OF HUSBAND	PERCENTAGE	N
No Reaction	24.3	34
He became wild/annoyed	70.7	99
He understood me	5.0	7
TOTAL	**100.0**	**140**

Source: Field Data, 19

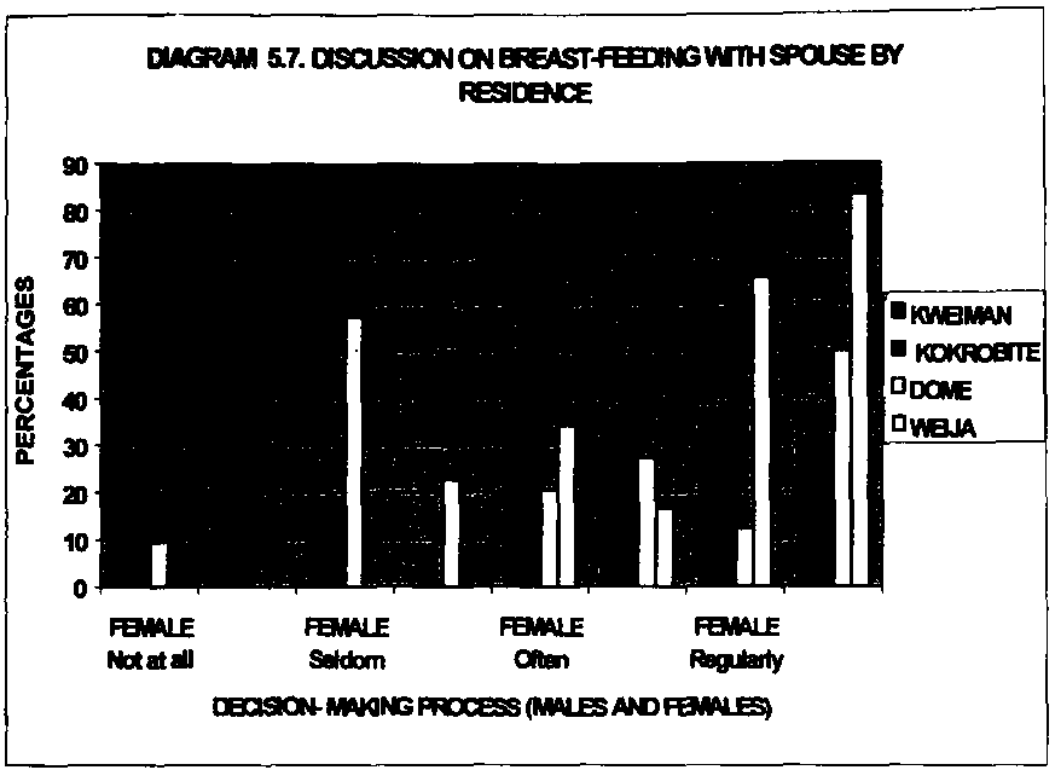
5.4. Breastfeeding and Abstinence

Breastfeeding and abstinence are both practices which ensure that the fertility of the women is kept below the biological level and increase the birth intervals of women as well as ensuring good health for the child and mother. This section assesses the level of spousal communication and how it affected decision-making on breastfeeding and abstinence.

5.4.1. Decision-making on Breast-feeding.

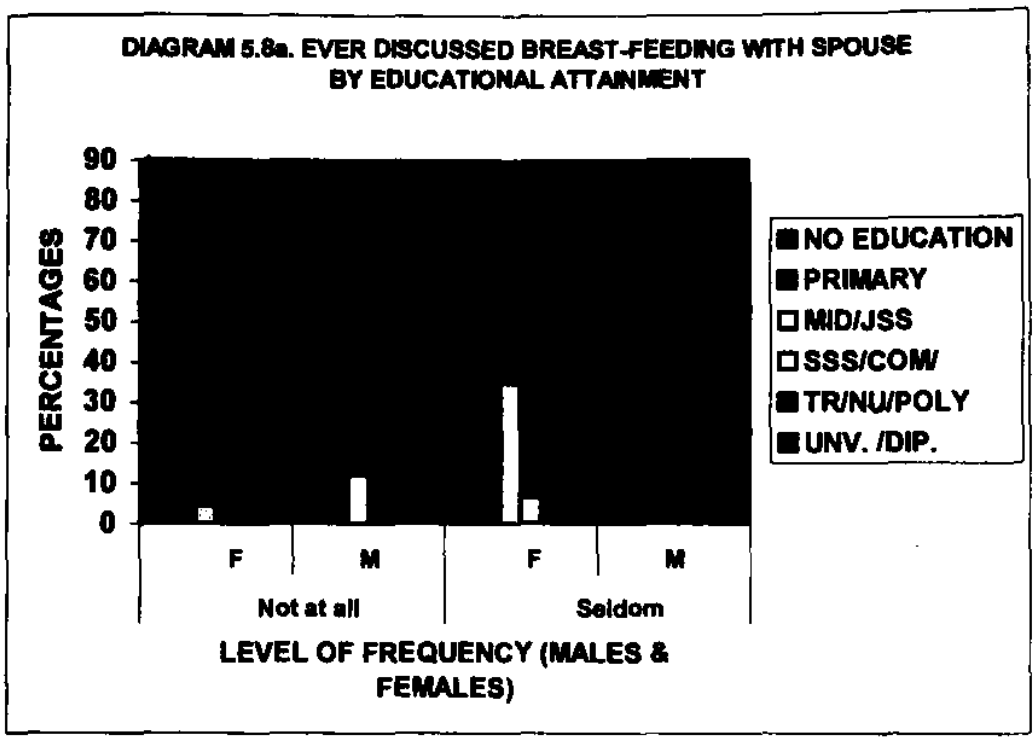
Diagram 5.7 shows the level of communication on breast-feeding between spouses by place of residence. Regardless of place of residence, more than two-thirds of respondents ''often'' and ''regularly'' discussed breast-feeding with their spouse. Residents at Weija reported the highest percentage of both men (83.3 per cent) and women (65.7 per cent) who had indicated that they ''regularly'' discussed the issue with their spouses. About 16 per cent of men and 2.2 per cent of women indicated that they had not discussed breast-feeding with their spouses. On the other hand,

38.7 per cent of women and 39 per cent of the men stated that they had "often" and "regularly" discussed the issue with their spouses.

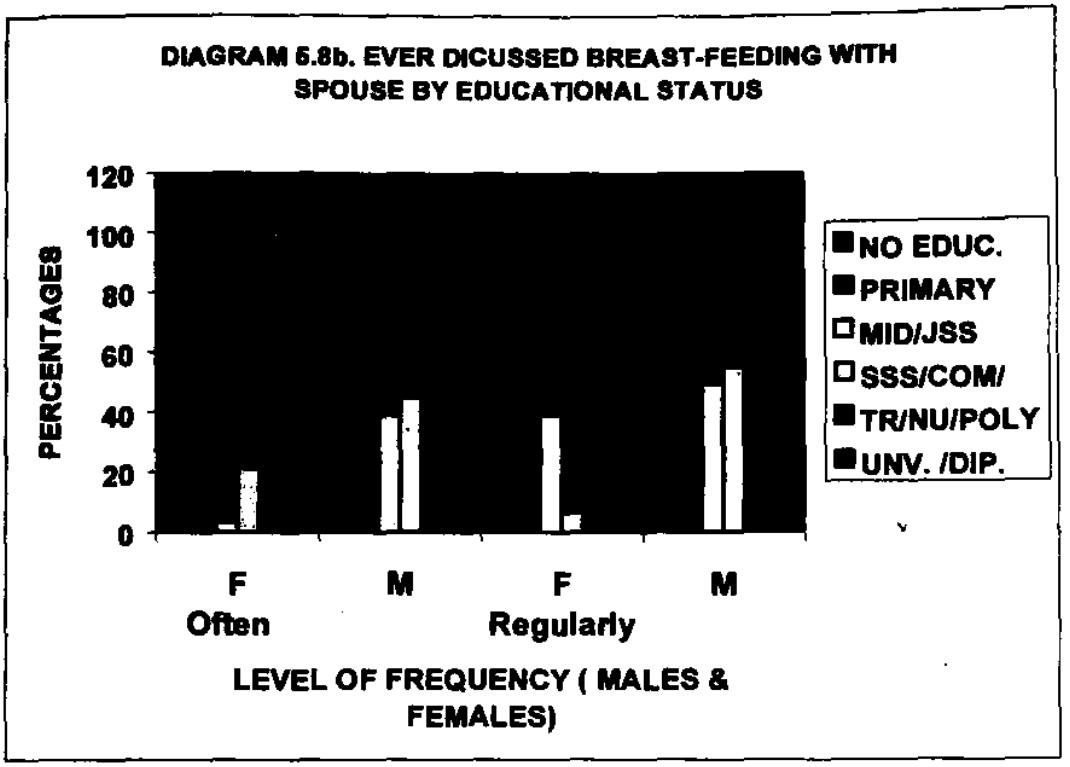


Source: Field Data, 1999

None of the men and women with post-secondary education, stated that they had discussed breastfeeding compared to 85.7 per cent of males and 15.8 per cent of females without any formal education. Thus, it appears that, the higher the level of education of respondents the more "often" and "regularly", couples discussed the issues (See Diagrams 5.8a and 5.8b). This is due to the fact that with education, the status of women increases and their ability to communicate to their husbands on reproductive matters also increases.



Source: Field Data, 1999.

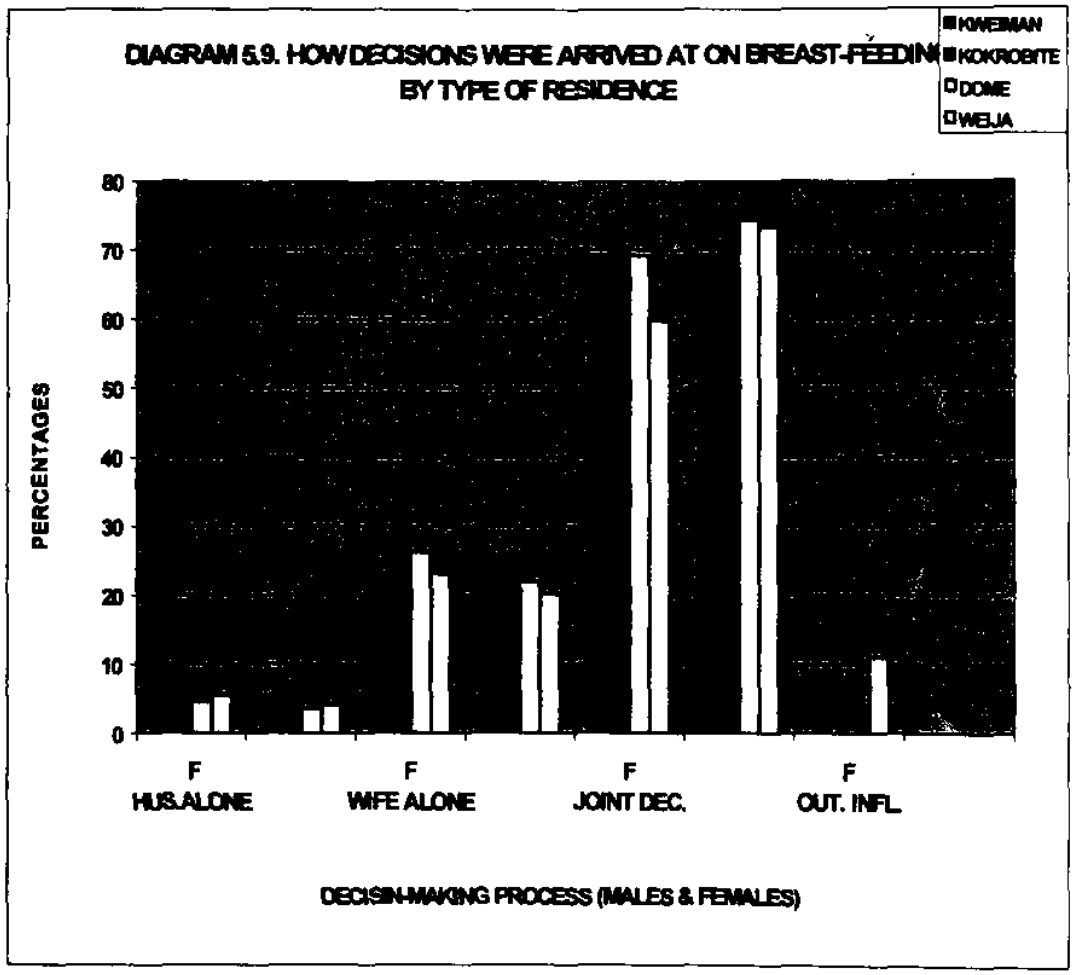


Source: Field Data, 1999.

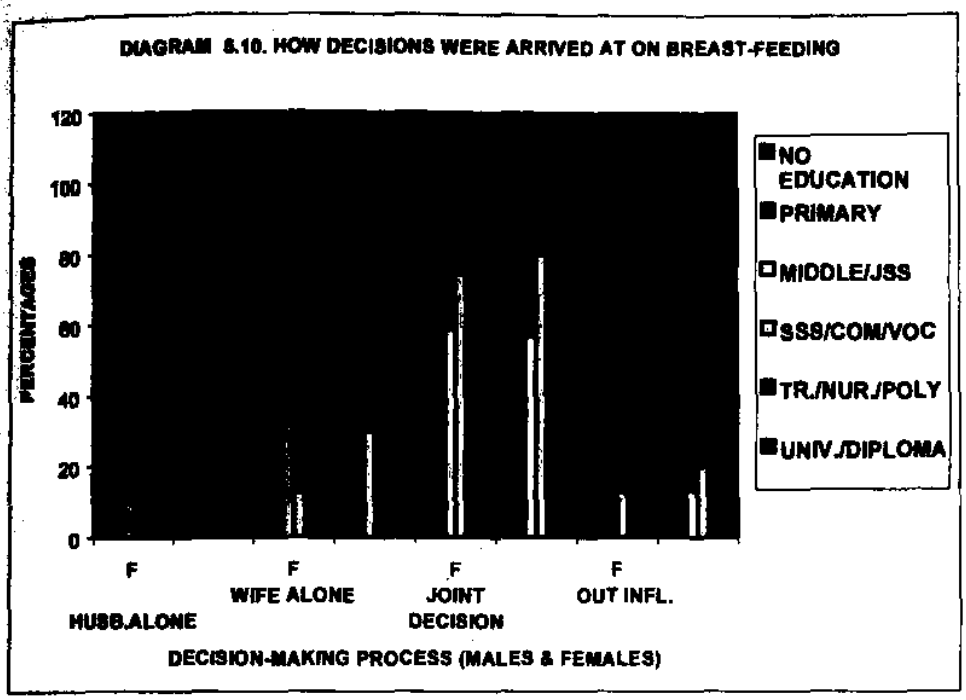
With respect to decision-making on breastfeeding, joint decision was the commonest in the household. More than two- thirds of respondents from both rural and urban areas cited joint decision-making as the process adopted on breast-feeding. Irrespective of residence, some husbands alone decided on the issue, although the percentage for rural respondents (13.3 per cent) was slightly higher than the percentage for urban (8.8 per cent) respondents (Diagram 5.9). Also, more than 20 per cent of respondents had indicated that woman took independent decision on the issue.

On the relationship between respondents' education and decision-making on breast-feeding, it was observed that, the higher the level of education the less likely it was for husbands alone to make decision on breast-

feeding. As shown in Diagram 5.10, none of the respondents with post-secondary education said that their husbands alone took decisions on breast-feeding. However, 23.8 per cent of women and 45.0 per cent of the men with primary education said men alone made the decision on the issues.



Source: Field Data, 1999

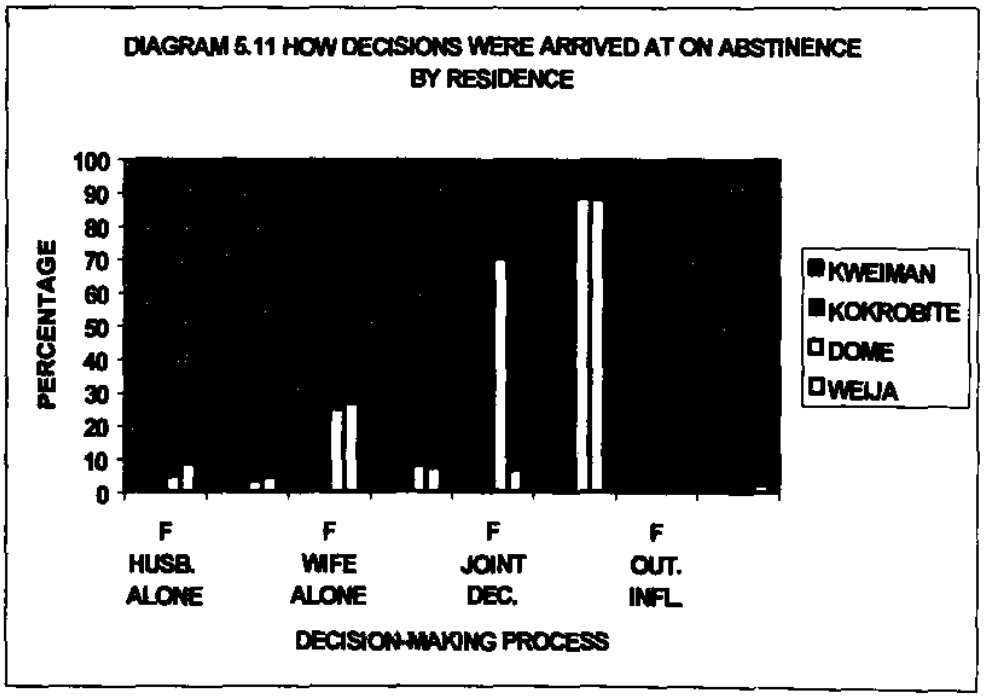


Source: Field Data.1999

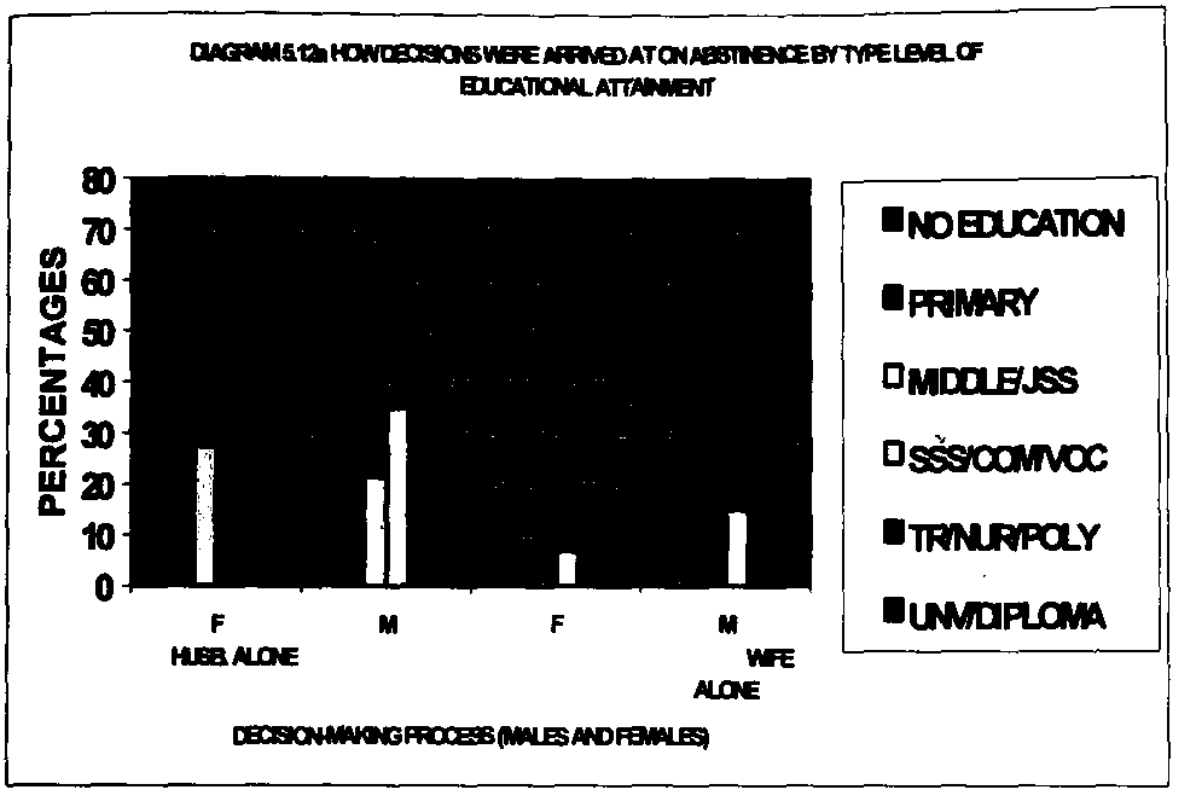
5.4.2. Decision-making on Abstinence

On abstinence, more women in rural areas (11 per cent) than in urban areas (7 per cent) said their husband alone took the decision. This is consistent with the response from the men, where about 24.0 per cent of those in rural areas compared to 4.0 per cent in urban, said they had taken such a decision alone. Furthermore, whereas about 26.0 per cent of women in urban areas claimed they had taken such a decision alone, about 15.0 per cent of their rural counterparts did so. Also, outside influence was greater on rural women than their urban counterparts. Outside influence on males (about 6.0 per cent) was also higher than on females (about 5.0 per cent). Since men are the primary decision-makers, any influence on them

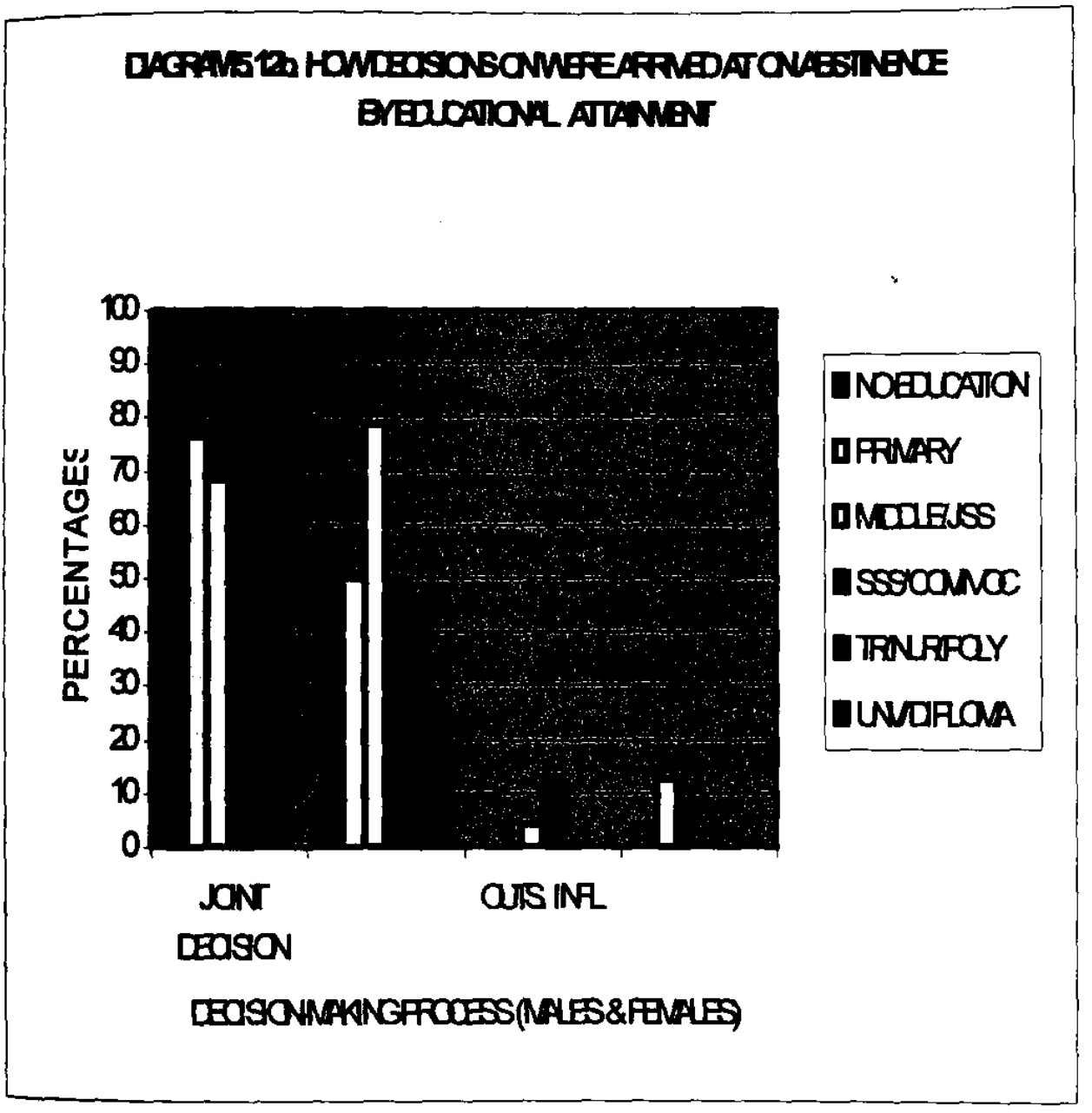
would affect the fertility behaviour of women. Thus, outside influence such as that from parents is more likely to be on the man than on the woman. Also, men are constantly under societal pressure to prove their manhood and maintain the family lineage, hence they are more likely to be under influence from outside than women. These responses however, differ from those on the resumption of sex after birth. This is because whereas women in the rural areas said their husbands alone never took the decision on the resumption of sex after birth, 11 per cent of the same women said their husbands took the decision alone on abstinence (Diagram 5.11).



Source: Field Data, 1999.



Source: Field Data, 1999.

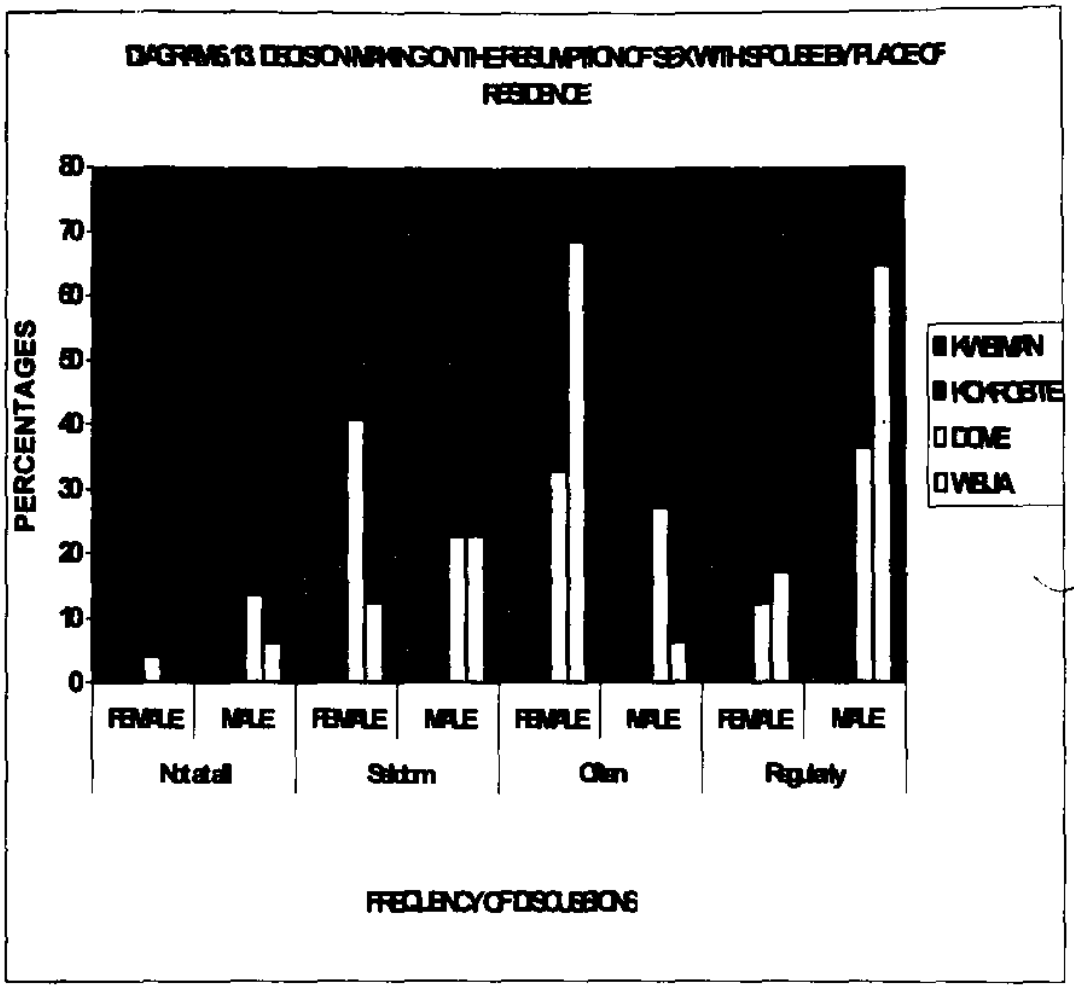


Source: Field Data, 1999.

A comparison by educational attainment shows that education has an impact on degree to which females have control over sexuality (Diagrams 5.12a & 5.12b). The higher the level of education the more likely it is for women to make independent decision on abstinence. For example, while no woman with educational attainment below secondary level had ever made an independent decision on abstinence, the percentage of women who had ever made such a decision increased from 7 per cent for SSS/Com to 16 per cent for those who had had University/Diploma education. Influence from outside was more on females whose educational background is relatively lower than females whose educational background is relatively high. It is clear from the above that women can have control over their sexuality and reproduction if their level of formal education is increased. This is because with increased in formal education the perception of women would changes and their self-esteem increased.

5.5. Resumption of Sex after Childbirth

Traditionally, whereas women were expected to abstain from sex after childbirth, men can still go on with their normal sexual activities. Also, the decision as to when to resume sex after childbirth may be difficult when couples rarely discuss issues concerning sex.



Source: Field Data, 1999.

The decision-making process of respondents regarding how and who decide(s) on the resumption of sex after childbirth is presented in Diagram 5.13. There is no clear pattern between urban and rural residents regarding discussion on the resumption of sex after childbirth. For example, about 22 per cent of the females as against 5.3 per cent of the males said they had never discussed the

issue with their spouse. The influence of education on the level or frequency with which spouses discussed the resumption of sex after childbirth shows that, about 11 per cent of men with post-secondary education had not discussed the issue with their wives while 100 per cent of the women with post-secondary education did "often" or ''regularly'' discussed the resumption of sex with husbands. In general, the women who discussed the issue ''often'' with their husbands increased from 52 per cent for those without any formal education to 100 per cent for those with University education (Table 5.9). The possible explanation for the relatively high percentage of people who ''often'' discussed the issue is that, it is difficult to recollect the regularity with which the issue has been discussed. On the other hand, it is not difficult to say the issue had ''often'' been discussed thus people may have opted for ''often'' rather than ''regularly''. On how decisions were arrived at on the resumption of sex, 50 per cent of the men and two-thirds of the women reported that they took joint decisions on the issue.

Table 5 .9. Discussion on the Resumption of Sex with Spouse by Educational Attainment

EDU STATUS	DISCUSSED RESUMPTION OF SEX									
	NOT AT ALL		SELDOM		OFTEN		REGULARLY		N	
	F	M	F	M	F	M	F	M	M	F
NO EDU.	12.0	85.7	32.0	0.0	52.0	14.3	4.0	0.0	44	41
PRIMARY	0.0	0.0	18.8	0.0	81.0	50.0	0.0	50.0	19	14
MID/JSS	6.4	18.8	33.0	15.9	28.5	30.4	32.1	34.9	85	69
SSS/COM/VOC	0.0	0.0	20.0	0.0	80.5	45.0	0.0	55.0	12	13
TR/NUR.POLY	0.0	10.7	0.0	50.0	100.0	0.0	0.0	21.4	10	11
UNIV/DIPL	0.0	0.0	0.0	0.0	100.0	33.3	0.0	66.0	4	1
N	45	38	54	31	24	39	51	41	174	149

Source: Filed Data, 1999.

Table 5.10. How Decisions were Arrived at on the Resumption of Sex After Childbirth by Type of Residence.

SETTLEMENT	RESUMPTION OF SEX							
	HUSBAND ALONE		WIFE ALONE		JOINT DECISION.		OUTS. INFLU.	
	F	M	F	M	F	M	F	M
KWEIMAN	0.0	23.4	21.4	12.2	78.6	64.4	0.0	0.0
KOKROBITE	0.0	21.0	22.6	15.2	77.4	43.8	0.0	0.0
DOME	5.9	25.8	17.6	12.7	76.5	61.5	0.0	0.0
WEIJA	19.0	31.2	10.3	10.6	60.3	49.8	10.3	8.4
(TOTAL) N	19	21	18	20	48	49	19	14

Source: Field Data, 1999

None of the women in the rural areas said their husband took the decision alone but about 13 per cent of the males said that the women had made the decisions alone. At Weija about 9 per cent of the respondents indicated that outsiders had influenced their decision on the issue (Table 5.10).

Table 5.11 presents decision-making on the resumption of sex after birth by educational attainment. Only 13.1 per cent and 19.2 per cent of men with Middle/Junior Secondary and Secondary/Commercial/Vocational/Technical education respectively and 12.8 per cent of females with Senior Secondary/Commercial/Vocational/Technical certificates had been influenced from outside. Females at all levels of educational attainment except Primary (23.8 per cent) and Middle/JSS (5 per cent) said their husbands never took independent decision on the issue. However for the males, those without any formal education, Middle/JSS leavers and University/Diploma graduates had indicated that they took the decision alone.

Also, whereas respondents irrespective of the type of residence had experienced some outside influence with respect to abstinence, only residents from Weija have had some influence from outsiders on the resumption of sex. While people may perceive the latter as more sensitive and would not want to talk about it, women would also lie probably to favour their husbands and to avoid provocation and a possible confrontation. This is because some men often accuse their wives of making false accusations against them, especially, when they felt the answer provided by their wives were not in their favour.

Table 5.11. How Decisions were taken on the Resumption of Sex After Childbirth by Educational Attainment

EDUC STATUS	DISCUSSED RESUMPTION OF SEX							
	Husband Alone		Wife Alone		Joint Decision		Outside influ	
	F	M	F	M	F	M	F	M
NO EDUC.	0.0	0.0	18.2	42.9	81.8	51.1	0.0	0.0
PRIMARY	23.8	50.0	0.0	0.0	76.2	50.0	0.0	0.0
MID/JSS	4.0	0.0	26.7	24.6	69.3	62.2	0.0	13.1
SSS/COM/VOC/	0.0	34.0	0.0	0.0	87.2	46.2	12.8	19.2
TR./NUR/POLY	0.0	25.8	46.2	0.0	53.8	74.2	0.0	0.0
UNIV/DIP	0.0	0.0	100.0	0.0	0.0	100	0.0	0.0
N	19	21	18	20	48	49	19	14

Source: Field Data, 1999.

5.6. Conclusion

The right of women to decide on a wide range of issues including those on sexuality is dependent on perception regarding the rights and status of women and men in the society. In general, men have more control than women over decision-making on issues such as use of family planning methods, when and how to have sex and use of condoms.

Although the analyses showed that women have some level of autonomy in terms of decision-making, men were still the primary decision-makers on sexual activity, fertility and contraceptive use. As wives are acquired through the payment of exorbitant bride prices, women's input into decision-making

on reproduction is secondary. In the study area women, after marriage become their husbands' "property", were absorbed into the husband's lineage. Women's primary function then becomes the production and rearing of children for the husband and his lineage (Bawah et. al, 1999). Any attempt by women to take control of their reproductive function is considered as shirking of marital obligation and interference in the natural process of reproduction.

The freedom of women to decide on how many children to have and when (or whether) to have them have, therefore, been circumscribed by fear of violence, fear of withholding affection and the fear of preference for another wife. The fear of domestic violence for instance, has reduced women's ability to negotiate for safer sex. Thus, the mere prevalence of wife battering, irrespective of the magnitude, is enough to deter women from making informed decisions about their reproductive behaviour (Sai, 1994).

The implications are that women are forced to practise unhealthy reproductive health behaviour which may have adverse consequences on their health. The dominance of men in decision-making process and the fact that women have to seek permission from their male counterparts before using family planning services for instance, create physiological, psychological and emotional situations that could have adverse consequences on women.

CHAPTER SIX.

SUMMARY, IMPILCATIONS OF THE STUDY AND CONCLUSION

6.0. Introduction

This concluding chapter examines the relationship between women's rights and health, within the safe motherhood framework developed by McCarthy and Maine (1992) later revised by Tinker and Koblinsky (1993). According to the model, a number of interrelated factors operate to influence maternal health. These factors are the level of education of the woman, access to and control of income and resources and the level of isolation. Also the general attitude of other members of the family towards reproductive health issues influence women's decision-making on reproductive health and the use of maternal health care and family planning services. The model will help to explain how these factors classsified as contextual, intermediate and proximate determinants influence maternal health in the Ga District.

The safemotherhood framework by Tinker and Koblinsky (1993) was adopted for the study because it is more elaborate and had discussed more issues affecting women's status and health than the original framework by McCarthy and Maine (1992). It has discussed most of the factors that affect women's

health in the Ga District and so provided a general basis for the study. However, the factors discussed in the framework are general and could not explain all the intricate issues involved and how these issues had woorked to affect the health of individual women in the District.

6.1. Rights, Responsibilities and Maternal Health.

Gender defines the roles men and women are expected to perform in the society and the associated rights and responsibilities. These roles and their associated rights and responsibilities, are determined by cultural and religious beliefs and to a large extent are structured by family, marriage and kinship relationships. These traditional norms, beliefs and practices have also shaped the perception of people on roles for men and women, status, power and freedom in the study area.

The study showed that the educational level of males in the study area was generally higher than the females, as 19.4 per cent of the females compared to 12.9 per cent of the males in the study area had no formal education. Males with tertiary education were 9 per cent while only 4 per cent of their female counterpart had tertiary education. A breakdown by residence showed that, out of the total women who had attained tertiary education, only 36.1 per cent of them were in rural areas.

It was found out that more females (23.8 per cent) were in business/trading than males (11.5 per cent) and the percentage of females who are unemployed was 15.3 per cent while that for the males was 9.0 per cent. The data also revealed that, the more lucrative jobs such as engineering, medical doctors, military and university lecturing were those recommended for men. On the other hand, cooking, sweeping, fetching water and caring for children were still considered as the preferred activities for women. Also, jobs that require little or no formal education and relatively less strenuous efforts such as hair dressing, dressmaking, salesgirls and midwifery/nursing were those recommended for women. These are activities that have limited women's access to resources, personal autonomy and mobility.

The decision-making power of women in the study area on when, and under what circumstance they will have sexual relations and when, and how often they intend to have children have been limited by their low status in the society. For example, 40 per cent of men had had pre-marital sex compared to 30.4 per cent of the females. On extra-marital sex, 27.8 per cent of the men and 9.1 per cent of the women indicated that they had engaged in extra-marital sex. The study further showed that 70 per cent of the women reported that their husbands got annoyed when they attempted to refuse sex with them. About 54 per cent of the men and 38.1 per cent of the women took independent decisions regarding family size and about half of the women felt they would be insecure in their marriage without children. Consequently, some women were found to

have compromised their right to decide and their health in order to stay in marital unions.

The antenatal health-seeking behaviour of women in the study area was influenced by factors such as the educational level of the woman, distance to health centre, parity, type of marriage (polygynous or monogamous) and husband's educational attainment. Moreover, the decision of the woman to choose a place of delivery depends greatly on her place of residence, level of education, her husband and immediate family members. All these factors directly or indirectly affect women's status and decision-making in the home and society at large. The relationship between women's rights and maternal health is therefore not direct but is mediated by a set of socio-economic, cultural and political mechanisms.

Thus, for women in the study area, sexual and reproductive health is not dependent exclusively on their own behaviours, but also, situations and behaviours of others. The perception that wives cannot refuse sex with their husbands under any circumstance, and could not hit back when beaten by their husbands or report cases of battering give men unlimited authority over women. As observed in the study area, this may expose women to a wide range of health hazards through their inability to protest over their partners multiple extra-marital relations.

Women's control over their sexuality and independent decision-making on reproduction could be interpreted as an abrogation of responsibility and challenging men's authority and therefore some of them have little say in reproduction and reproductive health matters. Thus, although decisions on some issues in the household such as breast-feeding and abstinence may be arrived at jointly, women will always respond to men's sexual demands irrespective of the health implications because of fear of reaction from their husbands. Also, as women have relatively low economic resources, they still rely on their husbands for economic support and so their control over their sexuality and reproduction is circumscribed by that fact. Thus, despite the fact that the women were generally aware of their reproductive rights they were unable to exercise these rights because of the low status of women in the society.

The next section will relate the safe motherhood framework to findings in the study area. That is, it will explain how the contextual, intermediate and proximate determinants influence maternal health in the Ga District.

6.2. Safe Motherhood Framework and Maternal Health in the Ga District

Understanding gender roles, rights and responsibilities provide insights into the behaviour of men and women. This is because in the Ga District, as in Ghana,

rights and responsibilities associated with gender roles, influence decisions on reproductive health issues.

Gendered behaviour in the Ga District, reflected in the level of educational attainment of the woman, family pressures, the socio-economic status of the woman, personal expectations and religious affiliations have contributed to shape decision-making on a wide range of issues including sexual and reproductive health. For instance, 60 per cent of women and 80 per cent of men in the study area still consider the refusal of a woman to have sex with her husband in any way as wrong. Under this condition, women would be unable to ask their partners to adopt safer sex behaviour or refuse sex, even if they run the risk of being infected with STDs due to the fear that they would face reprisal, be divorced or lose intimacy and affection with their husbands.

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It has been observed that, communication between spouses makes it possible for decision on issues such as reproductive health to be arrived at jointly. It was also observed that, the status of women influences their ability to communicate with their spouse. For example, as the woman's status, compared to that of the man, increases, either through education and economic empowerment, they are able to communicate with their spouses on reproductive health matters and participate in reproductive decision-making. This is because the higher the status of women the better informed they are and the more likely they are able to assert their influence on decision-making and stand up to themselves. For

example, in the study, 100 per cent of women with University/Diploma education had discussed the resumption of sex with their spouses, only 50 per cent of those without any formal education had indicated that they did so. Also higher education was found to be associated with urbanisation as only 9.5 per cent of the females and 3.0 per cent of the males with tertiary education were in the rural areas. Women with higher formal education are therefore more likely to be concentrated in urban areas and closer to health care facilities. They are also able to receive appropriate and timely health care because they are likely to be in the position to pay. Thus, in the Ga District, women with higher education are more likely to receive better maternal health care than their counterparts without any formal education.

It has long been observed that there is a relationship between women's status and maternal health. However, the safe motherhood framework used has not given how these factors may affect pregnancy at different stages and how these factors operate in different societies. The association between a woman's level of education and maternal health lies in the fact that, education is associated with late marriages, use of family planning methods, increased avenues for women to be employed, adequate information about symptoms of complications and the likelihood to make timely decision to seek better health care. However, the effect of education on a woman may be limited by other factors such as her place of residence and religious affiliation. Where the woman belongs to a

religion whose members do not believe in medical care her health situation may be different from others in the same socio-economic and cultural group.

Despite the shortfalls in the framework, it has corroborated the study on many issues relating to maternal health and women's rights in the Ga District. For instance, it was observed that, there is a linkage between the socioeconomic status of women and maternal in the Ga District. The higher the socioeconomic status of women's, the more likely they able to stand up for themselves and make decisions on their reproductive health and other matters relating to their well-being. Such women are well informed and are able to challenge and seek redress on any negative socio-cultural practice that may affect them adversely. This is consistent with Tinker and Koblinsky's framework which has identified and discussed this relationship. For example, the safemothehood framework observed a relationship between the reproductive health of women and their right to make and implement decisions. This right to make and implement decisions has be observed to be influenced by the socioeconomic status of women such as their income level, educational attainment and place of residence.

To a large extent, the framework has corroborated the study on the linkage between maternal health and women's rights but fails to explain the mechanisms involved in the relationship. The linkage is assumed to be direct but there are other factors that may confound this direct relationship which has not been discussed by the framework.

6.3. Implications for Research into Sexuality and Reproductive Health in Ghana.

During the research work into sexuality and reproductive health in the Ga District certain issues, some of which have implications for research methodology in Ghana were encountered. Some of these relate to the use and interpretations of concepts to reflect the meaning they intend to give under different socio-economic conditions. For instance, concepts such as "household" and filial relationship had different meanings in the area. "Sister" and "brother" in Ghanaian context can refer to cousins, that is daughters or brothers from paternal and maternal Uncles and Aunts. Ambiguities in these concepts distort the meaning which these terms intend to give and so there is the need to devise a means to give precision to them. Similarly, traditional practices such as sleeping arrangements, where women live with their female matrilineal relatives and men with their male patrilateral relatives, resulting in separate male and female compounds, created problems regarding the composition of a household.

The emerging issue of people requesting for money or gifts during surveys in the country has serious implications for research. There is the view that, research is a profit making enterprise and so respondents should be remunerated for responding to the questionnaires. Researchers and research

institutions that are compelled to entice respondents with gifts have compounded the situation. This is unethical and has serious repercussions on future research in terms of the financial cost and the quality of data. This is due to the fact that there is the tendency for respondents to lie so as to favour researchers when they are given gifts.

Researchers should also investigate mechanisms underlying the behaviour of phenomenon in detail and should not just depend on superficial relationships. For instance, while it is true that distance to health care centres may have a negative relationship with attendance, this may not always be the case all the time and everywhere (chapter 4). The mechanisms underlying such relationships could be examined and understood before generalisations are made.

6.4. Recommendations for Policy-making and Intervention

The safe motherhood framework by Tinker and Koblinsky, (1993), indicated that, although the focus of safe motherhood is on pregnancy and childbirth, many of the conditions that affect pregnancy outcomes are determined before pregnancy. These conditions, some which are classified into contextual and intermediate determinants, influence maternal health through a combination of social, economic and cultural factors which influence pregnancy remotely. Empowerment of women and the improvement of their social, political,

economic and health status through education and employment opportunities are essential for a better reproductive life of women and their children and should therefore be the target of safe motherhood programmes.

Since most of the conditions which occur prior to pregnancy are preventable, a re-examination of laws and practices that tend to encourage the subordination and alienation of women from decision-making will enable them to exercise their sexual and reproductive rights (Sai, 1994). Sensitising policy-makers, governments and service providers to seek fertility regulation and reproductive health as a way of empowering women rather than a means of controlling population growth, saving the environment, and speeding up economic development will also prevent complications during pregnancy. Reproductive health programmes should be tailored to reflect the complex relationships between the sexes, which affect reproductive behaviour. Programmes that recognise the influence of gender and the specific needs of each of the sexes as well as those that encourage spousal communication and joint decision-making about reproduction should be pursued (Cook, 1994).

This requires that, safe motherhood programmes take into consideration the various stages of pregnancy and the factors that influenced pregnancy at each of these stages. Safe motherhood services must therefore be available to women from the primary health care level up through first-referral level obstetric care in order to reduce maternal morbidity and mortality.

6.5. Conclusion

Although changes in perceptions of traditional norms and practices have been observed among respondents, especially urban residents, the social structure of the area still supports traditional values associated with gender roles, rights and responsibilities. Peoples still adhere to gender-based stereotypes and so any attempt to reverse the existing structures so as to empower women iš likely to generate tension. This is due to the fact that such measures have the potential of disturbing the existing power relations and arrangements. For example, although family planning and the use of contraceptives to enable women to take control over their sexuality is recognised, its potential has not been realised because men would interpret the use of family planning as an attempt by women to abrogate their reproductive obligation and challenge the decision-making authority of men.

Also there are still marked disparities in power between men and women. Therefore, the introduction of new ideas that seek to change the existing power relations without changes in traditional norms and values through education could create anxieties and conflicts between men and women. Thus there is the need to modify the legal system and traditional institutions to conform to new attitudes and norms. The domestic protection of women's human rights should be strengthened and governments should be made to abide by their human rights obligations including those of women.

APPENDIX I

FEMALE QUESTIONNAIRE ON MATERNAL HEALTH AND WOMEN'S RIGHT IN THE GA DISTRICT.

A. BACKGROUND OF RESPONDENTS

1. How old are you? (in complete years)
2. Religious Affiliation

(a) Traditional	[ ]	(b) Catholic	[ ]
(c) Anglican	[ ]	(d) Methodist	[ ]
(e) Presbyterian	[ ]	(f) Pentecost	[ ]
(g) Moslem	[ ]	(h) Other, (please specify.....	

3. Ethnicity

(a) Guan	[ ]	(b) Ga-Adangbe	[ ]
(c) Ewe	[ ]	(d) Fanti	[ ]
(e) Ashanti	[ ]	(f) Akwapim	[ ]
(g) Other Akan	[ ]	(h) Grushi	[ ]
(i) Mole-Dagbane	[ ]	(j) Manya Krobo	[ ]
(k) Yilo-Krobo	[ ]	(l) Hausa	[ ]
(m) Grumah	[ ]	(n) Other, (please specify).....	

4. Highest Educational Attainment

(a) No formal education	[ ]	(b) Primary	[ ]
(c) Middle/JSS	[ ]	(d) SSS/Comm/Voc/Tec	[ ]
(e) Training/Nursing/Polytech	[ ]	(f) University/Diploma	[ ]

(g) Other, (please specify).....

B. MARRIAGE

5. Marital Status

(a) Never married (**Go to 22 if not married**)	[ ]	(b) Widow	[ ]
(c) Married	[ ]	(d) Divorced	[ ]
(e) Separated		[ ]	

6. How old were you when you first married?.....

7. What is the age of your husband/Partner?.....

8. What is your husband's level of education?

(a) No formal education [ ] (b)Primary [ ]

(c) Middle/JSS [ ] (d) SSS/Comm/Voc/Tec [ ]

(e) Training/Nursing/Polytech[ ] (f) University/Diploma [ ]

(g) Other, (please specify).....

9. How many times have you been married?.....

10. Form of marriage (s)	1st	2nd	3rd	4th
(a) Customary	[ ]	[ ]	[ ]	[ ]
(b) Ordinance/church	[ ]	[ ]	[ ]	[ ]
(c) Church	[ ]	[ ]	[ ]	[ ]
(d) Islam	[ ]	[ ]	[ ]	[ ]
(e) Consensual	[ ]	[ ]	[ ]	[ ]

(f) Other, (please specify).....

11. How was your partner chosen?

(a) Entirely by myself (b) With the help of family

(c) Consent of family (d) Entirely arranged by family

(e) Other, (please specify).....

12. At what age did you have your first sexual intercourse?.....

13. Did you have any sexual relationship before marriage? Yes [ ] No [ ]

14. Have you ever been forced to have sex with a man before?

Yes [ ] No [ ]

15. If yes, is the person different from your first husband? Yes [ ] No [ ]

16. Does your husband has any other wives? Yes [ ] No [ ]

17. If yes, what is your rank (eg 1st, 2nd, 3rd .....)

18. If yes, how many?.....

19. How long have you been with your present husband?.....

20. Do you live with your spouse in the same house? Yes [ ] No [ ]

21. If no, where does he live?

(a) Family house in the neighbourhood (b) Another part of the town

(c) Another village/town (d) Travelled (e) Other, (please specify)...

C. ECONOMIC STATUS

22. What is your occupation? Please state.....

23. For how long have you been in your present occupation.....

24. Do you have any source of income? Yes [ ] No [ ]

25. If yes, what is the source?.....

26. If no, how do you cater for yourself?.....**(if not married go to 30)**

27. What is your husband's occupation?.....please state

28. Have you entered into any economic co-operation with your husband?
Yes [ ] No [ ]

29. If yes, indicate the type of co-operation and reasons for entering into such a co- operation?.....

30. What is your approximate income in a day/week/month.....

31. Which of the following items do you own yourself? (Tick all that apply)

(a) Radio	[ ]	(b) Television	[ ]
(c) Video	[ ]	(d) Bicycle	[ ]
(e) Truck	[ ]	(f) House	[ ]
(g) Car	[ ]	(h) Fish boat	[ ]
(i) Fishing	[ ]	(j) Shop/store	[ ]

32. Who bear (s) the expenditure on the following **(for only married women)**

Items	**Man**	**Woman**	**Both**	**Other (specify)**
(a) Electricity	[ ]	[ ]	[ ]	[ ]
(b) Water	[ ]	[ ]	[ ]	[ ]
(c) School fees of children	[ ]	[ ]	[ ]	[ ]
(d) Food	[ ]	[ ]	[ ]	[ ]
(e) Children's clothing	[ ]	[ ]	[ ]	[ ]
(f) Medical expenses	[ ]	[ ]	[ ]	[ ]

(g) Rent [ ] [ ] [ ] [ ]

(f) Car maintenance (if any)[ ] [ ] [ ] [ ]

(h) Other, please specify[ ] [ ] [ ] [ ]

33. Do you have any personal savings? Yes [ ] No [ ]

34. If no, why?.....

35. Are you a member a credit union? Yes [ ] No [ ]

36. If no, Why not?.....

37. If yes, state your reasons for being a member of the union.....

.....

38. What are your plans towards your old age?

(a) Rely on remittances from children (b) Rely on social security

(c) Rely on investment in business (d) Rely on husband (if married)

(e) Rely on relatives (f) No plans for the future

(g) Others, please specify.....

D. HEALTH AND FERTILITY CHARACTERISTICS

39. How many children would you like to have? Male.....Female.....

40. Why that number?.....

41. How many life births have you given birth to throughout your lifetime?
Male..... Female.....

42. How old were you when you had your first child?.....

43. Have you ever had a miscarriage? Yes [ ] No [ ]

44. If yes, how many times?.....

45. Did you ever had pregnancy before marriage? (if marriage) Yes [ ] No [ ]

46. If yes, how many?.....

47. Did you consult anyone for antenatal care when you were pregnant with your first child? Yes [ ] No [ ] **(if no go to 51)**

48. How many months was the pregnancy before you consulted this person?

49. How many times did you go for consultation?

50. What was the reason?

(a) Problem with pregnancy

(b) Going well

51. If 47 is no, what was the main reason why you did not go for antenatal care during pregnancy?

(a) Going on well

(b) Too far away

(c) Too expensive

(d) Lack of time

(e) Health staff unfriendly

(f) Other, please specify.

52. Are you planning to have more children? Yes [ ] No [ ]

53. If yes, why?.....

54. If no, why?

(a) Have reached menopause

(b) Have enough children

(e) Husband does not want children

(f)Not married

(c) Due to ill health

(g) Other, please specify

(d) Using contraceptives

55. If you are in your menopause, what changes have you observed in your health?.....

56. What is the reaction of your husband (**if married)** towards the changes that have taken place in you?.....

57. Did you consult any person for advice when these changes started occurring? Yes [ ] No [ ]

58. If yes, who?.....

59. If no, why not?.....

60. How many sisters have ever had, born to the same mother (including those who are now dead)? [ ][ ]

61. How of these sisters died during pregnancy? [ ] [ ]

62. How many of these sisters died during childbirth? [ ] [ ]

63. How many of these sisters died during six weeks after the end of a pregnancy? [ ] [ ]

E. KNOWLEDGE AND USE OF CONTRACEPTIVES

64. Have you/partner ever used any contraceptives? Yes [ ] No [ ]

65. If yes, which of these have you ever used?

(a) Condom	[ ]	(f) Diaphragm	[ ]
(b) Withdrawal	[ ]	(g) Pill	[ ]
(c) IUD	[ ]	(h) Female sterilisation	[ ]
(d) Foaming tablets	[ ]	(i) Rhythm	[ ]
(e) Injection	[ ]	(j) Postpartum abstinence	[ ]

(k) Other, specify.....

66. Are you currently using any contraceptive(s)? Yes [ ] No [ ]

67 If no, why?.....

68. If yes, what health problems did you encounter by using any of these **contraceptives?**.....

69. Did you consult your partner before using the contraceptives?

Yes [ ] No [ ]

70. Give reason for your answer.....

71. Have you ever been influenced by anybody to have children?

(Tick the appropriate answer)

(a) Nobody	[ ]	(d) Husband	[ ]
(b) Parents	[ ]	(e) Friends	[ ]
(c) In-laws	[ ]	(f) Medical personnel	[ ]
(g) Other, please specify		[ ]	

72. What is the nature of the influence?.....

73. Would you feel insecure if you have not given birth in your **marriage?** Yes [ ] No [ ]

74. Give reasons for your answer.....

F. HEALTH FACILITY

75. Which of the following do you normally consult when you are pregnant?

(a) Medical Doctor [ ] (b) Midwife/Nurse [ ] (

c) Traditional Birth Attendants [ ] (d) Traditional Priest [ ]

(e) Church Priest/Priestess [ ] (f) Other, specify [ ]

76. What are your reasons for choosing that particular health service?

(a) Receive good care (b) Workers are nice to patients

(c) Cost is low (d) Not far from home

(e) Receive early treatment (f) Free transport to health centre

(g) Belong to the same religion (h) Other, please specify.

77. Which of the following do you use when ill?

(a) Medical Doctor (b) Traditional Priest/Priestess

(c) Self-medication (d) Herbalist

(e) Faith healer (f) Other, please specify

78. What are your reasons for your choice?

(a) Receive good care (b) Worker arenice

(c) Receive early treatment (d) Not far from home

(e) Free transport to health centre (f) Low cost

(g) Belong to the same religion (h) Other, please specify

79. How far is the health centre from where you live?.....

80. Who attended to your entire delivery?

Child	**Attendant**	**Quality of Service**	**Reasons**
First.....			
Second.....			
Third.....			
Fourth.....			
Fifth.....			
Sixth.....			

81. Have you ever experienced any health problem (s) associated with childbirth Yes [ ] No [ ].

82. If yes, mention them?.....

83. Mention some of the problems pregnant women in your locality face

84. What do you think are responsible for these?.....

H. HOUSE AND ENVIRONMENTAL SANITATION

85. What type of house do you live in?

(a) Owner occupier (Bungalow) (b) Owner occupier (shared)

(c) Family house (d) Hired premises (alone)

(e) Hired group (f) Other, (please specify)

86. How many of you live in a household? [ ] [ ]

87. Number of rooms source of water?

88. What is your source of water?

(a) Stream (b) Lake

(c) Pipe/Bore hole (d) Well

(e) Tanker trucks (f) Other, (please specify)

89. What is the approximate distance (in kms) from your house to the source of water supply?.....

90. What problems do you face with your water supply system?.....

91. What type of toilet do you use?

(a) Personal WC (b) Public WC

(c) Public pit latrine (d) KVIP

(e) Bush (f) Other, (please specify)

I. GENDER ROLES AND WOMEN'S STATUS/RIGHTS

92. Do you discuss any of these with you partner?

(a). Children's educational matters (school fees, clothing)

Yes [ ] No [ ]

(b) Currents affairs Yes [ ] No [ ]

(c) Politics Yes [ ] No [ ]

(d) Acquisition of household items Yes [ ] No [ ]

(e) Acquisition of physical property (land, house) Yes [ ] No [ ]

(f) Other, (please, specify) Yes [ ] No [ ]

93. Do you usually do these things with your partner?

(a) Sitting at table to eat Yes [ ] No [ ]

(b) Visit your relation Yes [ ] No [ ]

(c) Visit his relation Yes [ ] No [ ]

(d) Visit hometown Yes [ ] No [ ]

(e) Attend church together Yes [ ] No [ ]

(f) Attend other funerals together Yes [ ] No [ ]

(e) Attend other social functions (eg parties) Yes [ ] No [ ]

(f) Other, please specify.....

94. Have you ever discussed the following with your partner?

ISSUE DISCUSSED WITH SPOUSE	FREQUENCY 1.Not at all. 2.Seldom 3. Often.4.Regularly	WHY
Desired family size		
Birth spacing/contraceptive use		
Resumption of sex after childbirth		
Breastfeeding		
Other, please specify		

95. Have you ever discuss pregnancy prevention with your spouse?

Yes [ ] No [ ]

96. If yes, what did you discussed?.....

97. If no, why have you not discussed any issues of that nature?.....

98. Who usually bring up the issue? (a) Husband (b) Wife

99. How are decisions are arrived at on the following.

ISSUES	1. Husband 2. Wife 3. Joint decision 4. Outside Influence
Children's education	
Acquisition of household items	
Acquisition of physical property	
FERTILITY/HEALTH Desired family size	
Birth spacing/contraceptive	
Resumption of sex after childbirth	
Breastfeeding	
Visit to hospital for treatment	
Send children to hospital for treatment	
CONTRACEPTIVE/USE To use a method	
Choice of a method	
Decision to discontinue method	
Abstinence	

100. Who bears your hospital expenses during pregnancy?

(a) Husband (b) Both of us (c) Others (specify)

101. Does your husband help you in your household chores during

pregnancy?

(a) Always (b) Sometimes (c) Does not help at all

102. Does your husband accompany you to hospital/clinic when pregnant?

(a) Always (b) Sometimes (c) Does not accompany

103. Is it right for men to go for another woman without their wife/wives' knowledge? Yes [ ] No [ ]

104. Give reasons for your answer.....

105. Should men be allowed to have more than one wife? Yes [ ] No [ ]

106. Give reasons for answer.....

107. Can a married man have a girlfriend? Yes [ ] No [ ]

108. Give reasons for your answer.....

109. Can a married women have a boyfriend Yes [ ] No [ ]

110. Give reasons for your answer.....

111. Should females have equal rights as males to inherit their

(a) Father's property? Yes [ ] No [ ]

(b) Mother's Property Yes [ ] No [ ]

112. Give reasons for answer.....

113. Should men beat their wives or partners for whatever reason?

Yes [ ] No [ ]

114. Give reasons for you answer.....

115. Should women hit back if their husbands hit them? Yes [ ] No [ ]

116. Give reasons for your answer.....

117. Which of the following places would you advice women to take their husbands/partners to if they were battered?

(a) Police station (b) Court

(c) Women Lawyers (d) 31st December Women's Movement

(e) Chief's Place (f) National Council for Women

(g) Development (NCWD)

(h) Other, please specify.....

118. Give reason for your answer.....

119. Have you ever been beaten by you husband/partner?

Yes [ ] No [ ]

120. If yes, did you report him to any authority? Yes [ ] No [ ]

121. If no, why?.....

.....

If never married go to 123

122. Have you ever refused to have sex with your husband for whatever reason? Yes [ ] No [ ]

123. If yes, what was the reason(s).....

124. What was his reaction?.....

125. Does a women have the right to refuse sex with her husband for whatever reason? Yes [ ] No [ ]

126. Give reasons for your answer.....

(Go to 128 if not married)

127.Do you normally ask you husband to help you in your household activities? Yes [ ] No [ ]

128. If yes, what activities do you normally ask for from your husband?.....

129. If no, why don't you ask him to help you?.....

130. What is his reaction if you ask him to help you?.....

131. What do you consider to be the household chores for

(a) MEN

(b) WOMEN

132. What do you consider to be the family responsibilities of (list 4 for each sex)

(a). MEN

(b). WOMEN

133. What do you consider to be the ideal occupations for (list 4 for each sex)

(a). MEN

(b). WOMEN

136. What do you consider to be the level

(a). Men should be educated?.....

(b). Give reasons for your answer.....

137. Women should be educated?.....

138. Give reasons for your answer.....

139. Did you inherit any property from your father? Yes [ ] No [ ]

140. If yes, what did you inherit?.....

141. Did you inherit any property from your mother? Yes [ ] No [ ]

142. If yes, what did you inherit?.....

143. Do you have any women organisation in your locality? Yes [ ] No [ ]

144. If yes, do you belong to any of them? Yes [ ] No [ ]

145. If yes, did you consult your husband before joining? Yes [ ] No [ ]

146. Give reasons for your answer.....

148. Mention at last two rights of women, which have been violated by

(a). Your husband or partner?.....

(b). Society?.....

149. If you don't belong to any organisation, why?.....

150. What help do these organisations give to women in your locality?.....

151. What do you think should be done to improve upon the status of women by

(a). the government?.....

(b). the locality?.....

(c). the family?.....

(d). the husband?.....

APPENDIX II

MALE QUESTIONNAIRE ON MATERNAL HEALTH AND WOMEN'S RIGHT IN THE GA DISTRICT.

A. BACKGROUND OF RESPONDENTS

1. How old are you? (in complete years)
2. Religious Affiliation

   (a) Traditional [ ] (b) Catholic [ ]

   (c) Anglican [ ] (d) Methodist [ ]

   (e) Presbyterian [ ] (f) Pentecost [ ]

   (g) Moslem [ ] (h) Other, (please specify.....
3. Ethnicity

   (a) Guan [ ] (b) Ga-Adangbe [ ]

   (c) Ewe [ ] (d) Fanti [ ]

   (e) Ashanti [ ] (f) Akwapim [ ]

   (g) Other Akan [ ] (h) Grushi [ ]

   (i) Mole-Dagbane [ ] (j) Manya Krobo [ ]

   (k) Yilo-Krobo [ ] (l) Hausa [ ]

   (m) Grumah [ ] (n) Other, (please specify).....
4. Highest Educational Attainment

   (a) No formal education[ ] (b)Primary [ ]

   (c) Middle/JSS [ ] (d) SSS/Comm/Voc/Tec [ ]

   (e) Training/Nursing/Polytech[ ] (f) University/Diploma [ ]

(f) Other, (please specify).....

5. What is your occupation? (please state).....

B. MARRIAGE

6. Marital Status

   (a) Never married **(Go to 13 if not married)**[ ] (b) Widow [ ]

   (c) Married [ ] (d) Divorced [ ]

(e) Separated [ ]

7. How old were you when you first married?.....

8. How old were you when you first married?.....

9. How many wives do you have? [ ]

10. What is your wife' s level of education?

(a) No formal education [ ] (b)Primary [ ]

(c) Middle/JSS [ ] (d) SSS/Comm/Voc/Tec [ ]

(e) Training/Nursing/Polytech[ ] (f) University/Diploma [ ]

(g) Other, (please specify).....

11. How many times have you married?.....

12. Form of marriage (s)	Ist	2nd	3rd	4th
(a) Customary	[ ]	[ ]	[ ]	[ ]
(b) Ordinance/church	[ ]	[ ]	[ ]	[ ]
(c) Church	[ ]	[ ]	[ ]	[ ]
(d) Islam	[ ]	[ ]	[ ]	[ ]
(e) Consensual	[ ]	[ ]	[ ]	[ ]

(g) Other, (please specify).....

13. How was your partner chosen?

(a) Entirely by myself (b) With the help of family

(c) Consent of family (d) Entirely arranged by family

(e) Other, (please specify).....

14. At what age did you have your first sexual intercourse?.....

15. Did you have any sexual relationship before marriage? Yes [ ] No [ ]

16. Have you ever been forced to have sex with a woman before?

Yes [ ] No [ ]

17. If yes, is the person different from your first wife? Yes [ ] No [ ]

18. How long have you been with your present wife?.....

B. TYPE OF RESIDENCE/LIVING ARRANGEMENT

19. Number of rooms occupied by household.....

20. **If married**, do you live with your spouse in the same house?

Yes [ ] No [ ]

21. If no, where does she live?

(a) Family house in the neighbourhood (b) Another part of the town

(c) Another village/town (d) Travelled (e) Other, (please specify)...

D. PREGNANCY AND CHILDBEARING

22. How many children would you like to have? Male..... Female.....

23. Why that number?.....

24. Do you have any children of your own?.....

25. If yes, how many?.....

26. With how many women? [ ]

27. At what age did you have a child for the first time? [ ] [ ]

28. Have you ever been influenced by anybody to have children?

(Tick the appropriate answer)

(a) Nobody	[ ]	(d) wife	[ ]
(b) Parents	[ ]	(e) Friends	[ ]
(c) In-laws	[ ]	(f) Medical personnel	[ ]
(g) Other, please specify	[ ]		

29. Do you accompany your wife to hospital/clinic when pregnant?

(a) Always

(b) Sometimes

(c) Don't accompany

30. Do you help your wife/wives in the household chores?

(a) Always

(b) During pregnancy

(c) After childbirth

(d) When ill

31. Do you think pregnant women should be given special treatment by their husbands? Yes [ ] No [ ]

32. If no, why not?.....

33. If yes, mention 4 special treatments husbands need to give to their wives when pregnant?.....

34. Do you help your household chores during pregnancy?

(a) Always (b) Sometimes (c) Does not help at all

E. CONTRACEPTIVES USE

35. Have you/partner ever used any contraceptives? Yes [ ] No [ ]

36. If yes, which of these have you ever used?

(h) Condom	[ ]	(f) Diaphragm	[ ]
(i) Withdrawal	[ ]	(g) Pill	[ ]
(j) IUD	[ ]	(h) Female sterilisation	[ ]
(k) Foaming tablets	[ ]	(I) Rhythm	[ ]
(l) Injection	[ ]	(j) Postpartum abstinence	[ ]

(m) Other, specify.....

37. If no, why have you/spouse not used any of these methods?.....

38. Are you/spouse currently using any contraceptive(s)? Yes [ ] No [ ]

39. If yes, what method (s) are you using? (state methods).....

40. If no, why are you not currently using any method?.....

41. Have any of these influenced your decision to use any these method (s)?

(a) Distance	[ ]	(d) Cost	[ ]
(b) Convenience	[ ]	(e) Side effect	[ ]
(c) Reaction from wife/wives	[ ]	(f) Other, please specify	[ ]

F. COMMUNICATION

42. Do you discuss any of these with you partner?

(a). Children's educational matters (school fees, clothing)

Yes [ ] No [ ]

(b) Currents affairs Yes [ ] No [ ]

(c) Politics Yes [ ] No [ ]

(d) Acquisition of household items Yes [ ] No [ ]

(e) Acquisition of physical property (land, house) Yes [ ] No [ ]

(f) Other, (please, specify) Yes [ ] No [ ]

43. Do you usually do these things with your partner?

(a) Sitting at table to eat Yes [ ] No [ ]

(b) Visit your relation Yes [ ] No [ ]

(c) Visit his relation Yes [ ] No [ ]

(d) Visit hometown Yes [ ] No [ ]

(e) Attend church together Yes [ ] No [ ]

(f) Attend other funerals together Yes [ ] No [ ]

(e) Attend other social functions (eg parties) Yes [ ] No [ ]

(f) Other, please specify.....

44. Have you ever discussed the following with your partner?

ISSUE DISCUSSED WITH SPOUSE	FREQUENCY 1. Not at all. 2. Seldom 3. Often. 4. Regularly	WH Y
Desired family size		
Birth spacing/contraceptive use		
Resumption of sex after childbirth		
Breastfeeding		
Other, please specify		

45. Have you ever discuss pregnancy prevention with your spouse?

Yes [ ] No [ ]

46. If yes, what did you discussed?.....

47. If no, why have you not discussed any issues of that nature?.....

48. Who usually bring up the issue? (a) Husband (b) Wife

49. How are decisions are arrived at on the following.

ISSUES	1. Husband 2. Wife 3. Joint decision 4. Outside Influence
Children's education	
Acquisition of household items	
Acquisition of physical property	
FERTILITY/HEALTH Desired family size	
Birth spacing/contraceptive	
Resumption of sex after childbirth	
Breastfeeding	
Visit to hospital for treatment	
Send children to hospital for treatment	
CONTRACEPTIVE/USE To use a method	

Choice of a method	
Decision to discontinue method	
Abstinence	

H. ECONOMIC STATUS

50. What is your occupation? Please state.....

51. For how long have you been in your present occupation?.....

52. Have you entered into any economic co-operation with your wife?

Yes [ ] No [ ]

53. If yes, indicate the type of co-operation and reasons for entering into such a Co-operation?.....

54. If no, why have you not entered into any co-operation with your wife?..... .....

55. Some people have joint savings with their wives. Have you ever done so?

Yes []No []

56. If no, would you want to do that? Yes []No []

57. What is your approximate income in a day/week/month.....

58. Who bear (s) the expenditure on the following (for only married women)

Items	**Man**	**Woman**	**Both**	**Other**
(a) Electricity	[ ]	[ ]	[ ]	[ ]
(b) Water	[ ]	[ ]	[ ]	[ ]
(c) School fees of children	[ ]	[ ]	[ ]	[ ]
(d) Food	[ ]	[ ]	[ ]	[ ]
(e) Children's clothing	[ ]	[ ]	[ ]	[ ]
(f) Medical expense	[ ]	[ ]	[ ]	[ ]

(g) Rent	[ ]	[ ]	[ ]	[ ]
(f) Car maintenance (if any)	[ ]	[ ]	[ ]	[ ]
(h) Other, please specify	[ ]	[ ]	[ ]	[ ]

59. What do you consider to be the household chores for (list 4 for each sex)

(a) MEN

(b) WOMEN

60. What do you consider to be the family responsibilities of (list 4 for each sex)

(a) MEN

(b) WOMEN

61. What do you consider to be the ideal occupations for (list 4 for each sex)

(a) MEN

(b) WOMEN

62. What do you consider to be the level

Men should be educated?.....

Give reasons for your answer.....

Women should be educated?.....

Give reasons for your answer.....

63. Does a woman have the right to refuse sex with her husband for whatever reason? Yes [ ] No [ ]

64. If yes, under what circumstances can she refuse to have sex with him?.....

65. Should a married man be allowed to marry more than one wife?

Yes [ ] No [ ]

66. Give reasons for answer.....

67. Can a married man have a girlfriend? Yes [ ] No [ ]

68. Give reasons for your answer.....

69. Can a married women have a boyfriend Yes [ ] No [ ]

70. Give reasons for your answer.....

71. **Should men** beat their wives or partners for whatever reason? Yes [ ] No [ ]

72. **Give reasons** for you answer..... .....

73. **Should women** hit back if their husbands hit them? Yes [ ] No [ ]

74. **Give reasons** for your answer.....

75. **What do** you consider to be the level men must be educated to?.....

76. **Give two reasons** for your answer.....

77. **What do** you consider to be the level women must be educated to?.....

78. **Give reasons** for your answer.....

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