A Case Study from Ghana:
Understanding the Links between Sexual and Reproductive Health, Gender Equality and Poverty Reduction

By Akosua K. Darkwah

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1.0 Executive Summary

Ghana is an interesting case study for this project for two reasons. First, it has an anomalous reproductive health profile. The country has the lowest Total Fertility Rate (TFR) in West Africa and one of the lowest in the sub-region. As at 2008, the TFR for the country was 4.0, for urban areas it was 3.1 and for the Greater Accra area, the most urbanized part of the country, it was 2.5 (GDHS 2008). This is a quite rapid decline from a TFR of 6.4 children per woman as at 1988. Even more interesting is the fact that the Contraceptive Prevalence Rate (CPR) stood at a low 24% in 2008. Some scholars such as Grey and Blanc (2002) argue that abortion rates help explain the gap between the CPR one should expect given the low TFR and what actually pertains as measured by the GDHS. Abortion in Ghana, however, inspite of a liberal law, accounts for between 13% (Sedgh 2010) and 25% (Baiden 2009) of maternal mortality cases in the country. In other words, in Ghana if the assertions of Grey and Blanc (2002) are valid, a low TFR has been achieved at the peril of women’s lives, quite contrary to what one would expect if reproductive health concerns were addressed systematically in the country.

Second, the country exhibits quite some discord between its policies and its practices. Over the years, Ghana has been influenced and positively impacted by the global regimes in first Family Planning and later Reproductive Health. It joined the UN system of Population Censuses in 1960 and was an African Pioneer in the development of official Population Policy. It has an illustrious son, Fred Sai who is well known in international circles for his work on Reproductive Health. Fred Sai was the president of the International Planned Parenthood Association during the International Conference on Population Development (ICPD) held in Cairo in 1994 at which the conceptual shift from a narrow emphasis on family planning to the much broader notion of Reproductive Health was made. As president of such a key institution, he was instrumental in the processes that led to this effort and worked tirelessly to ensure that the Ghanaian State in its policies and practices reflected the conceptual shifts from Population Control to Reproductive Health. Two years after ICPD, the Ghanaian Reproductive Health Service Policy and Standards were developed and revised in 2003 to incorporate sexual health and gender based violence.

The extent to which it can be said that the Ghanaian state has bought into the concept of Reproductive Health is, however, debatable. This is obvious in two ways. First, funding of some aspects of Reproductive Health such as the provision of condoms nationwide and the safe motherhood initiative have been left almost entirely to international donors whose continuous support of such programs cannot be guaranteed as evident in the withdrawal of USAID support for condom purchases during the tenure of Republican leader George Bush. Second, policy measures are not always followed with the financial resources and educational campaigns that would make the full implementation of the policies possible. The issue of abortion, which is a crucial life and death issue in Ghana, is a good example of the strengths as well as limitations of Reproductive Health stances in Ghana. The country has one of the most liberal abortion laws in sub-Saharan Africa. Promulgated in 1985, the law permits abortion if the pregnancy is the result of rape, incest, defilement of a female idiot or if the pregnancy threatens the woman’s physical or mental health or if there is a strong likelihood that the child would have a serious deformity. Knowledge about the law among both the populace and health service providers is, however, quite low. Only 4% of women think abortion is legal (GMHS 2007). Forty six percent of
maternal and child health-related workers were also unaware of the conditions under which abortion could be offered in the country a full two decades after the law had been passed (Aboagye et al 2007). In addition, the state has not moved beyond its liberal policy stance on abortion to a provision of the resources that would make it possible to operationalise the policy. Less than 1 in 7 public health facilities in the country have the necessary facilities to offer safe abortions (Aboagye et al 2007). Unsurprisingly then, complications from unsafe abortions continue to be a major cause of maternal mortality in the country (Morhee and Morhee 2006).

While Ghana’s Reproductive Health record demonstrates some inconsistencies in terms of achievements on some issues and failings on others, the story on poverty is fairly consistent. Over the last two decades, evidence from the Ghana Living Standards Surveys show very clearly that the rates of poverty have decreased substantially all across the country, some regions obviously faring better than others. Over a fifteen year period, the percentage of people living below the extreme poverty line dropped by half. From a high of 36.5% living below the extreme poverty line in 1991/92, the rates of poverty were down to 18.2 by 2005/6. However, feminization of poverty persists. Nsowah-Nuamah et al (2010:1) show quite convincingly that this is so. Drawing on GLSS data from 1991/92 to 2005/06, they show that while the incomes of both men and women dipped initially and then rose later on, the dip was more severe and the rise less dramatic for women than for men. Over the 15 year period, therefore, while men’s incomes rose by 58%, women’s incomes rose by 42%.

Ghana has the advantage of the known relevant global datasets such as the Living Standards Survey (GLSS) and the Demographic and Health Surveys (GDHS) which have been conducted systematically since the 1980s. She also has the advantage of particular datasets such as the Ghana Maternal Health survey (GMHS) conducted in 2007 and the Ghana National Youth Reproductive Health Survey (GNYRHS) conducted in 2004. These surveys allow for an assessment of a variety of reproductive health concerns such as STIs, limited largely to HIV/AIDS, contraceptive use and knowledge, fertility levels, breastfeeding practices as well as maternal and child health. In addition, the range of socio-demographic variables incorporated in these surveys allow for a range of analyses that explore the links between our two main variables of interest; reproductive health on one hand and economic growth/household income on the other. Apart from the surveys, there have also been a variety of studies, predominantly sub-national in scope, that explore the relationships between reproductive health and economic growth. With one exception, the studies reviewed here define poverty quite narrowly in terms of income.

McNelly and Dunford (1998) evaluate a micro-credit program run in the Lower Pra area of the Western Region of Ghana and demonstrate the extent to which the provision of micro-credit improved reproductive health, particularly child survival by encouraging breastfeeding including the feeding of newborns with the antibody rich first milk. A decade later, a manager of the programme (Martei 2008) confirmed these findings. It is important to note that there was an intervening variable here; education. Indeed, the micro-credit programme was named ‘Credit with Education’ which highlights the extent to which education on child nutrition and health matters was a key component of the micro-credit scheme.
A second aspect of reproductive health that is linked to household income in the Ghanaian context is adolescent sexuality. The gendered and class dimension to adolescent sexuality has been consistently evident in the GDHS. Among Ghanaians aged between 15 and 24, almost twice as many women as men had their first sexual experience before age 15. While age at first sexual intercourse for Ghanaian males had very little to do with their socio-economic status, the situation was quite different for Ghanaian females. For this group, there was a negative correlation between age at first sexual intercourse and socio-economic status to which the young female belonged.

Maternal mortality rates (MMR) are also linked to poverty in the Ghanaian context. Ghana has unacceptably high levels of maternal mortality. Indeed, the intractability of MMR led to the Minister of Health declaring maternal mortality as a national emergency in 2008. Ghana is not on track to achieve the Millennium Development Goal (MDG) of halving its maternal mortality rates by 2015. The GMHS (2007) estimates that the MMR in Ghana is between 378 deaths per 100,000 live births and 451 deaths per 100,000 live births. These estimates mask wide variances in the rates based on location. The three northernmost regions in Ghana (Upper West, Upper East and Northern Regions) are the poorest in the country. They also have the highest maternal mortality rates in the country. MMR is linked to delays of three kinds. First are the socio-cultural factors within the family context that delay the decision to seek medical attention. In Ghana, for example, prolonged labour is traditionally seen as a sign that the woman in labour had been unfaithful to her partner. Instead of seeking care, they would rather go through a lengthy process of getting the woman to confess. A second delay is in accessing health facilities and the third in receiving care. The second delay is linked very much to the economic development of the community in which a woman lives. Poor transportation networks as is the case in the northernmost parts of Ghana are a key contributory factor to the high maternal mortality rates in that part of the country.

With respect to fertility levels in the country, there is a negative correlation between incomes and fertility levels. The wealthiest part of the country, Greater Accra Region has a TFR of 3.0 children per woman while Northern Region, the poorest region in the country, has a TFR of 6.8 children per woman, a difference of nearly 4 children. The relationship between poverty and fertility has long been established and indeed served as the impetus for the development of population policies in the 1960s to arrest poverty in the developing world. Lane (1994) notes, however, that increasingly the causal link between fertility and poverty is contested. Malthusian doomsday predictions have not come to pass as the Green revolution has made it possible for mankind to increase crop yields and continue to feed itself. Aside the role of intervening variables in determining the extent to which fertility impacts on poverty, increasingly scholars question the uni-directionality of causality between fertility and poverty. While high fertility can lead to high levels of poverty as the costs of care increases, so also could high levels of poverty lead to high levels of fertility especially in the African context where as the Caldwells (1987) have argued, children serve as an informal means of social security. Thus, while clearly we see in the Ghanaian context that fertility levels and household income levels are linked, it is unclear which variable affects the other.

The links between household income and abortion in Ghana are quite interesting. On the one hand, poverty serves as a key determinant in women’s desires for an abortion. For a fifth of the
surveyed women in the GMHS of 2007, poverty served as their major reason for seeking an abortion. However, the ease with which an abortion can be had in the Ghanaian context is dependent largely on one’s financial circumstances. Costs can range between a low of US$9 to as high as US$90 depending on whether one seeks the abortion in a public or private facilities (Henry and Fayorsey 2002). Since few public facilities offer the service as already alluded to, abortions are easiest to obtain in a private facility, that is if a woman can afford it. Unsurprisingly therefore, the GMHS (2007) data highlights the fact that abortion rates are highest among wealthy Ghanaians. Class is not the only factor of importance here, education is also key. Both the GMHS (2007) and previous work by Ahiadeke (2001) allude to the fact that educated Ghanaian women are far more likely to seek an abortion than uneducated ones. Adanu and Tweneboah (2004) in a study of women seeking abortion in Accra, the capital city, provide some insight as to why this may be the case. One of the top three reasons cited for seeking an abortion in this study was the unwillingness on the part of the women to have their educational aspirations curtailed because of a pregnancy. For these women, access to abortion services made it possible for them to pursue their educational goals be it tertiary or vocational education which would then guarantee them a secure source of income in the future. This is one good example of the links between reproductive health and household income although the causal relationship between these two is inferred and not demonstrated in the Adanu and Tweneboah (2004) study.

While in seeking abortion services, Ghanaian women with higher levels of education and income are much more likely to do so than otherwise, a similar pattern has been identified in terms of wealth and the likelihood of seeking treatment for a sexually transmitted infection. In the only study that examines the extent of symptoms of a broad range of sexually transmitted infections in the Ghanaian context, Adanu et al (2008) ascertained that women with a high wealth index (measured by ownership of a range of assets) were much more likely to seek care for symptoms of STIs than those with a low wealth index.

Two general orienting points need to be made about the six sets of studies already discussed. First, in four out of the six cases, poverty is measured narrowly as income. In two of the studies, another variable, education shows up as a matter of interest but in different ways. In one case, education comes up as an intervening variable in determining whether micro-credit impacts positively on child survival or not (McNelly and Dunford 1998). In the second case, a woman’s educational aspirations also influence the likelihood that she would seek an abortion (Ahiadeke 2001; Adanu and Tweneboah 2004). In both of these studies, the focus is not explicitly on education. The data available on contraceptive use in the Ghanaian context, however, looks specifically at the role of education in determining the use of contraceptives. This data is important for our purposes because of its conception of poverty, explicit or otherwise. Drawing on the capabilities approach pioneered by the famed Nobel Prize winning economist Amartya Sen, social scientists increasingly recognize the limits of conceptualizing poverty in terms of income only. While this approach is elegant in terms of its simplicity, it misses the complexity of people’s lives that is best captured using a capabilities approach. Key to the capabilities approach is an emphasis on what people are able to do and to become in their given contexts. As Sen (1993: 30) puts it:

The capability approach to a person’s advantage is concerned with evaluating it in terms of his or her actual ability to achieve various valuable functionings as a part of living.
The corresponding approach to social advantage – for aggregative appraisal as well as for the choice of institutions and policy – takes the set of individual capabilities as constituting an indispensable and central part of the relevant informational base of such evaluation.

The capabilities approach allows for an assessment of the variety of restrictions that individuals face in different contexts when they attempt to fulfill their dreams. This can include discriminatory practices on the basis of race, ethnicity, gender, sexual orientation, disability or religion as well as cultural norms particularly those concerned with what women can/cannot do that limits their access to a range of resources including education. The literature that explores the relationship between education and contraceptive use in Ghana shows very clearly how access to education expands a woman’s choices in terms of enhancing her ability to choose modern contraceptive methods. Contraceptive use in Ghana is generally low. A quarter of women use some form of contraception; 17% use a modern method such as the pill or the injectable while 7% use traditional methods such as periodic abstinence. There is a positive correlation between contraceptive use and levels of education. While 30% of married women with secondary or more levels of education use a method of contraception, the same is true for only 14% of married women with no education (GDHS 2008).

A second issue to note about the studies already discussed including that on contraceptives that explore the relationships between reproductive health on one hand and economic growth/household incomes is the uni-directionality of causality in these studies. In all of these studies as detailed above, economic growth or household income determines reproductive health and not vice versa, which is what is of prime interest to UNFPA. A key exception to the general state of affairs in the scholarly literature available on the Ghanaian context is the Women’s Health Study of Accra. This study is unique in a number of ways. First, it is longitudinal. Second, it is a recent study, both phases having been collected in the last decade. In fact, data analysis of the second wave is currently ongoing. Third and most important, this study is the first in the country that systematically incorporates social science questions in the dataset that will allow for interpretation along the lines that UNFPA would find of interest. A few of the papers derived from this study interrogate the extent to which reproductive health or ill-health impacts on economic growth/household income. One such paper that begins to tease out some of these relationships is Fink and Hill’s (2011) piece on “Fertility, Household Structure and Female Economic Activity – Evidence from the Women’s Health Study of Accra.” The major finding, contrary to what pertains in many other places, is that whereas the presence of children, including especially pre-school children, does not decrease women’s ability to participate in the formal sector, it does affect their participation in the informal sector. This anomaly is explained by the fact that the majority of the women in the informal sector in this study were underemployed (Fink and Hill 2011:5). This study shows the importance of specifying the nature of employment (fulltime or part-time) as well as sector (formal or informal) in determining whether or not child care responsibilities will impact on women’s work patterns and by extension incomes.

A second paper of interest to us explores the impact of preventive reproductive health on poverty. Lince et al (2011:12) provide demonstrate that 50% of the women who sought fertility treatment and 59% of those who went in search of preventive reproductive health care such as
breast examinations, nutrition education or HIV tests missed a day of work largely because of difficulties with accessibility. Again, this study like the study by Fink and Hill (2011) explores the impact of reproductive health on household income. However, it is important to note that the implications of this lack of work on their incomes can only be inferred. Economic anthropologists demonstrate how in contexts such as Ghana, market transactions are socially embedded. As such, missing a day of work does not necessarily imply a loss of income. However, Lince et al (2011) do not provide us with enough information to ascertain whether missing a day of work led to a loss of income or not and the intervening variables that determined whether or not this happened.

Clearly, recent publications based on particularly the second wave of the WHSA demonstrates that this is a dataset which can be mined for our purposes to more forcefully establish the causal links between reproductive health as an independent variable and economic growth/household income as a dependent variable taking into consideration possible intervening variables such as cultural norms about work, gender, power and so on as well as resources like health and education. There is already some indication that the authorities of the Women’s Health Study of Accra would be agreeable to other party interrogation of their data.

Nonetheless, while the WHSA goes a long way in helping us tease out the causal relationship between reproductive health and economic growth/household income, the survey does not have an explicit focus on these issues. Neither is sufficient attention paid to the myriad intervening variables including cultural norms, gender equity and time use that shape whether or not reproductive health has consequences for economic growth/household income. It may be possible perhaps to enter into a collaborative agreement with the researchers involved in the WHSA so as to engage in a third round of the survey that draws on the same population and focuses explicitly on the issues of concern to the UNFPA.

Alternatively, having mined the Ghanaian literature on the subject, two things have become quite clear. First, there is a dearth of literature in the Ghanaian context on reproductive health and poverty where the latter is defined from a capabilities approach so as to capture not just income levels but also the extent to which resources such as human, social and physical capital including health and education as well as gender norms around such issues as access and control of resources. Second, the literature already available largely makes the case for poverty, narrowly defined, impacting on reproductive health and not vice versa. Noting these two gaps, Ghana does provide interesting opportunities to conduct a variety of studies outside of the WHSA framework that would seek to overcome the lacunae already identified in the existing literature. There are two possible studies that can be conducted drawing on the uniqueness of the Ghanaian context.

First would be a longitudinal study of adolescents whose sexual and reproductive health needs are met through the provision of safe sex services information as well as abortion care to ascertain the extent to which this prevents unwanted pregnancies and thus assures their educational goals. Existing literature suggests that abortion may very well be used as a form of contraceptives in the Ghanaian context (Grey and Blanc 2002). Yet elsewhere in the world, abortion is largely used when contraceptives have failed, not in place of contraceptives. One key explanation for this anomaly may be the general lack of information on sexual and reproductive
health matters that would allow Ghanaian women particularly the youth to practice safe sex and thus fulfill their educational goals. The Planned Parenthood Association of Ghana runs a number of resource centres for young people aged between 10 and 24. A matched sample study of youth who attended these centres and those who did not (including those who got pregnant and chose abortions as well as those who got pregnant and kept the babies) will provide information that could allow for stronger assertions to be made about the link between reproductive health, in this case, adolescent sexual and reproductive health and individual income years down the line.

Secondly, Ghana has seen steep and yet uneven declines in its levels of fertility over the last two decades such that while some parts of the country have TFRs almost nearing replacement level, other parts still have quite high TFRs. This makes it a good place to conduct a study that teases out the extent to which declines in fertility impact on household income. This is particularly important given that the Focused Investigations on Reproductive Health and the Time Use and Health Study both conducted as part of the second wave of the Accra Women’s Health Study shows clearly that Ghanaian women work for long hours and moderate wages throughout their reproductive years. Pregnancy, child care and even delivery does not disrupt this pattern much (Poppov 2010: 3). This suggests then that low incomes on the part of these women may have little to do with their reproductive health and a lot more to do with the nature of the labour market in which they operate. The extent to which this is the case needs to be explicitly explored and established. Again, here a matched sample longitudinal study would enable us to decipher the mechanisms by which fertility declines are translated into improved household incomes. A variety of variables could be tested such as the extent to which declines in fertility improve the health of women and thus their income generating abilities or the extent to which freedom from childcare obligations makes it possible for such women to take advantage of income generating opportunities that come their way.
2.0 INTRODUCTION

Ghana has a distinguished record of academic and programmatic research connecting gender norms to poverty. Ghana also has a history of a complicated interest in the study of and intentional action on population which covers pioneering concern with population control to new, broader concerns with Reproductive and Sexual Health. Direct examination of the links between Reproductive and Sexual Health and Poverty, including those filtered through a gender lens, is, however, rare in Ghanian academic as well as programmatic literature. A recent, systematic thesis examining the insufficiency of explicit attention to the link between reproduction and poverty in Ghana points to an emphasis on a medical rather than a broad political economy approach (Boakye 2009). Two iconic pioneers of Population Studies in Ghana provide a compelling account which clearly shows why academic and policy concern in these issues has been often potted rather than inter-connected. They clearly dissect the complicated ideological contests, the virgin intellectual spaces as well as the accidents of history which created our fields of interests as they are in Ghana today (Caldwell and Sai 2007). An inter-generational pair of feminist Ghanaian authors summarily explains this condition in terms of an intentional amnesia on power in the discourses on gender in Ghana (Anyidoho and Manuh 2010). Also, an active feminist researcher on demographic themes in Ghana has provided a deep perspective on her own scholarly progress in these fields which points up the late development of critical concern with the broad, structural issues that affect or are affected by Reproductive and Sexual Health in Ghana including its implications for household income (Adomako Ampofo 2010).

This review cannot, therefore, be a first-order taxonomy of studies that adequately interrogate the full range of relationships in which we are interested. It would first illustrate the general, orienting points we have made above by focusing on the institutional context in which reproductive health and gender equality needs are addressed. We then offer a concentrated assessment of existing data sets that are likely to be relevant to our interests. Next, we focus on a systematic presentation of the relationships between poverty and sexual/reproductive health status in the Ghanaian context drawing on the available literature. We end by touching on new directions in Ghana Studies which promise a more conjoined attention to the importance of Reproductive and Sexual Health in explaining the nexus between Gender and Poverty in Ghana.

3.0 THE INSTITUTIONAL AND NORMATIVE CONTEXT FOR UNDERSTANDING SEXUAL/REPRODUCTIVE HEALTH AND GENDER EQUALITY IN THE GHANAIAN CONTEXT

3.1 SEXUAL/REPRODUCTIVE HEALTH

It has been argued in broad intellectual history accounts that in Ghana there has been an important movement from population control to reproductive health. Population control has been a dominant metaphor in international family planning programs since the 1960s. It has frequently meant pursuing a single-minded goal of fertility limitation, often without sufficient attention to the rights of family planning clients. In contradistinction, Lane (1994: 1303) notes that,
A reproductive health framework would provide a broader programmatic focus that could bring needed attention to such issues as sexually transmitted diseases, infertility, abortion, reproductive cancers and women’s empowerment generally.

The argument for the need to move from an emphasis on population control to reproductive health had a significant feminist dimension. As Lush et al (1999: 774) put it: women's rights activists pushed for a change in the rationale behind family planning programmes to shift the emphasis from controlling the number of children a woman bears to helping women achieve reproductive goals safely and effectively.

Ghana was at the cutting edge of the Population Control movement particularly on the African continent. President Kwame Nkrumah, Ghana’s first president, readily agreed to enroll Ghana in the United Nations system of rigorous Population Censuses in 1960. A request was also made to the Population Council which provided the initial support for the beginning of academic demography at the University of Ghana. Although for ideological reasons Nkrumah opposed the family planning movement and other aspects of Population Control, including banning the use of contraceptives in Ghana, the intellectual roots of Demography which he significantly helped shape for Ghana was in the Population Control vein. Soon after his overthrow in 1966, the full rump of Population Control, including its significant Non Governmental Organisations, was openly promoted in Ghana with the support of the new military government. Ghana was able to produce what is regarded as Sub Saharan Africa's first official Population Policy. This was very much in the mould of Population Control. Its management was firmly based in the Ministry of Finance to emphasize the dominant view of the time that population had to be controlled primarily in the service of efficient economic growth (Caldwell and Sai 2007).

While institutional attention to Reproductive Health issues within the bureaucracy of the state in Ghana is moving in the direction of full integration, critical assessment has pointed up many systemic constraints to integration. The 1994 International Conference on Population and Development in Cairo is universally acknowledged as a major force in the enhancement of the place of Reproductive Health in the Ghanaian Health system. The upsurge of HIV/AIDS and feminist advocacy are also given credit. It has been vocally argued that the Ghana health system has made only token acknowledgement of the upsurge of Sexual and Reproductive Health. In priority setting in the Ministry of Health, it has been argued that old fashioned traditional disease-ranking and cost-effectiveness measures dominate. In addition, neither the Sexual and Reproductive Health Donor network within Ghana nor the wider community of attentive publics in the Sexual and Reproductive Health field in Ghana has been important in setting the agenda (Mayhew and Adjei 2004). One of the authors of this study is himself a key part of the movement of Ghanaian, middle-ranking health professionals who have engineered an evidence-led campaign for very fundamental change in the Ghana Health System in ways that include making it friendlier to Sexual and Reproductive Health concerns.

Within the constraints noted above, Donors have been shown to have captured particular aspects of the Sexual Reproductive Health field in Ghana. Such break-up, it has been
argued, has made a total perspective on the Sexual and Reproductive Health field itself more difficult and its inter-connection to broader Development issues such as poverty even more so (Mayhew 2002). Donors also convene on the turf of developing countries with the baggage of ideological battles from their home countries. Given the touchiness of reproductive health issues in many countries, there is a big complication at the level of recipient countries like Ghana which often do not have the capacity to decipher and strategically relate to this distant politics:

Donors (usually) are not neutral, philanthropic givers of gifts. Donors are subject to national and international political interests that can influence their decisions on program and service support to the detriment of local needs. This is currently the case in the United States. The anti-abortion stance of recent Republican administrations (starting with that of Ronald Reagan) has resulted in a policy (the so-called gag rule) that denies aid for family planning funding to any foreign nongovernmental organization (NGO) that uses its own money to provide abortions, engage in abortion counseling or referral or advocate changes in abortion laws, regardless of the needs of the population being served.

(Mayhew 2002: 220)

Turf keeping by the donors makes it difficult for countries like Ghana to ensure effective harmonization of the international aid it receives in Health. The main programmatic vehicle for achieving harmonization, the Sector Wide Approach, struggles. In Ghana this has had serious implications for the availability of condoms, a vital part of the Reproductive health arsenal in these times:

Not all donors are committed to the [sector wide] approach, however, and tensions are evident when groups of donors remain outside the SWAp. In Ghana, for example, most European donors have pooled their funds into a SWAp, but key sexual and reproductive health donors-USAID and the UN agencies (notably UNFPA)-remain outside and continue to support and deliver separate sexual and reproductive health program activities. This can inhibit the effectiveness of the SWAp because national policymakers may not see any necessity for the holistic planning that the SWAp is designed to promote. For example, the government in Ghana did not initially include a budget line for condoms (the main-stay of sexual and reproductive health programs) because USAID and UNFPA were continuing to fund condom supplies outside the SWAp. To keep sexual and reproductive health needs and requirements on the national agenda, sexual and reproductive health supporters must make the case for sufficient resources to national-level decision-makers (Mayhew 2002:222).

Similarly, in the safe motherhood domain, a study of thirteen programmes noted that there was very little coordination, including integration in the Ministry of Health’s Sector Wide Approach. It was noted that the programmes were dominated by international donors and emphasized narrow service provision rather than broad community based intervention (Okiwelu et al 2007). Focusing on service provision makes it less likely that poverty concerns would be addressed. The study concludes that “Safe motherhood may still be on
the policy agenda in Ghana, but could be at risk of being lost in the milieu of other interests during programme implementation.” (Okiwelu et al 2007: 366).

The study goes on to note that in the complex navigation of various donor interests on safe motherhood, the conversation between relevant Ghanaian official agencies and Ghanaian civil society gets lost. Since a major constraint to a more progressive Sexual and Reproductive Health stance in Ghana is the quality of deep cultural values held in society, this deprivation assumes great seriousness.

Unlike the programmatic aspects of sexual and reproductive health in Ghana, the academic wing of the sexual and reproductive health community in Ghana is active and growing. A strong analytic tradition in demography has blossomed, a useful overview of which is presented in Awusabo-Asare et al (2004). In this broad overview of Ghanaian demography with emphasis on adolescents, many interesting relations within the domain of demography itself are outlined but connections to broad development issues including poverty is not strong. This is partly because traditional demographic analysis focuses on a narrow range of factors that affect fertility. It is only in recent years that feminist demography has emerged which allows for a broader conceptualization of the relationships between fertility and a host of other social factors including poverty. A Ghanaian feminist demographer in explaining her intellectual trajectory makes this clear:

During my early years … I was attracted by the discourse on women’s ‘control over their fertility’ and the focus on their ‘reproductive health’. Constructions of women around childbearing and motherhood seemed logical to me, given my training in development and later in social demography. …a critical (feminist) approach came belatedly and more slowly. There was something seductive in the development and demographic literature, supported by findings from large-scale surveys that pointed to the need to enhance women’s uptake of modern family planning services for their physical and even emotional well being. Not to be ignored were the benefits that would accrue to countries of the Global South if women had fewer children. The methodological process based on quantitative analyses also made it possible to see the women (and men) as mere numbers. I am not proud to acknowledge that if I ran statistical analyses that suggested women had an ‘unmet need’ for contraception, I would get excited. However, slowly an intuitive and intellectual transformation occurred: I became uncomfortable with the instrumental approach to issues of women’s reproductive health and behaviour. Slowly, I began to reject much of what I was reading and sought alternative paradigms, for there was something wrong with the binary picture that essentially represented African women as not intelligent enough to be able to determine their fertility, or as completely dominated by and obedient to men. One day, I discovered that there were feminist demographers, and once I began to examine reproductive issues with a more critical eye informed by a feminist perspective, well-established and taken-for-granted concepts such as the notion of women’s ‘unmet need’ for family planning began to crumble (Adomako Ampofo 2010: 34).
Survey studies, undertaken every so often do provide us some insights that support the feminist demographic approach. The Ghana Demographic and Health Survey (GDHS) of 2008, for example makes it clear that there is a gendered and class dimension to adolescent sexuality in Ghana. Among Ghanaian youth aged 15-24, the percentage of women who had sexual intercourse before the age of 15 is almost twice as high as that of men, specifically 7.8% versus 4.3% (GDHS 2008: 266). Similarly, while there is very little variation among male youth from different socio-economic backgrounds in terms of their initiation into sexual activity, there is a direct relationship between socio-economic background and sexual initiation for Ghanaian female youth. The richer the economic background of a female youth, the higher her age at first sexual contact.

### 3.2 GENDER AND POVERTY

The general feminization of poverty is well established in the academic study of Ghana as well as in programmatic and advocacy perspectives. Qualitative as well as quantitative studies have firmly established that women are poorer in Ghana. The Ghana component of the World Bank supported system of generalized household surveys, the Living Standards Survey, has been useful in this respect. Lawrence Haddad (1991) mined the initial versions of this household survey to show gender-differentiation of processes which lead to poverty outcomes in Ghana. He was also able to contribute data on Ghana as one of the ten countries for extending the United Nation’s World Women data (Quisumbing et al 2001). A relevant conclusion was that

> Stochastic dominance analysis reveals that differences between male- and female-headed households, and between males and females, are often insignificant, except for Ghana and Bangladesh, where females are consistently worse off. These results suggest that cultural and institutional factors may be responsible for higher poverty among women in these countries.

Quisumbing et al 2001: 38.

The study concluded that using a poverty line of $365 per person per year, Ghanaian currency, using purchasing power parity conversion, 82.5 per cent of female headed households were deemed poor whereas 77.2 per cent of male headed households were deemed poor. In comparison, in Botswana the equivalent figures were 0.0 and 0.6 and for Ethiopia 99.6 and 100 (Quisumbing et al 2001: 38).

The authors noted the limits of focusing narrowly on income/poverty in assessing the differences in well-being between females and males. They argued as had Sen (1998) that other social indicators such as nutrition, health, time allocation, adult and infant mortality rates may also differ widely across males and females and require further study. Constance Newman and Sudharshan Canagarajah (2000) have been able to use an additional round of the Ghana Living Standards Survey to interrogate gendered poverty dynamics in Ghana and Uganda and, for Ghana, were able to show that at the individual level, women were poorer than men but the gender of household headship itself is not a robust predictor of poverty.
The GLSS continues to provide rigorous quantitative indications of significant gender differences in poverty outcomes in Ghana. A recent assessment of the various rounds of the Ghana Living Standards Survey to date confirms that poverty has been halved in Ghana over the period from 1991 to 2005. However, a gender-focused reading of the research gives many points for worry. For men as well as women, incomes fell over one period of the research and rose in another. However, the fall for women was deeper and the rise less pronounced. The study shows that:

For men there was a fall of 6% over the period 1991/92 to 1998/99 while for women there was a fall of 13%. In rather dramatic contrast, over the period from 1998/99 to 2005/06 the earnings of men increased by 64% and for women by 55%
Thus while ultimately, men’s earnings had increased by 58%, women’s earnings had increased by 42% (Nsowah-Nuamah et al 2010: 1).

Data collated by the Organisation for Economic Cooperation and Development (OECD) supports the assertions of Nsowah-Nuamah et al (2010). The data shows that while in 2006, female GDP per capita in Ghana was $1035, the equivalent for males was $1454.

There has been concern that even when the bare facts of significant gender induced differences in poverty are accepted in Ghana, it still does not sufficiently affect public and social action. Agnes Atia Apusigah (2007) makes such an argument with regard to the entire post independence period. She invokes major assessments to show that as at 2007, the gender mainstreaming project in Ghana was severely challenged. It would appear that since then, collective advocacy and skillful deployment of multi-level arguments has brought improvement on this score. Ghana’s current development of a national medium-term development framework includes a significant technical component on gender and a recent, important Donors’ meeting of the Government of Ghana and its major donors also had an organic technical group on gender which included national experts as well as a technical team from the Donor community. A more recent assessment of related issues highlights progress in official policy and action but notes that policies and programming in its area of attention – social protection through direct cash transfer to the vulnerable, known as the Livelihood Enhancement Against Poverty (LEAP) programme – overly concentrate on economic risks and vulnerability such as income and consumption shocks and stresses rather than social risks such as gender inequality, social discrimination, unequal distribution of resources and power at the intra-household level as well as limited citizenship (Amuzu et al 2010). The study notes a lack of interest in using the opportunity of a community of beneficiaries of cash transfer for social capacity-building including for reproductive health issues (Amuzu et al 2010: x).

This biased focus on the economic is also reflected in many other gender-related studies of Ghana. It is not surprising then that issues of reproductive and sexual health do not make a significant appearance in broad development policy and programming in the country. The limited usefulness of programming in reproductive and sexual health is evident in a national policy to exempt women from paying for delivery care in public, mission and private health facilities in Ghana. It begun as a small part of Ghana’s Highly Indebted Poor Country (HIPC) initiative but was surprisingly continued and broadened such that it
was presented in the international development press as a direct, personal deal between the former British Prime Minister Gordon Brown and former Ghanaian President John Agyekum Kufuor. Analysis of this policy by a group of authors including people who have long been part of the Ghana Health system (Witter et al 2009) found at least ten major faults although the authors politely present them in terms of challenges. What they have to say on the poverty aspects of this policy is telling:

The results from the evaluation suggest that inequalities can decrease in response to a universal exemption. In the 18 months after fee exemption was introduced, the largest increase in facility utilisation in Volta Region was amongst the poorest (first quintile), while in Central Region it was amongst the poor (second quintile). In terms of household payments, the incidence of catastrophic out-of-pocket (OOP) payment was found to fall. For the poorest quintile, the proportion paying more than 2.5% of their income dropped from 55% before the policy to 46% after. Using the poverty head count, the proportion of households falling into extreme poverty as a result of their delivery payments reduced from 2.5% before the policy to 1.3% after. However, the proportionate decrease in OOP payments was greater for the richest households (22%), compared to the poorest (13%). Moreover, to reach the poorest and the poor in some areas, additional demand-side cost issues such as transportation costs, might need to be addressed.

(Witter et al 2009: 2)

Again, the capacity of the state for sure-footed targeting was shown to compound the broad poverty connections raked by the intervention-

Exemptions do not address non-facility costs. This is reasonable in areas which have easy access to services, but will be inadequate in areas with substantial distance barriers. The IMMPACT evaluation found that facility costs formed the largest proportion of overall household costs for deliveries in Ghana, particularly for more expensive procedures (40% of costs for normal deliveries but 80% for caesarean sections prior to the exemptions policy). These emergency procedures are both lifesaving and potentially catastrophic for households, and should therefore receive priority in exemptions policies. In Ghana, however, the evaluation found that even facility costs were not reduced to zero by the exemption policy - the reduction was of a magnitude of 28% for caesarean sections and 26% for normal deliveries. This points to the need to assess real impact on households to ensure that subsidies are adequate and that they are being passed on in reality to users. Analysis of funding flows to the delivery exemption policy found an average public expenditure on the scheme of $22 per delivery compared with an average ‘benefit’ to clients of around $10 per delivery. This difference in value may reflect regional differences (the cost data came from Central Region while the benefits data came from Volta) or it may reflect facilities not passing on the full cost reduction to users.

(Witter et al 2009: 3)
3.3 THE PLACE OF HIGH POLITICS
The research as well as programme literature on our concerns does not often cover high politics although in many important ways our subjects are inevitably political. Our concerns are often personal but they are also political for, as the feminist and other bodies of knowledge have powerfully taught us, the personal is often political as well. It has been established in the general literature that there is a tendency to focus on biomedical issues and micro-demography at the expense of large structures and processes, especially state politics. We have noted the significance of policy dynamics in the Ghanaian context in previous sections, but these operate below the higher political levels of vision development and broad goal attainment.

Two major factors account for this lacuna. First, the Ghanaian women’s movements, which have had much incentive to be concerned with the macro, including political aspects of the subjects we are interested in often shy away from being considered directly political (Fallon 2008). Second, even in the academic interrogation of gender in the Ghanaian context, as argued by two active Ghanaian feminists (Anyidoho and Manuh 2010) there is an intentional amnesia on power. A pioneer, very well regarded bibliography of Women in Ghana pointed up the fact that there is insufficient attention on analysis of large structures and processes, especially macro politics (Ardayfio-Schandorf and Kwafo-Akoto. 1990). A major volume on “Reproductive Change in Ghana” does not include Policy or Political Science analysis and not much Macro Economics. Nonetheless, the editors at many points intone the importance of this gap including in their final sentence – “we caution against a myopic narrowness of perspective: there must always be a recognition of the broader structural contexts and changes – the larger forces – that drive reproductive change.” (Agyei-Mensah et al 2005: 245).

Notwithstanding the insufficient attention paid to the importance of huge structures and processes, including high politics, in the analysis of our subjects there has been relevant political struggles which seek to affect the fundamentals of Ghanaian state and society. Two distinguishable but connected domains of contestation may be identified. The first seeks a fuller citizenship centred on gender equality. The second counters the dominant ideology and mores which sustain the current inequities. The most important manifestation of the first domain of struggle has involved coalitions of often elite, urban-based women’s organizations contesting the state for a fuller citizenship often on an ideational, and, occasionally, on a physical protest level. The three coalitions, all of which emerged within the last fifteen years, are the Network for Women’s Rights in Ghana (NETRIGHT); The National Coalition on Domestic Violence Legislation; and the Women’s Manifesto Coalition. These coalitions involved organization members as well as prominent individuals and had a great deal of overlap in terms of membership. NETRIGHT emerged out of critical study of the national, primarily governmental, machinery for addressing women’s issues by the radical research and advocacy organization Third World Network. The coalition on Domestic Violence had the very specific objective of birthing a new statute law on the issue. The movement for a Women’s Manifesto was initiated by the Pan African women’s movement Abantu for Development which constituted a support “Women’s Manifesto Project” to backstop the broader political coalition. Many important aspects of these struggles have a direct bearing on our interests in Reproductive Health, poverty and gender equality. The concerns of the Domestic Violence Coalition in particular had an obvious, direct bearing as the issue of Domestic Violence was often in the context of marriage
and the issue of “marital rape” became the touchstone of contestation. The Women’s Manifesto, which seeks to influence the political platforms presented at elections in Ghana, covers a wider range of relevant issues and NETRIGHT has campaigned on a range of issues including the economic rights of women and its relationship to the feminization of poverty in Ghana.

The records of these coalitions have been well presented, often by feminists who were directly involved in the struggles (Tsikata 2007, 2009; Adomako Ampofo 2008). Limitations have been recorded even by those who were themselves part of the struggle. Tsikata (2009) has consistently underlined the elitist nature of these coalitions and the need to go beyond the NGO frame of thought and action. A recent academic thesis on these movements approaches them in a more distant, critical manner. Aggor (2009) deploys an effective adaptation of Foucault’s master concept of governmentality to argue that, in the end, although these coalitions were well intended, they worked unintentionally to support the control mechanisms of the Ghanaian state as they were drawn into sites of contestation primarily driven by the Ghanaian state and its transnational supporters. This significantly theoretically driven thesis is intertwined with extensive interviewing of those involved in the struggles. Aggor’s Critical Theory connects to a fundamental aspect of the underdevelopment of the state in Ghana. Political sociologists have long pointed to the fact that the state in Ghana has a very weak social welfare capacity and that there are simply insufficient opportunities for policy discussion of “soft” welfare issues which deeply affect the everyday life of purported citizens. For our purposes these arguments have been conveniently presented by Maclean (2002) in the context of a comparison of Ghana and its Francophone neighbor Ivory Coast.

The second domain of contestation of major significance to our interests in Reproductive Health, Poverty and Gender Equality concerns the contestation of more diffuse but widely held fragments of dominant ideology and mores which limit the citizenship of women and their capability for full enjoyment of their reproductive rights. We noted in our earlier discussions of abortion and harmful traditional practices that often even when the Ghanaian state accedes to progressive general norms it does not have the infrastructural capacity to ensure that the general principles are applied in sufficient individual cases. Ghana hosts a rich collection of studies which present important, detailed points requiring policy attention but which receive next to no attention at all. In her contribution to the major University of Ghana conference on Reproductive Change, Oppong (2005) presented a summary of her life work with an obvious sub-text that there have been few real opportunities for these important issues to be aggregated in the political process for policy action. Esi Sutherland Addy (2006) contributed an arresting chapter to a volume on HIV/AIDS in Ghana which showed the depth of mores and values which work against the reproductive rights of women in Ghana. In April 2011, in her Keynote Address to the Humanities Colloquium of the University of Ghana, she repeated that the norms persist and extended the charge to the academe for insufficient attention to the issues. In this domain of contestation as well, a recent academic doctoral thesis has argued that, as this dominant ideology and mores affect HIV/AIDS in Ghana, the challenge is much bigger than existing thought and analysis has assumed (Wertheimer 2010). Wertheimer argues for a total sea change in the articulation of major domains of social existence in Ghana if the apparently mundane issues which fuel the HIV/AIDS crisis in Ghana are to be corrected.
Politics is the art of the possible. Within the fundamental constraints noted above, it must be said that certain individuals and organizations have been able to work the interstices of the state to the benefit of globally-significant, positive outcomes for Reproductive Health and Gender Equity in Ghana. The recent autobiography of Fred Sai of Ghana shows in many places how personal commitment can slowly and carefully work the overwhelming, negative pressure of our structural situation in Ghana (Sai 2010). The Western Region in Ghana is also being put on the global map of good practices in Maternal Health through the PROMISE process significantly powered by the personal commitment of the Regional Director of Health Linda Vanotto (PROMISE stands for Promote Maternal Infant Survival Excellence. See http://tinyurl.com/44htnxt http://tinyurl.com/3qomhsz and http://tinyurl.com/ctuta8)

4.0 RELEVANT DATASETS
For our purposes, there are two groups of relevant survey data, the first focusing on poverty and the second set on sexual and reproductive health. All of these surveys almost by definition have a strong gender focus as well. There is one major dataset on poverty: the Living Standards Surveys. The Ghana component of the World Bank supported system of generalized household surveys, the Living Standards Survey, provides a world-class integrated instrument, which has been used to produce quantitatively rigorous studies on poverty issues especially. In addition, social household data is canvassed within its compass and there is obvious scope for more analysis along the lines of our interests. The Ghana Living Standards Survey (GLSS) has been carried out consistently since the early 1980s and a new round is being planned now. It has been historically very difficult to get access to the full, soft data although the situation is changing. We have secured access to the full, soft version of the most recent round and our understanding is that release of the full, soft version of all the rounds of the Ghana Living Standards Survey is on the cards within the context of the World Bank’s Open Data initiative. In addition, the Ghana Demographic and Health Survey (GDHS) provides some basic demographic information that gives insights into poverty issues in Ghana. Ghana has been part of the well-known system of Demographic and Health surveys since 1988. In addition to providing basic demographic information, the most recent, 2008, survey collected information on a range of sexual and reproductive health matters: fertility levels, marriage, sexual activity, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, domestic violence, and awareness and behaviour regarding AIDS and other sexually transmitted infections. Thus, the GDHS is a much more wide-angled resource compared to the Ghana Maternal Health Survey (GMHS) which we describe below, but it has the advantage of being available over a long period of time. The GDHS complements the GMHS well for it has different emphases even where the same topic such as contraception is concerned and it covers HIV/AIDS fully.

The most comprehensive dataset which focuses primarily on sexual and reproductive health is the recent (2007) GMHS which was originally planned as a baseline survey for a USAID project. It is a rigorous, nationally representative survey which, we understand, is very likely to be repeated on a regular basis from now on. Its descriptive entry in the USAID Development Experience Clearing House system deserves long quotation:
The GMHS is the first nationally representative survey to collect comprehensive information on maternal morbidity and mortality in the country. The survey gathered information on maternal health in two phases. Phase I was fielded in some 240,000 households to obtain information on deaths in the households and more specifically female deaths. Phase II followed with a verbal autopsy on the causes of deaths for 4,203 women age 12–49 identified in Phase I. In addition, a woman’s questionnaire fielded in Phase II in a sub-sample of households collected information from 10,370 women age 15–49 on a wide range of maternal health-related issues pertaining to pregnancies, live births, abortions and miscarriages, and utilization of health services in relation to these events. Also included in this questionnaire was a sibling history that allowed for the calculation of maternal mortality in Ghana.

A decade earlier, the Ghana National Youth Reproductive Health Survey (GYRHS) was conducted. The GYRHS (1998) was a nationally representative survey administered to 5,640 youth aged 12–24 (2,533 females and 3,107 males). This survey covered a range of sexual and reproductive health topics such as sexuality, pregnancy, abortion, STIs and HIV/AIDS, and preventive behaviors. Similarly, in 2004, a national survey of adolescents was undertaken with funding from the Alan Guttmacher Institute based in New York and led by Kofi Awusabo-Asare, one of Ghana’s most distinguished demographers. Its areas of interests were similar to that of the GYRHS.

Beside the huge national datasets which are more readily available, there are smaller sets which, even when sub-national, may have data relevant to our purposes. The Government of Ghana tends to control these smaller sub-national datasets often developed for its own policy and operational purposes. There are also important datasets within academic and private (NGO) domains. Access to these sets is obviously more circumscribed but when a firm determination has been made that an existing data set would be crucial for our purposes, specific approaches can be made to access and assess them.

5.0 LINKS BETWEEN POVERTY AND SEXUAL/REPRODUCTIVE HEALTH

5.1 MICRO CREDIT AND SEXUAL AND REPRODUCTIVE HEALTH

Ghana’s Development Experience encompasses a concern with microcredit well before its contemporary faddishness. From the very early 1970s, important, home-bred experiments were begun in what is now called microcredit. These schemes failed largely because of the extraordinarily poor macro-economic environment in which the country found itself. The schemes were primarily responses to the balance book crises of the banks which introduced them and the extraordinary pump-priming of the military government for local food self-sufficiency (Anyimadu 1988). There was very little attempt to focus specifically on women and the new, enlightened perspectives on Reproductive Health but some of the schemes ended up with dominant female participation, anyway. There may, therefore, have been a long, policy-induced outplay of the relationships between credit to women and positive general and reproductive health outcomes which are now consistently invoked although studies to that effect are sorely lacking.
Today, Ghana is a full member of the micro credit revolution. The Grameen Foundation is in Accra, the capital city, although its primary focus here is on technology and health. Most ordinary commercial banks in Ghana have also made a conscious attempt to incorporate microcredit schemes in the services that they offer clients (Derban 2008; Asiama et. al. 2007). In addition, a vigorous community of knowledge and practice specifically focused on microcredit has emerged in Ghana.

Globally significant projects which seek to link microcredit and women’s health have been implemented in Ghana (Martei 2008; MkNelly and Dunford 1998). The Freedom from Hunger Credit with Education programme in Ghana, and the Lower Pra River area in South Western Ghana in particular, has been studied extensively and enables fairly firm statements on the relationship between MicroCredit and Reproductive Health and other health factors concerning women. MkNelly and Dunford (1998) is a rigorous, multi year study with a 1993 baseline and 1996 repeat in the Lower Pra area specifically designed to track social effects of the programme using comparisons from non participants in the Programme area as well as analogous, control communities in areas where there were no Credit with Education activities. The study has been widely cited. A Grameen Foundation report summarizes it usefully in these terms:

In Ghana, participants experienced an increase in monthly nonfarm income of $36, compared to $17 for the comparison group. Participants were more likely to breastfeed their children and more likely to delay the introduction of other foods into their babies’ diets until the ideal age, and they were more likely to properly rehydrate children who had diarrhea by giving them oral rehydration solution. These impacts paid off in a significant increase in height-for-age and weight-for-age for children of participants. (Goldberg 2005: 8)

The study was able to conclude that a wide range of Reproductive Health, specifically child survival variables including giving newborns antibody rich first milk and not using feeding bottles improved in ways that can be directly attributed to participation in the Credit with Education Programme. It was found that in 1993 only 60 per cent of the respondents who participated in the programme gave their newborns antibody rich first milk and that in 1996, after participation in the programme, the figure had risen to 98 per cent. In the control communities with no Credit with Education activities, there was no such marked improvement, the figures being 61 per cent and 71 per cent for 1993 and 1996 respectively (MkNelly and Dunford 1998: 33). Similar positive developments were seen in feeding bottle use, which is not recommended. It was found that in 1993, 88 per cent of the relevant respondents who participated in the programme used feeding bottles and that in 1996, after participation in the programme, the figure had appropriately fallen to 23 per cent. In the control communities with no Credit with Education activities, there was less marked improvement, the figures being 83 per cent and 60 per cent for 1993 and 1996 respectively (MkNelly and Dunford 1998: 34) These trends have been recently broadly confirmed by a manager of the programme (Martei 2008).

Inspite of the optimistic outcomes of the Freedom From Hunger with Credit Education Programme, there is evidence that the positive aspects of change expected among Ghana’s female microcredit beneficiaries are exaggerated. Researchers primarily at the University
of Cape Coast, which has emerged as a leader in the academic wing of the microcredit communities in Ghana, have argued that first of all, women are consistently and systematically underrepresented as beneficiaries of microcredit schemes in Ghana. This obviously has negative implications for poverty alleviation (Annim et al. 2008), not to mention women’s sexual and reproductive health needs. We also have to factor into the Ghanaian condition Patrick Bond’s powerful dismissal of the claims of the microcredit movement with particular emphasis on poverty and health promotion (Bond 2007).

5.2 ABORTION
The issue of abortion points up the strengths as well as limitations of Sexual Reproductive Health in Ghana. Abortion in Ghana is a serious issue. Abortion is most common among women age 20-24, one in eleven of whom report having had an abortion in the five years preceding the survey (GMHS 2007). Eleven per cent of all maternal mortality is attributed to abortion and maternal mortality is itself the second leading cause of death among women of reproductive age in Ghana (Sedgh 2010). Twenty five percent of maternal deaths among women within the ages of 11 and 19 are due to abortion (GMHS 2007). Poverty plays a role in determining whether or not a woman wants to have an abortion as well as whether or not a woman can afford an abortion. One in five women who had an abortion in the five years before the survey reported that the main reason for the abortion was that there was no money to take care of a baby (GMHS 2007). Further analyses of the GMHS (2007) also reveal that abortion rates are higher among educated and wealthy women than among women with no education and those who are very poor. Similarly, Ahiadeke (2001) notes that abortion is most common among the educated, urban Christian women of Southern Ghana. In terms of costs, Henry and Fayorsey (2002) noted that abortion costs ranged from 30,000 to 300,000 cedis, the equivalent of 9 to 90 US dollars at the time depending on whether the abortion was procured in a public or private facility. Thus, Baiden (2009) notes that the costs of abortion have implications for accessibility to abortion services.

Analysts accept that Ghana has a relatively enlightened legal regime on abortion although this is not sufficiently disseminated. Since 1985, Ghanaian law has permitted abortion for pregnancies that result from rape, incest, or “defilement of the female idiot,” where there is high risk that the child would suffer from a serious deformity, or if the pregnancy threatens the woman’s physical or mental health (MOH, 2008a). The lack of knowledge about the law is evident in a recent survey of health care facilities in 10 districts which found that; only 21 percent of providers knew all the legal indications for abortion; 23 percent of providers incorrectly reported that the abortion law requires written consent from the woman’s partner; and around half of providers reported having concerns about providing abortion services because of their religious beliefs (Aboagye et al 2007: 4). Hill et al (2009) confirm this finding during their study in the main teaching hospital in Kumasi. They report that only 54% of maternal and child health-related workers were aware of the true nature of Ghana’s abortion law, with 35% believing that the law permits abortion only to save the life of the woman. More than 50% of the workers also reported they would be unwilling to play a role in performing pregnancy terminations. Knowledge among potential users is also low. The GMHS (2007) reports that only 4 percent of
women think that abortion is legal in Ghana and among these, 17 percent say they do not know under what circumstances abortion is legal.

In addition to the lack of dissemination about the law inspite of its existence for a quarter of a century, the state did not integrate safe abortion into national reproductive health policy until 2003 (Ipas, 2008). In 2006, the Ghana Health Service released new standards and protocols for safe abortion services that include direction for interpreting Ghana’s abortion law. These standards were developed in collaboration with Ipas, WHO, and other stakeholders (Aboagye et al., 2007).

In general, public policy stances on abortion are broadly positive as evident in the fact that a major pan-African consultation on abortion by the major advocacy agency Ipas was recently hosted in Accra with strong Government of Ghana support. However, the state, it has been argued, does not do enough to ensure that the norms it has pronounced in its laws are in fact operative (Lithur 2004). The state itself is unable to provide the infrastructure necessary for providing the specific comforts implied by its own abortion laws. As recently as three years ago, fewer than 1 in 7 public health facilities reported offering legal abortion services (Aboagye et al 2007). Meanwhile, there is a very strong cultural incentive for women to be secretive about their abortion practice because of the cultural value placed on childbearing. Lithur (2004) has noted for example that those who are known to have had an abortion in a community are shunned and given anti-abortion derogatory names. Her family, especially among the Ga ethnic group of the south, is likely to be branded the “family where its womenfolk remove pregnancies”. This has implications for the abortion methods chosen (Hill 2009). The cost of unsafe abortions in Ghana is deemed to be very high. An intensive study of four years of hospital data on antenatal services, deliveries and maternal deaths in a poor but very well researched North Eastern district in Ghana concludes that complications of unsafe abortion accounted for twenty nine per cent of maternal deaths (Baiden et al 2006). Overall, both advocacy and research interest in abortion in Ghana points to the need for “comprehensive woman-centred care” (Brookman-Amisah 2004).

5.3 HARMFUL CULTURAL PRACTICES
Harmful cultural practices that affect the reproductive health of women in Ghana occupy a similar analytic space to abortion. Public and social stances are deemed to be progressive in Ghana but the infrastructural capacity to shape real processes does not exist and research and advocacy concerns concur that not enough is being done to change the situation. In an exceptional study at the Navrongo War Memorial hospital in North Eastern Ghana, employing retrospective extraction and analysis of delivery data at the hospital from 1st January 1996 to 31st December 2003, it was found that 29 per cent of all deliveries were associated with Female Genital Mutilation although the prevalence, on the whole, declined over time (Oduro et al 2006).

A more recent investigation of Female Genital Mutilation in the same geographical area shows that despite the decline, the problems persist (Ako and Akweongo 2009). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was a major impetus of the national effort against Female Genital Mutilation in Ghana.
Indeed, statutory law on FGM was the only regulatory measure adopted following the state’s ratification of the CEDAW in 1989. Half a decade later, the Criminal Code of 1960 was amended to include the offence of FGM. The Domestic Violence Bill of 2007 also supports the criminalization of FGM. Despite all these legal provisions, however, it has not been possible to eradicate the practice. Community norms supporting the practice including the belief that uncircumcised women grow up to become stubborn and unruly and will not be accepted by their ancestors upon death are quite strong. In addition, the state itself, Ako and Akweongo (2009) suggest, has not been able to translate the legal provisions into concrete measures on the ground. Community awareness of the law for example is very limited.

5.4 MATERNAL MORTALITY
The GMHS (2007) provides two sources of estimates of maternal (or pregnancy-related) mortality, the sibling history in Phase II and the household deaths with verbal autopsy in Phase I. The pregnancy-related mortality ratio (PRMR) for the 7-year period preceding the survey, calculated from the sibling history data, is 451 deaths per 100,000 live births and for the 5-year period preceding the survey is 378 deaths per 100,000 live births. The PRMRs for the 10 years preceding the survey indicate that the risk of death per birth is higher for younger women (age 15-19) and older women (age 35-44), compared with women aged 20-34. The highest number of deaths was reported during pregnancy, followed by delivery, and the postpartum period, though the differences are not large. The maternal mortality ratio, calculated from maternal deaths identified among the 240,000 households sampled in Phase I for the 5 years preceding the survey, is estimated at 580 per 100,000 live births. Mortality rates in Ghana are linked to poverty for the maternal mortality rates are highest in the three northern regions of Ghana (Upper West, Upper East and Northern Regions) which are also the three poorest regions in the country.

5.5 FERTILITY
The GMHS data on fertility collected from the pregnancy history show that the total fertility rate for the three years preceding the survey is 4.6 children per woman aged 15-49. The age-specific rates indicate that the prime reproductive years among Ghanaian women are the twenties and early thirties. The data available does not make direct links between fertility levels and poverty measured in terms of income, but if we use location as a proxy, we get a pretty good sense of the ways in which income influences the numbers of children a woman has. Rural women have on average two children more than urban women (5.5 versus 3.4 children per woman). Fertility is also lowest in Greater Accra (3.0), the part of the country with the lowest levels of poverty and highest in the Northern region (6.8), the poorest a nearly four-child difference.

5.6 CONTRACEPTIVE USE
About one in four currently married women (24 percent) is using some method of contraception. Modern methods are more commonly used than are traditional methods; 17 percent of married women use modern methods, while about 7 percent use traditional methods. Of the modern methods, the pill (5 percent), and injectables (6 percent) are most widely used. Periodic abstinence is the most popular traditional method and is used by 5 percent of married women (GDHS 2008). The data available does not make it possible for us to make direct links between contraceptive use and poverty levels. However, if we use
levels of education as a proxy for wealth, with the assumption that those with higher levels of education are generally wealthier, then the GDHS does provide some evidence of a link between wealth and contraceptive use. The use of contraceptive methods increases with increasing level of education. For example, 30 percent of married women with secondary or higher levels of education are using a method of contraception compared with 14 percent of married women with no education (GDHS 2008).

5.7  RISKY SEXUAL BEHAVIOUR
The most recent GDHS provides us with insight into the sexual behavior of respondents including the number of partners they had had in the year preceding the survey and whether they had sex with someone who was not a spouse or cohabiting partner (higher-risk sex). Results show that only 2 percent of women who had sex in the year before the survey report having more than one sexual partner in that time period. This is considerably lower than the level of 17 percent among men aged 15-49. Similarly, only 23 percent of women, compared with 42 percent of men, report that they had sex in the previous year with someone who was not a spouse or marital partner. Again, as with other key variables of importance to those in the sexual and reproductive health field, the links between risky sexual behavior and poverty are not explored in this survey.

6.0  NEW DIRECTIONS
The Women's Health Study (WHS) of Accra, a collaboration between Harvard University and the University of Ghana, is a major, multi-disciplinary effort which begun in 2003 and is being continued in an even more fundamental social science vein. This makes it crucial for our purposes. The Women's Health Study of Accra is:

a population-based cross-sectional survey that was conducted in 2003. Using the data from the Ghana 2000 census, the 1731 enumeration areas in Accra were stratified by socioeconomic status and 200 were selected with probability proportional to population size within the socioeconomic strata. Each household in the selected strata was visited in order to compile a list of women aged 18 and older who were usually resident in the household. A random sample of 17 women per enumeration area was selected for the survey. A total of 3183 women were interviewed at home, with a questionnaire, by trained interviewers between March and September 2003. The interview included questions on demographic characteristics, lifestyle habits, living conditions, general health and reproductive health.”

(Adanu et al 2008: 152)

This ambitious self-reporting survey, clinical and laboratory study has led to many publications although the majority have a narrow focus on medical matters (Chen et al 2005; Duda et al 2007a; Duda et al 2007b; Duda et al 2006; Hill et al 2007). It can be seen that the multi-authored studies from the Women’s Health Study of Accra cover a number of disciplines but does not focus particularly on economic themes, and, for that matter poverty. A partial exception is a 2008 study of “Sexually Transmitted Infections and Health Seeking Behaviour among Ghanaian Women in Accra” (Adanu et al 2008) which created a “wealth index” based on the reported ownership of assets and used the
index as a major parameter of analysis. It was found that a high wealth index was a protective factor for having a Sexually Transmitted Infection. Higher wealth was associated with seeking care for infection.

The original Women's Health Study of Accra was interested in the “Spatial Inequalities in Poverty” but the results were somewhat inconclusive and the measures of poverty had to be very complexly derived from National Census Data and not from the survey. It was reported that “variability in poverty from locality to locality was able to explain only 11% of the variation in health levels from locality to locality. Although this was statistically significant, it is “obviously not as high a level as we would have expected” (Adanu et al 2008: 158). The second phase of the Women’s Health Study of Accra, “Reproductive and Overall Health Outcomes and Their Economic Consequences for Households in Accra, Ghana”, focuses more pointedly on social science themes and poverty. An overview of the research explains that the study explores the links between health broadly defined and wealth at the household level. In setting out the study, the authors recognize that an individual’s economic activity is not only affected by her own health, but also by the health of other members in the household. Health is a key determinant of household wealth in general, and female labor force participation and income in particular. The main purpose of the work is to quantify the nature and strength of the two-way connections between health and household prosperity.

(Joshi 2009: 42)

The second round of the Women’s Health Study of Accra has seen the end of field operations and data is now being captured and analysed. Between January and February 2011, preliminary presentations and papers from the second round were made available online, especially within the Population and Poverty Network. They give some indication of the ways in which the study would become even more relevant to social studies. It is clear that very detailed analyses at the individual and household levels would become possible. It is, however, not unlikely that the deep detail afforded may itself stand in the way of tracing the broad level implications of the links between sexual and reproductive health and poverty which is the focus of this paper and larger project. Policy capacity for the appropriation of such finely honed welfare information in Ghana has been historically limited and even the social science research associated with the new wave of the Women’s Health Study of Accra so far is dominated by very particular concerns in Population Studies.

The second wave of the Women’s Health Study of Accra has seven distinct operations: the main survey, for which fieldwork ended in July 2009; a Verbal Autopsy Study, for which fieldwork ended in August 2009; a Time Use and Health Study, for which fieldwork ended in March 2010; a Focused Investigations on Reproductive Health (FIRH) survey, for which fieldwork ended in November 2009; Focused Investigations on Reproductive Health Focus Group Discussions, for which fieldwork ended in March 2010; FIRH In-depth Interviews, for which fieldwork ended in March 2010; and a Housing and Welfare Study of Accra, for which fieldwork ended in March 2010. According to a December 2010 report, work is continuing on the processing of all these sub studies (PopPov 2010: 3). The processes of the second wave are woven in a tight, nested fabric. The main survey had two components, a repeat of 1819 original
subjects from the 2003 Women’s Health Study of Accra and a new sample of 995 new subjects. The sample for the Time Use and Health Study was drawn from the Repeat cases of the main survey. The sample size was 1254. The sample for the Focused Investigations on Reproductive Health survey was drawn from the Time Use and Health Study sample. The sample size was 400 (Hill 2010; Hill and Doupcheva 2010). These careful, nested relationships allow comprehensive and bold interpretation.

Recent presentations and papers provide a handle on these processes. This is especially rich for the Focused Investigations on Reproductive Health (FIRH) Survey and the Time Use and Health Study (TUHS). A major, overarching conclusion of the second round of studies is that ‘Women work long hours and for moderate wages throughout their lives. Pregnancy and child care do not interrupt this intense work pattern, even after delivery” (Poppov 2010: 3).

The major conceptual framework in the second wave postulates a major causal relationship between use of health services, health or illness, women’s income and household wealth. It is also assumed that sexual activity and reproduction, including child rearing affects health or illness (Hill 2010).

The early study of the Focused Investigations on Reproductive Health Survey launches a direct challenge on central assumptions of the Sexual and Reproductive Health community (Lince, et al. 2011). It is argued that

Most definitions of reproductive health, including a recent WHO effort to measure the burden of sexual and reproductive health worldwide, focus very narrowly on the morbidity and premature mortality that can be readily identified within standard medical taxonomies. Here, we draw attention to more widespread challenges faced by women, taking a more holistic approach. A woman’s reproductive health needs change as she ages.

(Lince, et al. 2011: 1)

The rich data from the survey is used to mount enquiries along several small paths such that the authors are able to rigorously investigate a relatively large number of morbidities and investigate associations amongst them. Indeed, this can be seen as a credible attempt to widen the definition of Reproductive Health beyond the new grounds claimed through the Cairo International Conference on Population and Development (ICPD) processes. This bravado enables the writers of the Women’s Health Study of Accra to stake the major intellectual claim that:

Many of these (health seeking) activities do not involve conditions recognized as serious or life threatening by physicians or nurses since they are so common and are often not life-threatening. Several features are nonetheless serious since they have important social and economic consequences and because several conditions or issues accumulate in the form of co-morbidities among the most disadvantaged. We are thus introducing a relatively novel concept we are calling “reproductive health management” to capture concisely the range of issues related to ordinary sex and reproduction but common to women everywhere. Very few data exist on reproductive health management including its
associated cultural norms and behaviors, by which we mean not only dealing with morbidity and health risks but also with the daily challenges of maintaining good sexual and reproductive health.

(Lince et al. 2011: 1)

The stage is thus set for a fine analysis of the expenditure of time and money to acquire goods and services for combating co-morbidities associated with reproduction including queries on menstruation, pregnancy, contraception, infections of the reproductive or urinary tracts, sexually transmitted infections, and preventative care. After advanced statistical investigation of association toward causality, the conclusion of the authors is especially significant for our interests:

A significant proportion of the FIRH respondents are currently burdened with reproductive ill health (defined here as menstrual irregularity or RTI, UTI, STI symptoms). When exploring linkages between ill health and wealth, we noted that SES (socio economic status) does not seem to play a role in determining reproductive ill health. Rather, certain biological and lifestyle factors such as age and marital status (which is potentially an indicator of sexual activity) seem to be more strongly associated.

(Lince, et al. 2011: 20)

With respect to our key interest, that is the impact of preventive reproductive health on poverty, Lince et al (2011:12) provide some insight when they demonstrate that 50% of the women who sought fertility treatment and 59% of those who went in search of reproductive care such as breast examinations, nutrition education or HIV tests missed a day of work. However, the implications of this loss for their incomes can only be inferred. Considering that the majority of the sample worked in the informal sector as traders, it is likely that missing a day of work had no impact on their incomes because their stalls could be left in the care of kin or other traders who would not undercut their sales because of the social embeddedness of markets in the Ghanaian context.

The Time Use and Health Study component of the second wave of the Women’s Health Study of Accra has also been recently mined in a study of the associations with reproductive health and situation and women’s work (Fink and Hill 2011). The specific research interest is to investigate the impact of children in the household on women’s work. The main data resource of this component is daily diaries, tracking their activities on a 30 minute basis over a period of 3 months which respondents were trained to fill. “In total, 120,374 daily diaries were collected, each containing 48 30-minute blocks, resulting in a total number of 5,777,952 time use records.” (Fink and Hill 2011: 5). This large resource is complexly combined with other segments of the Women’s Health Study of Accra and other demographic and social data to arrive at the conclusions on contemporary female labor participation and other time use patterns in Accra. Interestingly the authors are able to construct a category on time spent commuting, in recognition of Accra’s increasingly unbearable traffic. The major finding, contrary to what pertains in many other places, is that whereas the presence of children, including especially pre-school children, does not affect women’s participation in the formal sector, it affects participation in the informal sector. This anomaly is explained by the fact that the majority of the women in the informal sector in this study were underemployed; they worked between 3 and 4 hours a day since they
did not have regular employment (Fink and Hill 2011:5). Thus once they had children, they chose to spend more of their time on childcare than on looking for more permanent work in the informal sector.

The Women’s Health Study of Accra thus presents important vistas for our interests. It has so far been developed with a bias toward inward-looking intensive interrogation of its information. There is some evidence that its planners intend more macro adaptations of its information as well. In the plan for analysis, there has been provision for a group on “Political and Legal Analyses” as well as “Policy Issues” (Hill and Douptcheva 2010) but these do not seem to have been explicitly canvassed yet. There is obvious scope, perhaps need, for third party interrogation of this rich information source, and there is every indication that the owners are agreeable. As the World Bank consistently argued in its major piece on Reproductive Health (White 2006), the Reproductive Health Community would need to be very strategic if it is to make itself more central to macro concerns of development, including poverty concerns. It may need lessons from the nutrition and development community, especially in repeated third party analyses, on how to claim a more central location for surprisingly Reproductive Health concerns are not well tracked even on to the food security dynamic (Dodoo and Ezeh 1999).

7.0 CONCLUSION
Our review shows that although there are not many studies in the Ghanaian context that explore the relationship between Sexual and Reproductive Health on the one hand and poverty on the other, including when factored through the prism of gender, there are many important discrete studies which cover some of the needed issues but have much more particular interests. The existing literature can be built on and extended from within to properly interrogate our wider range of issues. The construction of the new research project on Reproductive and Overall Health Outcomes and Their Economic Consequences for Households in Accra, Ghana out of the Women's Health Study of Accra, in its complex system of sub units and its own challenges for maintaining appropriate focus on a grand, cross-cutting issue like poverty, points the way to how we may proceed in doing this.
8.0 REFERENCES


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