Graduate School of Development Studies

Challenging Unequal Gender-Based Power Relations
in Sexual and Reproductive Health: A Case Study of
SEND Ghana's Eastern Corridor Livelihood Security
Promotion Program (ECLSPP)

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Dedication

This research paper is dedicated to the memory of my late dear mother Ms. Francisca Anne Abaaza Avatim for her untiring efforts at nurturing my two sisters and me.

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AGI	The Alan Guttmacher Institute
AIDS	Acquired Immune Deficiency Syndrome
CSOs	Civil Society Organisations
ECLSPP	Eastern Corridor Livelihood Security Promotion Programme
GDHS	Ghana Demographic and Health Survey
GELAP	Grassroots Economic Literacy and Advocacy Programme
GPRS	Ghana Poverty Reduction Strategy
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
ICPD-POA	International Conference on Population and Development- Programme of Action
MDGs	Millennium Development Goals
NGOs	Non-Governmental Organisations
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women

Abstract

There has been a growing recognition for the need to address issues of unequal gender-based power relations in sexual and reproductive health at the research, policy and programming levels. This is because sexuality and gender are key issues that determine demographic and reproductive health behaviours in all societies, contributing to poor health outcomes of both women and men and aggravating the reproductive health lives and well-being of women. As such, the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing recommended that sexual and reproductive health programs and policies be designed to empower women to manage their sexuality safely and effectively and involve men to play positive, proactive and responsible roles in promoting their health and that of their families.

Through a case study of SEND Ghana's Eastern Corridor Livelihood Security Program, this research paper explores how Non-Governmental Organisations' (NGOs) programs work to empower women and involve men to promote gender equity in sexual and reproductive health. This study was undertaken by analysing SEND Ghana program documents and in-depth field interviews held with staff members, program beneficiaries and community members in the organisation's program area. Analysis using the men's involvement approach shows that programs that actively involve men enhance their ability to overcome socio-cultural factors which reinforce dominant notions of masculinity. This improves communication between partners and men's support with regards to decisions on women's sexuality and reproductive health. Using the women's empowerment framework, it was realised that empowering women has the ability to increase their confidence level to discuss issues of sex with their partners and to independently make decisions pertaining to their sexual and reproductive health rights and well-being. However, it was noticed that men felt alienated and threatened as they were left out in the program despite the changes in women's well-being.

This paper therefore argues that a women's empowerment approach needs to be reinforced by involving men, since the active involvement of men will result in the attainment of the best possible sexual and reproductive health outcomes for both women and men. It also argues that since empowerment can result in an increase in the demand for sexual and reproductive health services, there is the need to cater for the provision of these services to meet the potential demand. Further, research is recommended to understand how other institutions like government and service providers are addressing unequal gender-based power relations in sexual and reproductive health.

Relevance to Development Studies

Widespread gender disparities, particularly male dominance in gender roles, have significantly shaped men and women's sexuality, reproductive preferences, and health practices. This has negatively affected women's sexuality and reproductive health rights and well-being and the achievement of demographic goals of many developing countries. Thus, a study of how one non-governmental organisation works to challenge unequal gender-based power relations in sexual and reproductive health is relevant to deepen our knowledge and understanding, and to share lessons on how best this can be done to contribute to development efforts.

Keywords

Chapter 1   Introduction

1.1   Background

The 1994 Cairo International Conference on Population and Development (ICPD) Program of Action (POA) was identified as a landmark consensus document by population experts and women's health and rights advocates with regards to the formulation of policies and programs to address issues of reproductive health and population (Dixon-Mueller and Germain, 2000). The POA identified that the traditional demographic approach to population and family planning did not take into account issues of unequal gender power relationships and the social environments within which sex and child bearing decisions were made (ibid:71). According to Blanc (2001:190), gender-based power in sexual relationships is often unequal, with women having less power with 'these imbalances operat(ing) in the context of a nearly universal sexual double standard that gives men greater sexual freedom and rights of sexual self-determination than women'. Gender-based power relations within sexual relations manifest and interact in gender-based violence, women's economic dependence on men, traditional roles of men and women, fertility preferences, social construction of masculinity and its association with power and risk taking, and cultural practices which restrict women's mobility (ibid).

Blanc (2001) and Greene (2000) note that unequal gender-based power relations, particularly male dominance in sexual relationships, often results in negative health consequences for both women and men and aggravates the sexual and reproductive health lives of women. This situation hinders communication between partners about making decisions with regards to sexual relations and reproductive health, prevents women from accessing reproductive health services, interferes with the attainment of sexual health and pleasure among men and women, and increases women's vulnerability to unwanted pregnancies and contracting HIV infections and other sexually transmitted infections (STIs) (Speizer, et al, 2005:131). When couples disagree about the desirability of pregnancy and the use of contraceptives within situations where male authority is predominant 'men's opinions about these issues may overrule women's, even though the women often must implement the decisions made on these matters' (ibid).

The ICPD-POA recognized that issues of sexuality and gender 'lie at the heart of demographic and reproductive health behavior in all societies' and therefore by raising issues of gender equality, female empowerment, girl's and women's sexual and reproductive health rights, and men's responsibilities, it presents a sexual and reproductive health approach to population planning that is not guided by population targets but rather puts issues of health, empowerment and rights at the centre (Dixon-Mueller and Germain, 2000:70-71). This approach is intended to

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enable women to manage their own fertility safely and effectively by conceiving when they desire to, terminating unwanted pregnancies, and carrying wanted pregnancies to term; to have a healthy and pleasurable sexual life free of disease, violence, disability, fear, and unnecessary pain and death associated with sexuality and reproduction; and to bear and raise healthy children when and as desired (Dixon-Mueller and Germain, 2000:70-71).

Based on this, government institutions and non-governmental organizations (NGO's) have designed policies and strategies which include the empowerment of women and the involvement of men in their programs with the aim of addressing issues of gender inequality and improving women's reproductive health status and decision making. It is based on this that some empirical evidence on how organisations are implementing this idea of involving men and empowering women to promote sexual and reproductive health is needed. Thus, this study will shed light on how this works locally in meeting the sexual and reproductive health needs of women for the purpose of sharing lessons and best practices in the implementation of sexual and reproductive health programs.

1.2 Research Problem

In order to address the negative impact of unequal gender-based power relations on women's sexual and reproductive health lives, to address existing gaps in previous population and family planning policies and programs, and to achieve overall reproductive health and social development, the 1994 ICPD POA agreed on by 179 countries, including Ghana, linked 'programs to improve sexual and reproductive health with efforts to address the gendered values and norms that harm both men's and women's health and impede development' (Greene, et al, n.d:4). It specifically stressed the need for men to be responsible and participate in sexual and reproductive health and advised that:

efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancies shared control and contribution of family income, children's education, health and nutrition; and recognition and promotion of equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (UNFPA ICPD POA, 1994:4.27)

The ICPD POA has therefore become a guide for program and policy planners and government and organization researchers in the implementation of sexual and reproductive health programs. Various governments, including Ghana's, since the ICPD in 1994, have shifted focus from policies and programs aimed almost exclusively at women's fertility behavior in basic family planning programs and services to reproductive health (Greene, et al, n.d:4). Together with NGO's, various governments have, through a participatory process, developed policy documents, programs and standards for reproductive health services and adolescent reproductive health policies

(Viadro, 2000:2). Priorities in Ghana's policy, which is within the framework of the ICPD POA, are being implemented by government institutions and NGOs and include family planning, maternal and child health, and STD and HIV/AIDS treatment and prevention (ibid).

Despite the implementation of these policies and programs by government institutions and NGOs, Ghana has seen little improvement in women's reproductive health outcomes. The 2003 Ghana Democratic Health Survey (GDHS, 2003) indicates that the 'dramatic decline in fertility experienced in the eighties and nineties appears to have slowed' from 6.2 children per woman in 1988 to 5.2 in 1993, to 4.4 in 1998 and stalled currently at 4.4. These figures are currently high for the rural areas at 5.6 against the urban figure of 3.1. The northern part of Ghana, where patriarchal structures are dominant, has the highest, at 7.1 children per woman. Unplanned pregnancies rose dramatically from 9% in 1993 to 16 % in 2003. Twenty-four percent of all pregnancies were mistimed (wanted later). The proportion of unplanned births declined slightly from 42% in 1993 to 36% in 1998 and rose again to 40% in 2003. Even though there has been a decline in ideal family size among currently married women from 5.5 children in 1988 to 4.8 in 2003, there has been little change in this figure over the last ten years. It was realized in 2003 that contraceptive knowledge among women 15 to 45 years old was high (98%), but this did not translate into the use of contraceptives which was low at 25% among married women. The situation is even worse for the northern part of Ghana, which is at 12%.

These statistics clearly show the need to address issues of gender-based power inequities within sexual relations for a positive impact to be realized in women's sexual and reproductive health lives and for improved demographic outcomes. Several organizations, including NGOs, continue to be at the centre of complementing the efforts of the government of Ghana to address issues of gender inequality and the provision of reproductive health programs and services within the framework of the ICPD. This study is therefore focused on analysing and gaining insights into how these illusive gender-based power relationships in sexual and reproductive health are attempting to be changed at the local level by change agents. I am however not interested in assessing the effectiveness of program interventions but rather interested in seeing how programs work to unpack that which looks good on paper with what actually works on the ground. This will provide information on the blind spots of interventions, what works well and what can be done in the future by change agents. This will be done through a case study of SEND Ghana[1], a leading

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[1] SEND Ghana is the name of a West African based Non-Governmental Organisation that works to promote livelihood security and equality of men and women through participatory development and public policy advocacy. Its other two branches are in Sierra Leone and Liberia. Its rural north-eastern corridor program is operational in six (6) communities in four districts (East Gonja, Nanumba North, Kpandai and Kete Krachi) in the Eastern Corridor of Ghana. These communities are Salaga, Chamba, Bimbilla, Kpandai, Banda and Kete.

NGO in Ghana which works to empower communities in the Eastern Corridor of Ghana to improve its citizen's livelihood security situation.

1.3 Research Objectives/Questions

1.3.1 Research Objective

The objective of this study is to conceptualize and analyze how NGO programs work to promote gender equity in sexual and reproductive health, using a case study of SEND Ghana's Eastern Corridor Livelihood Security Promotion Program (ECLSPP) intervention areas.

To achieve this broad objective, the study investigated and found answers to the following questions;

1.3.2 Main Research Question

How is SEND Ghana's program strategy operationalized to challenge unequal gender-based power relations in women's sexual and reproductive health in the Eastern Corridor of Ghana?

1.3.3. Sub-Research Questions

1. How does SEND Ghana conceptualize and respond to factors that determine men's role in sexual and reproductive health?
2. How is SEND Ghana's program strategy viewed by community members in its effort to promote gender equity and women's sexual and reproductive health?
3. What are the challenges and lessons of SEND Ghana's ECLSPP in addressing unequal gender relations in women's sexual and reproductive health?

1.4 Relevance and Justification for the Study

Widespread patterns of male power and dominance in gender roles, which have been reinforced by socio-cultural beliefs and practices, have significantly shaped men and women's sexuality, reproductive preferences and health practices (Greene, et al, n.d:5-6). This situation has had significant negative implications on women's sexuality and reproductive health and affected the achievement of demographic goals of many developing countries. Green, et al (n.d) quoting from an interim report of the Millennium Project, noted that the

third Millennium Development Goal (MDGs), that seeks to promote gender equality and empowering women 'cannot be achieved without the guarantee of sexual and reproductive health and rights of girls and women'.

This study, which takes SEND Ghana's ECLSPP as a case, seeks to review and analyse how NGO programs are operationalized locally to promote gender equity in sexual and reproductive health. Information and lessons generated from this study is expected to inform and guide the work of policy formulators, implementers and also contribute to the ongoing discussions on how to address gender concerns in sexual and reproductive health programming and implementation.

1.5   Research Methodology and Limitation

To find answers to the research questions, both secondary and primary data was used. The secondary data involved a desktop study of a number of relevant documents including the ICPD POA, academic journals, books, the 2003 GDHS and SEND Ghana policy and program documents such as assessment reports, annual and evaluation reports, and publications. The primary data was collected through recorded in-depth field interviews in July and August 2009. The primary data was then transcribed and analysed.

1.5.1 Selection of SEND Ghana as Case Study

This research purposely selected as a case the operations of SEND Ghana's Eastern Corridor Livelihood Security Promotion Program (ECLSPP) because it provided me with easy access to study in-depth its explicit program aimed at addressing the contentious issues around gender inequality and sexual and reproductive health to draw lessons for future programming. It is worthy of note that SEND Ghana does not provide sexual and reproductive health services but only creates the enabling environment and as such the study missed out on this aspect for which more in-depth studies would be required.

SEND Ghana is a national advocacy and community-based NGO based in Ghana. Since its inception in 1998, its mission has been to promote good governance and gender equality between women and men and to improve the economic livelihood situation of the disadvantaged. It has integrated gender mainstreaming into its programs, management policies, and organisational systems. The organisation's ECLSPP, a community-based livelihood empowerment program, adopts a holistic approach to development, and contends that gender inequality alongside high fertility levels and unsafe sexual and reproductive health behaviours are obstacles to community development. As such, sexual and reproductive health and HIV/AIDS education and gender promotion have been core components and integrated into the various projects of its ECLSPP. This provides a case to analyse how the organisation conceptualises and responds to factors that are barriers to achieving sexual and reproductive health.

SEND Ghana's ECLSPP has worked closely and in partnership with district assemblies and communities to improve the livelihood insecurity

situation and to empower communities in the Eastern Corridor of Northern Ghana. It has played a catalytic role in the delivery of programs to nearly 8,000 people, the majority of who are women, in the areas of food security, agriculture market information and access, micro finance and credit union development, peace building, human rights and gender education, sexual and reproductive health, HIV and AIDS education, and development of small scale businesses[2]. Considering that SEND Ghana works with a large number of people, this is relevant for my study to gauge the views of beneficiaries and community members on the organisation's interventions.

Lastly, SEND Ghana has consistently worked in the Eastern Corridor since 2000 to improve the livelihood security situation of its people. This area remains one of the poorest in Ghana with dominant patriarchal structures and socio-cultural norms disadvantaging women with regards to sexual relations and reproductive health. Also common in the area is the situation of forced marriages among some tribes, younger women marrying older men, high levels of illiteracy especially among women and inadequate information on and access to sexual and reproductive health services. This situation has 'worked against the promotion of safe sexual and reproductive health practices' as women have limited autonomy and control over their sexual and reproductive health rights and thus find it difficult to 'negotiate for safer sex with their partners' (SEND Ghana, 2007:8). Relevant for my study is to understand the challenges and lessons SEND Ghana has learned from working in such an environment to address unequal gender relations in sexual and reproductive health.

1.5.2 Sampling Procedures

Three different categories of respondents were targeted for field interviews. These included SEND Ghana staff, SEND Ghana program beneficiaries, and community members within SEND Ghana's ECLSPP operational communities. Purposive sampling was used to select four key staff of SEND Ghana. This was made up of two staff at management level and two staff at the program implementation level who work directly with program beneficiaries. This method of sampling was used because it enabled me to select key informants within the organisation who were knowledgeable about SEND Ghana's program intervention in the eastern corridor of Ghana and so could provide the relevant information related to the research study. The two management staff members were the Country Director and the Program Officer in charge of the ECLSPP. They have been with the organisation since its inception eleven years ago. The two other staff members have worked directly with the program beneficiaries for five years. They are a Project Officer and a Community Information Officer.

Kpandai, one of SEND Ghana's six operational communities in the Eastern Corridor of Ghana was purposively selected, not only because of its diverse nature in terms of ethnic groupings and religion, but also because it

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[2] SEND Ghana website: http://www.sendwestafrica.org. Accessed on 31/10/2009

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was among the first communities SEND Ghana started operating in. It has hosted all of the organisation's interventions since SEND Ghana's inception in the Eastern Corridor in 2000. Respondents from Kpandai were therefore expected to be informed on the programs of SEND Ghana and could share their views on its operations. Primary information gathered from Kpandai was thus used as representative of the views of the other communities and to draw conclusions on SEND Ghana interventions with regards to the research topic. The choice of Kpandai was also convenient for me as it was easily accessible and ensured that I collected my research data within the limited time I had for the study. Kpandai therefore served as the community to gather the views of community members on the operations of SEND Ghana's ECLSPP.

A total of ten people from within and around Kpandai were selected based on purposive sampling. This was made up of six project beneficiaries and four community opinion leaders. The six project beneficiaries were randomly selected from a list provided by SEND Ghana staff on beneficiaries who have been involved with the organisation for five or more years. This was to ensure that beneficiaries of the organisation's programs could have enough experience to share on how they view SEND Ghana's program with regards to the research topic. The four community opinion leaders were also selected purposively based on their role in the development process of the community with the aim of getting their opinions and thoughts on how they view SEND Ghana's program interventions with regards to promoting gender equity in sexual and reproductive health. The purpose of selecting community members was also to reduce the possibility of bias from information gathered from SEND Ghana staff and project beneficiaries. These community members included a Chief, a teacher, a district assembly member and a youth leader. To ensure there was a gender balance, three women and three men were selected among the project beneficiaries, while two women and two men were selected from the community opinion leaders. The total sample size for the research was fourteen. This approach to sampling the respondents was used because it was considered appropriate as it fit with the time at my disposal for field work. As well, it ensured that the right and relevant people needed for the research were contacted.

1.5.3 Data Collection Methods

The study applied the in-depth interview method to gather the necessary information from the various respondents selected. This was done with the aid of an open-ended interview guide. Fact-to-face interviews were done with SEND Ghana staff, project beneficiaries and community opinion leaders to explore issues such as SEND Ghana's conceptualisation and responses to factors that determine men's role in sexual and reproductive health, and the difficulties and lessons learned in challenging unequal gender relations in sexual and reproductive health. This method ensured that project beneficiaries and community opinion leaders were able to share their experiences, views and opinions on the organisation's interventions and in particular, its efforts in promoting gender equity in sexual relations and reproductive health.

Three different sets of in-depth interview guides were developed to specifically target the three different categories of respondents. This was based on the fact that different forms of information were elicited from respondents. As part of the process, I recorded the interviews with the permission of the respondents. This was done to ensure that I didn't lose vital information that I would not have written down in the course of the interview, particularly as most of the interviews were conducted in the local languages of the area.

1.5.4 Practical Limitations

This research study is limited in scope as it is focused on one organisation and does not investigate the effectiveness and impact of SEND Ghana's ECLSPP. It is rather looking at how the organisation's program works locally to challenge unequal gender-based power relations in sexual and reproductive health decisions. Lessons learned from the findings should be taken as pointers to how organisations can work to challenge imbalances in gender relations in sexual and reproductive health.

Also, I initially thought that most of the respondents for the interviews would be from within the Kpandai Township. It was however realised that some of the respondents who were randomly picked from the list provided by SEND Ghana came from surrounding villages of Kpandai. A motorbike was therefore used at an extra cost to arrange for interview time and to conduct interview sessions. Interviews were also conducted at night with torchlight as this was the convenient time for the respondents. The reason was that the months of July and August were the peak period for farming activities and conducting interviews during the daytime was not suitable for the respondents.

It was also difficult to fix an appointment with the Country Director of SEND Ghana for an interview as he had a very busy schedule within the period of my field research. This was a key informant I needed to interview and this made me very anxious. My anxiety was over when I finally had a meeting arranged for my interview with him the night before I was scheduled to travel back to the Netherlands.

1.6   Organisation of the Study

This research paper has been organised into six chapters. Chapter one has provided a systematic background to the research study, raises the research questions and discusses how the study was undertaken.

Chapter two discusses the framework to conceptualise and analyse how an NGO can challenge unequal gender-based power relations in sexual and reproductive health.

Chapter three examines the context within which SEND Ghana's ECLSPP works to challenge unequal gender-based power relations in sexual and reproductive health.

Chapter four analyses and discusses how SEND Ghana is strategising and responding to factors that determine men's power to influence women's sexual and reproductive health.

Chapter five examines the views of project beneficiaries and community members on the interventions of SEND Ghana. This is followed by a discussion of the key challenges and lessons of the interventions faced by SEND Ghana.

Chapter six concludes the study by presenting a summary of the key findings upon which lessons are drawn.

Chapter 2   Framework to Conceptualise and Analyse how SEND Ghana is Challenging Unequal Gender-Based Power Relations in Sexual and Reproductive Health

2.1   Introduction

This chapter presents a review of literature of the key concepts used in the study and discusses the framework applied in the research to analyse how SEND Ghana is challenging unequal gender-based power relations in sexual and reproductive health. The focus of the study is to see how SEND Ghana's program works locally to address unequal gender-based power relations in sexual and reproductive health.

2.2   Unequal Gender Power in the Realm of Sexuality and Reproduction

Gender-based power affects both "power to" and "power over" in the whole domain of life, made up of different relations including gender relations. "Power to" includes legal and informal rights and a person's ability to access resources and pursue knowledge and personal goals. It 'cuts across most domains of human functioning, including familial, cultural, and institutional domains' (Kishor & Gupta, 2009:5). Women with this form of power would have the capability to act (Blanc, 2001:189). "Power over" on the other hand refers to a person's 'control over societal and household resources and decisions, cultural and religious ideology, and one's own and others' bodies' (Kishor & Gupta: 2009:5). This form of power can enhance a woman's capability to assert herself with regards to her wishes and goals irrespective of the obstacles or opposition she might face from another person (Blanc, 2001:189).

Unequal gender-based power in sexual relations is therefore referred to as 'the relative ability of one partner to act independently, to dominate decision-making, to engage in behavior against the other partner's wishes, or control a partner's actions' (ibid). Blanc (ibid) further notes that this power is about the comparative influence that one partner has over the other which is important in decision-making and that gender-based power 'derives from the social meaning given to biological differences between men and women'. It is however important to note that men tend to have greater power than women in sexual relationships, and, in some domains, even have power over women, particularly in a context where men have 'greater sexual freedom and rights of sexual determination than women enjoy' (Blanc, 2001 and Kishor & Gupta: 2009:5).

The economic and political status of men and women determine and reinforce these power imbalances in sexual relationships, which result in the

power of men to determine women's sexual and reproductive health outcomes. This influence of men's power on women's reproductive health can have effects that are direct and indirect, as well as biological and social (Dudgeon and Inhorn, 2004:1380). Unequal power relations therefore have several consequences on women's sexual and reproductive health lives. These consequences are evident in gender-based violence, reproductive health decision-making with regards to fertility, contraceptive use, use of reproductive health services, sexual health and pleasure, and vulnerability to sexually transmitted infections including HIV and AIDS.

These unequal gender-based power relations in which women are often the less privileged and at the receiving end of men's decisions in sexual and reproductive health matters is often reinforced by societal expectations of who a man is and how he should behave. These masculine characters bestowed on men are often formed over long periods of life, within complex social influences, with the influences of fathers, mothers, relatives, friends, sexual partners and workmates deeply involved in the process (Connell, 2007).

This conceptualisation therefore served as a guide in investigating and analyzing how SEND Ghana's ECLSPP conceptualises and intends to deal with factors that influence unequal gender-based power in sexual relations and reproductive health.

2.3   Hegemonic Masculinity

Masculinity refers to the culture that determines the socially constructed roles and identities of men that shape and endorse male behaviour. This takes different forms and varies from one culture to another (Connell, 2007 and Morrell, 1998:607). These masculinities are characterised by and stress male norms such as courage, aggressiveness, adventure, autonomy, competitiveness, dominance, strength, control, and toughness in the mind and body (Donald, 1993:644 and UNIFEM, n.d). These norms are formed over long periods of life through a combination of biological, cultural and social influences which shape men's power and influence gender inequalities in society (UNIFEM, Ibid).

According to Connell (2007), gender structures that involve 'relations between women and men, also involve relations among groups of men (and to a more limited extent among women) in the form of linked constructions of masculinity'. These links involve hierarchy and exclusion with one form of masculinities more socially dominant and others marginalised (ibid). This idea of hegemonic masculinity according to Morrell (1998:608) not only oppresses and subordinates women but also marginalises other masculinities such that the 'values expressed by these other masculinities are not those that have currency or legitimacy' but rather presents a new form of masculinity that shows 'how men should behave and putative "real men" do behave, as a cultural ideal'. This situation therefore bestows 'power and privilege on men who espouse it and claim it as their own' (ibid) and thus 'reflects and shapes men's social relationships with women and other men; it represents power and authority' (Courtenay, 2000:1388). According to Donaldson (1993:645), the central element of hegemonic masculinity is that 'women exist as potential sexual objectives for men while men are negated as sexual objects for men' and

women are seen as providing 'heterosexual men with sexual validation, and men compete with each other for this'. It is important to note that hegemonic masculinity does not necessarily make men nasty to women and that women can feel oppressed by non-hegemonic masculinities and can even 'find some expressions of hegemonic pattern more familiar and manageable'(ibid).

This power, authority, aggression and dominance associated with masculine behaviour have subordinated women and impeded their ability to take decisions related to their sexuality and reproductive health. The traditional belief that men should be risk takers, have frequent sexual intercourse with more than one partner to show their manhood, and to have power over women, have impeded women's ability to negotiate with their partners.

Challenging to change dominant notions of masculinity and commonly held attitudes, beliefs and behaviours does not just require simply persuading gender equal practices among men and boys. This is because the collective reality within the society which is influenced by the 'the institutional setting, or the peer group culture, pushes in the other direction' men who are willing to change (Connell, 2007). Challenging gender inequalities requires not just empowering women to redress their powerlessness, for example through micro credit and making reproductive health services and information available to them, but also that gender sensitive programs, strategies and policies aimed at redressing women's powerlessness needs to involve men (Chopra, et al, 2000:1607). The need for involving men requires a 'better understanding of how men view themselves, in relation with women and in relation with other men' as this 'makes men more conscious of gender as something that affects their own lives as well as those of women' (Chopra, et al, 2000:1607 and UNIFEM, n.d). This understanding provides a good step towards challenging gender inequalities and improving women's power in sexual and reproductive health decisions.

2.4   Women's Empowerment Approach

Challenging gender inequalities through the empowerment of women has been recognised as essential for the socio-economic development and health of nations (Kishor & Gupta: 2009:4). Women's empowerment and gender equality within one goal in the MDGs explicitly recognises that these two concepts are two sides of the same coin in that 'progress toward gender equality requires women's empowerment and women's empowerment requires increases in gender equality' (ibid). This therefore calls for programs and strategies aimed at addressing gender inequality in sexual and reproductive health to include empowerment of women.

Empowerment is the 'process by which the powerless gain greater control over the circumstances of their lives' and includes both resources (physical, human, intellectual, financial) and ideology (beliefs, values, and attitudes) (Sen and Batliwala, 2000:12). Chapter four of the 1994 ICPD POA states that unequal 'power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public' and notes that women's empowerment and autonomy together with an improvement in their political, social, economic and health status is not only an important end in itself but also needed to achieve sustainable development and

to address, women's sexual and reproductive health realities. The chapter continues by saying that policy and program actions by both governments and other organizations are needed to 'improve women's access to secure livelihoods and economic resources, alleviate their extreme responsibilities with regard to housework, remove legal impediments to their participation in public life, and raise social awareness through effective programs of education and mass communication' (UNFPA, 1994). This according to the ICPD POA would enhance women's decision-making abilities, including decisions regarding their sexuality and reproductive health.

Genuine empowerment should be seen by policy makers and change agents as both something supported from outside (extrinsic control) and something which is more about growing intrinsic capability (Sen and Batliwala, 2000:12-35). It should not be something bestowed or done by a change agent but rather claimed by those to be empowered and that women, who are mostly the disempowered need to do it themselves (Mosedale, 2005:244). There is often the risk in the empowerment process for change agents to emphasize the provision and access to external resources to the neglect of methods that would create the space for women to build their intrinsic capabilities such as self-confidence and to maintain control over this (Sen and Batliwala, 2000).

Change agents should therefore not see themselves as being capable of empowering women but should rather facilitate and catalyse the process of empowerment by creating favourable conditions and providing a supportive environment for women to empower themselves, particularly in situations where women have little control over resources (Mosedale, 2005:244 and Sen & Batliwala, 2000). The process of empowerment is rarely neutral, as 'people are empowered relative to others or, importantly, relative to themselves at previous times' and therefore involves changes in power relations that can lead to conflict. This has to be accepted and addressed (ibid). The empowerment process needs to acknowledge that the gender-based power relations present in sexual relationships, which needs transformation, enmeshes women's lives at different and interlinked levels in terms of their functioning, particularly at the household/family, and the community/village levels. How these interconnect and affect women vary in form according to the stage in each woman's life (Sen & Batliwala, 2000).

Central to the process of empowering women is the need to raise their awareness, knowledge, and capacity to be critical and able to analyze their problems, find solutions and work towards their implementation (Sen and Batliwala, 2000). Even though the strategy of empowerment of women is crucial for the transformation of gender and power relations and the enhancement of women's ability to take control over their lives, it is also crucial for such programs and strategies to involve men (Sternberg & Hubley, 2004:389-390). This is because a women's empowerment strategy 'without the involvement of men is at best a partial solution and at worst could create more conflict and result in more problems by increasing men's feelings of alienation' (ibid). When this is done, it addresses the issues of masculinities and discourages men's risk-taking behaviour. This behaviour of men, which is often defined and determined by the environments and societies within which men grow, compounds the problems of women (UNFPA, 2005). Involving men would not only ensure that they cooperate and participate in women's decision making processes without

fear of losing their masculine powers, but that they also 'play a positive and proactive role alongside women in promoting their own health and the health of their families and communities' (Sternberg , 2000:89 and Sternberg & Hubley, 2004:390).

2.5 Men's Involvement in Sexual and Reproductive Health

The 1994 Cairo ICPD POA realizing 'that men had a useful or even 'crucial' role in sexual and reproductive health promotion' (Sternberg & Hubley, 2004), particularly in their relationship with women, stressed the need for 'male responsibility and participation' in policies, strategies and programs aimed at addressing sexual and reproductive health (Greene, et al, n.d:6). The POA stressed in chapter four, section C that men have a role to play in addressing issues of gender equality because men in most societies exercise a great deal of power in every sphere of life, including personal decision-making and decisions regarding family size and for which policy and programming

> efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies……..(UNFPA, 1994:4.27).

Questions have however arisen concerning the effects of introducing programs and strategies aimed at involving men, particularly in 'areas that have traditionally been considered the preserve of women, such as childcare, pregnancy and fertility control' (Sternberg & Hubley, 2004). This is particularly so when widespread gender-based power inequalities within gender roles are 'strongly reinforced in cultural beliefs and practices, and that social construction of masculinity and femininity profoundly shapes sexuality, reproductive preferences, and health practices' with implications on women and men's reproductive lives (Greene, et al, n.d:6). The crucial question that arises with regards to male involvement is 'about whether men's involvement actually increases men's power over their female partners or whether it will help to empower women' (Sternberg & Hubley, 2004).

Even though men's involvement in sexual and reproductive health programs and strategies have increased men's control over women's fertility and may even worsen women's situations instead of empowering women so they can have more choices (Cornwall, 1998), men have 'responded positively to being involved in interventions.' They 'do actually want to be involved' with many responding positively to measures to involve them and they 'do in fact care about the welfare of their families' and show interest, approval and care for family planning (Sternberg & Hubley, 2004:394). These interventions have been able to 'reach men and fully engaged them in their programs' (ibid).

Therefore, involving men would not only improve their knowledge on sexual and reproductive health issues, but would also make them more likely to provide support to their partners with regards to making decisions on contraception and family planning which are more important to avoid unwanted pregnancies and the practice of safe sex (Wegner, et al, 1998:38).

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Men would be empowered to communicate and discuss sexual and reproductive health issues with their partners which 'will help them to be more sensitive to women's needs and therefore more supportive of participating in efforts of enhancing women's status', particularly during pregnancy and in making better decisions in terms of seeking heath care (UNFPA, 1998:15 and Wegner, et al, 1998:38). This would benefit both men and women and enable them to lead healthy and fulfilling lives as the health status and behaviour of men directly affects the reproductive health needs and concerns of women (The AGI, 2003:7). In effect, involving men 'increases their awareness, acceptance and support to their partners' needs, choices and rights' with regards to their sexual and reproductive health needs (UNFPA, 1998:15).

Strategies and interventions aimed at involving men however need to ensure that programs do not focus attention only on men and meeting only their sexual and reproductive health needs, but that:

> Given that the aim of the programmes is to improve the reproductive health of both women and men, better programmes have to develop concrete strategies to understand and incorporate the male perspective and male needs in the same way as attention is given to women's perspectives and needs. In order to avoid a shift in the locus of control, programmes should aim to incorporate adequate male involvement, not only more involvement. Thus programmes should be based on the understanding of gender dynamics, on how decisions are made and implemented, on the changing needs of both genders and their interaction. Much more needs to be known about the relations between men and women in the particular contexts where programmes will be set up in order to make an effective change (UNFPA, 1998:2).

Involving men as partners in sexual and reproductive health service delivery, means that there is the recognition that men have an influence on reproductive health options and decisions of women and that there is the need to encourage men and women to deal jointly with issues of contraception, emergency plans for labour and delivery, voluntary counselling and testing and post abortion counselling (UNFPA, 2005). This approach would go a long way to engage men in dealing with other issues such as gender-based violence and female genital cutting which directly or indirectly have implications on women's sexual and reproductive health.

Fears however have arisen among some critics that involving men to 'view sexual and reproductive health as important and not just women's responsibility will be difficult' (Sternberg and Hubley, 2004). They contend that 'resources earmarked for projects targeting women will be reallocated to projects that target men' (ibid). Others also see the promotion of men's involvement as threatening, as 'many women are suspicious of health planners' aim to increase men's participation in reproductive and sexual health, viewing this as part of a campaign which aims to win back power for men,' bearing in mind the sad experiences of the sexual revolution in the 1960s which did little to change women's subordinate position in sexual relations (Sternberg, 2000:97). In order to avoid male involvement affecting the quality of women's reproductive health services, creating competition for scarce resources and increasing men's control over women, programs should be

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carefully designed and integrated into existing health care structures and empowerment programs in such a way that they benefit both of the sexes (Wegner et al, 1998:38).

Although various approaches to male involvement have evolved over the years to address the socio-cultural norms and practices that perpetuate gender inequality, these have mainly been rhetorical. Most programs have mainly been women-focused contraceptive delivery with male involvement being centred on 'increasing contraceptive prevalence among both men and women' (Greene, et al, n.d). These do not take into account and address men's control over their own and women's sexuality and reproduction. In recent times, however, some interventions have positively engaged men to support, participate and cooperate in changing and promoting gender equity for the improvement of men and women's health (Sternberg, 2000:89). Such programs have offered men the 'opportunity to examine and question the gender norms that harm their health and that of their sexual partner' and therefore 'seek to move toward gender equity' by shaping sexual and reproductive health issues (Greene, et al, n.d: 9).

In investigating SEND Ghana's ECLSPP, this framework assisted in collecting and analysing information on the extent to which the program involves men in addressing gender equity in reproductive health.

2.6 Analytical Framework

This research adapted Blanc's (2001:190) organising framework for understanding the relationship between unequal gender-based power in sexual relationships and reproductive health to conceptualise and analyse how SEND Ghana acts as a change agent to promote gender equity, and address the influence of men's power to determine women's sexual and reproductive health outcomes in the Eastern Corridor of Ghana. Several factors play and interact at the individual, relationship, family/household, demographic, and community levels, to influence the balance of power in sexual relationships and the extent to which individuals and partners have the power to make decisions concerning their fertility, and access and use reproductive health services.

At the individual level, a person's economic status or educational background can influence the balance of power in sexual relationships and the ability to negotiate and make decisions. Also partnership type and communication between partners at the relationship level can impact on power relations and one's ability to make decisions. The socio-cultural norms and traditions of a community have an influence on power relations between partners and the ability of an individual to make fertility decisions and to access and use reproductive health services. This means analysing SEND Ghana's program to understand how it takes into account the influence of the effects of power outlined above to promote gender equity in sexual and reproductive health.

Gender-based power, according to Blanc, can directly affect a partners' capability to get information, to decide and take action relevant for protection and sexual and reproductive health. This is obvious in women's inability to negotiate for safer sex with their partners. Gender-based power relations, which have a causal relationship with violence in sexual relationships, have an

influence on reproductive health. Blanc's framework is useful to study SEND Ghana because it 'allows for the disempowering effect of violence on the balance of power within relationships' and that reproductive health services can have mediating effects on outcomes if they address unequal gender-based power relations. On the other hand, services that do not address power relations can contribute to, and worsen the capabilities of women to promote their health. The outcomes within reproductive health domains can also influence the balance of gender-based power in sexual relations.

It is assumed that shifting this imbalance of gender-based power and promoting gender equity in sexual and reproductive health decisions requires change agents to empower the powerless, in this case women, to 'gain greater control over the circumstances of their lives' (Sen and Batliwala, 2000). This empowerment process should not be one that only provides women access to resources but should be capable of building their self-confidence and assertiveness, and for them to maintain control over this. The empowerment process should not only be a package meant to shift the balance of power to women. It is much more complex, and men and women should be involved in the process in such a way that they are both empowered to have equal gender relations. The process of empowerment, which is rarely neutral (ibid), means that men may lose some of their privileges in society but they would also stand to gain in a more just social and sexual relationship. My perspective on women's rights in this whole setting is not one where men are absent or giving women power at the cost of men, even though this is often the most commonly held view. This raises questions about men and notions of masculinity for research.

This analytical framework is used to conceptualise and analyse how SEND Ghana acts to change the configuration that exists in the Eastern Corridor to promote gender equity in sexual and reproductive health.

Figure 1: An adapted framework to understand the influence of men's role in sexual and reproductive health and the role of change agents in promoting men's involvement and women's empowerment
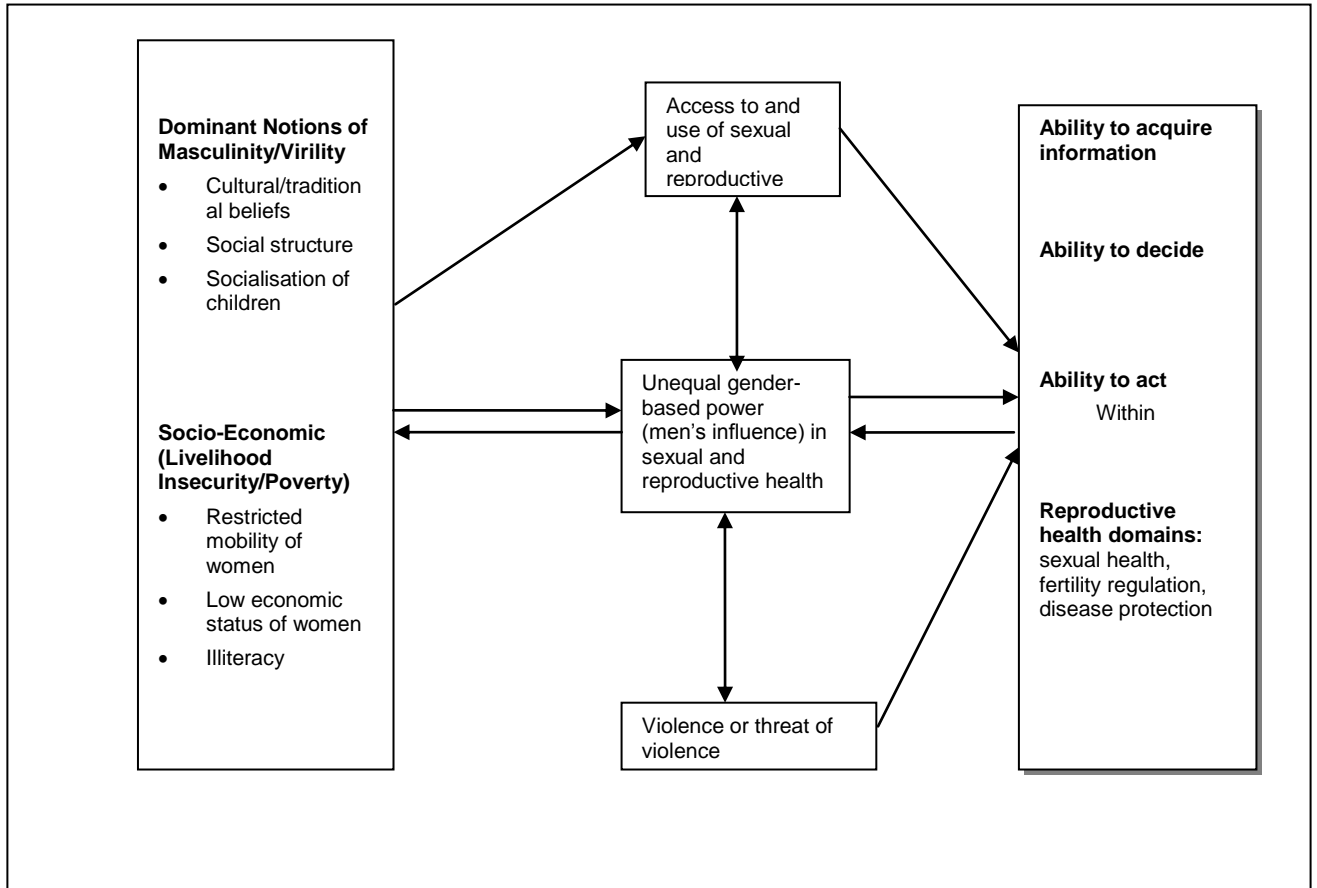
Source: Adapted from Ann K. Blanc (2001:191)

2.7 Conclusion

The concepts and framework discussed above are useful to address my research questions in this study. While the concepts of gender-based power relations and hegemonic masculinity enables me to analyse SEND Ghana's conceptualisation of factors that determine men's role in sexual and reproductive health, the concepts of women's empowerment and male involvement provides a basis to analyse the response strategy and the challenges and lessons it has learned. It also enables me to analyse the views of community members on this strategy.

Chapter 3 Contextualising SEND Ghana's Eastern Corridor Livelihood Security Promotion Program (ECLSPP)

3.1 Introduction

This chapter discusses the situational context within which SEND Ghana's ECLSPP operates and a brief background of how it features as a change agent within the context of promoting gender equity in sexual and reproductive health. This chapter lays a foundation to understanding how SEND Ghana conceptualises and responds to factors that influence unequal gender-based power relations in sexual and reproductive health for analyses in subsequent chapters.

3.2 The Context of the Eastern Corridor of Northern Ghana

The Eastern Corridor of Ghana, in terms of SEND Ghana's operations, is the belt of land that is situated to the east of the Northern Region of Ghana and stretches from the Krachi West District in the south to the Nanumba North District in the north. Five districts are located within this stretch of land and include the Krachi West District in the Volta Region, and Kpandai, Nanumba North, Nanumba South and East Gonja Districts in the Northern Region. These Districts, with a combined population of about 500,000 is ethnically diverse and home to the Krachi, Nchumbru, Nawuri, Gonja, Konkomba, Basari, Kotokoli, Nanumba, and other minor tribes (2000 Ghana Population Census).

The Eastern Corridor of northern Ghana is among the least developed and most conflict ridden areas in the country. Agriculture is the dominant economic activity, employing over 70% of the working population. Crops cultivated in this area include yams, rice, maize, cassava, groundnuts, sorghum, vegetables, millet and soya beans. Petty trading, small-scale enterprise activities, and artisanal work (tailoring, weaving, masonry and carpentry) are some of the other economic activities undertaken in the area. High rates of illiteracy, low levels of educational attainment and the lack of opportunities for skills upgrading has resulted in high levels of unemployment. The illiteracy rate of 78.7% in the Northern Region is among the highest in the country. The level is higher for females than males in the region, with the situation being worse in the rural areas (2000 Ghana Population Census).

The Eastern Corridor of Ghana also experiences widespread livelihood insecurity. The Northern Region within which the Eastern Corridor is situated is among the poorest regions in Ghana. According to the Ghana Poverty Reduction Strategy, poverty levels in Ghana declined from 52% in 1992 to 40% in 1998, but worsened in the Northern Region, increasing from 63% to 69% in the same period. Seven out of ten people were classified as poor (GPRS I, 2003). Table 1 is the estimated population and percentage of the poor in three districts of the Eastern Corridor in 1998.

Table 1: Selected District Population and Percentage of Poor

District	Population	% Classified as Poor
Kete-Krachi West	159,925	53
East Gonja	174,500	85
Nanumba North	144,378	88

Source: SEND Ghana Publication, 2007

This worsening state of poverty and livelihood insecurity has its roots in the historical neglect of the area by successive national governments coupled with the fact that it lies in the savannah zone, characterized by poor soils, highly unreliable rainfall patterns, entrenched cultural and traditional practices which inhibit change, disadvantaged women and a high incidence of ethnic-based resource conflicts (SEND Ghana, 2005). This situation demonstrates the lack of basic services available, notably access to education, health care, and adequate nutrition, particularly among breastfeeding and pregnant mothers and children in the area.

3.3 Sexual and Reproductive Health Challenges

Unequal gender disparities are very widespread in the northern part of Ghana, particularly in the Eastern Corridor. Women are disadvantaged and extremely limited in terms of opportunities for self-improvement. Gender inequality has been identified as one of the factors that has contributed to the high fertility levels and unsafe reproductive health behaviours together with the widespread and growing poverty in the area. The Eastern Corridor experiences a number of sexual and reproductive health challenges. The Northern Region of Ghana experiences the highest fertility levels in the country. The total fertility rate in the region currently stands at 7.1 children per women compared to the national average of 4.4, with 13% of women pregnant, verses national average of 7.4% (GDHS, 2003). This has been attributed to the low adoption of family planning and high incidences of teenage pregnancy.

The use of contraceptives among married women in the region is the lowest in the country. It is currently 12% compared to the national average of 25%. The incidence of adolescent childbearing with its potentially negative demographic and social consequences for the Northern Region is also high (ibid). The 2003 GDHS indicates that 15.7% of teenagers are mothers, while 7.9% are pregnant with their first child. This situation is the result of young people's inadequate access to information, a precarious livelihood insecurity situation, high levels of illiteracy, entrenched cultural and traditional norms and religious beliefs and practices. The cultural norms and practices have frowned upon and prevented open discussions on sex, sexuality and reproductive health and promoted unhealthy sexual and reproductive health practices such as promiscuity, multiple sexual partners and the need for large families. This has disempowered the youth and women to determine and make their own sexual and reproductive choices and worked against interventions aimed at improving sexual and reproductive health practices and reducing fertility rates at the community level (SEND Ghana, 2007).

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Dominant patriarchal structures in the Eastern Corridor have played against and disadvantaged women when it comes to their ability to make decisions about their sexuality and reproductive health. It is generally acceptable for men to be involved in extra marital affairs and to have many wives as a way to express their manhood. It is also common for younger women to marry older men and in the process inherit the sexual history of their husbands. Most of these young women are forced into early marriages and as such, it is difficult for them to negotiate for safer sex.

Women cannot openly discuss issues of sex with their partners or take decisions with regards to their sexuality without the explicit permission of their partners. Those who do, are seen as socially inept and as such have limited control over their sexual and reproductive health rights (SEND Ghana, 2007). SEND Ghana is operating within this configuration of unequal gender-based power relationships in sexual and reproductive health in the Eastern Corridor. SEND's aim is to improve the livelihood security situation of the rural poor using a holistic, people-centred and integrated development program.

3.4   SEND Ghana: The Change Agent

SEND Ghana, a branch of a West African based NGO with its headquarters in Accra, Ghana was founded in August 1998 with a mission to 'work to promote good governance and equality for women and men'[3]. Its programs and projects cut across the development and political spectrum, with most of its resources focused on addressing the root causes of gender inequality in a holistic and people-centred manner. The organisation has also committed itself to a gender mainstreaming approach which

> concedes that gender inequality and issues of development are most positively addressed through an integrated manner, which incorporates management policies, organisational systems, and program activities. SEND recognises that this inequality exists not only among project beneficiaries but is embedded in organisational culture and practices; therefore it would be highly ineffective to restrict the promotion of gender equality solely at the program level (SEND Ghana, 2006).

SEND Ghana currently runs two programs. The first is the Grassroots Economic Literacy and Policy Advocacy Programme (GELAP), a national advocacy program comprising the Ghana HIPC Watch, Trade Education and Campaign, Ghana Civil Society Organization (CSO) Millennium Development Goals (MDGs) Monitoring Campaign and the Ghana Civil Society Aid Effectiveness Forum. The second program, which is the focus of this research, is the Eastern Corridor Livelihood Security Promotion Program. It is a community-based livelihood empowerment program in the Eastern Corridor of Ghana.

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[3] http://www.sendwestafrica.org

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3.4.1 Principles of SEND Ghana

The following principles underpin SEND Ghana's mission[4]:

- Development is a human right that provides men and women with equal opportunities to actively participate in and contribute to the political, economic and social transformation of their communities.
- Development is multi-dimensional involving economic, political and social issues, requiring integrated programming approaches to promote community-driven development initiatives, economic literacy and policy advocacy.
- Forging strong partnerships with state and non-state actors that are characterised by mutual accountability, openness and effective communication to provide an enabling environment for innovative development programming.
- Self-managed community-based organisations are catalysts for promoting sustainability of development processes and initiatives.

3.4.2 SEND Ghana in the Eastern Corridor

SEND Ghana's ECLSPP was started in 2000 with the aim to promote, through a participatory and inclusive approach, the livelihood security and equality of men and women in the resource-poor and conflict ridden Eastern Corridor of northern Ghana. The organization embarked on an integrated approach to empower poor rural women and men. The ECLSPP is being sustained by five micro projects which are;

- Food Security through Cooperation(FSP)
- Gender, Human Rights and Peace Education(GRPE)
- Rural Youth Self-Employment, Sexual Reproductive Health and HIV and AIDS Education
- Rural Commercial Women, Micro Finance and Credit Union Development, and
- Eastern Corridor Agricultural Marketing Information Centre(ECAMIC)

To specifically address the challenges and factors that promote unequal gender-based power relations, especially the influence of men's role in sexual and reproductive health, gender and sexual and reproductive health and HIV/AIDS education has been incorporated into all the micro projects. This is because SEND Ghana sees these areas cross-cutting all development issues. It believes that unequal gender-based power relationships, particularly dominant notions of masculinity, relegate women to the background and has increased the high fertility levels and promoted unsafe sexual and reproductive health behaviours, thus impeding community development initiatives. As a result, to ensure that there is effective and safe sexual and reproductive health practices

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[4] http://www.sendwestafrica.org

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among partners to achieve livelihood security, SEND Ghana works to empower women and involve men in its program activities. It is doing this by partnering with the Ghana Health Service to provide technical support and provision of sexual and reproductive health services. It does this while creating an enabling environment by challenging the factors that promote men's power to determine and control women's sexual and reproductive health outcomes.

3.5 Conclusion

The Eastern Corridor of northern Ghana is bedevilled with a number of socio-economic and cultural factors that have affected its livelihood security situation. This has affected women's ability to determine their sexual freedoms and reproductive health rights. The integrated nature of SEND Ghana's ECLSPP appears to reinforce the organisation's national policy of addressing gender inequities in sexual and reproductive health. The next chapter looks at how it is doing this on the ground.

Chapter 4 Strategising to Challenge Unequal Gender-based Power Relations in Sexual and Reproductive Health

4.1 Introduction

This chapter focuses its attention on analysing and discussing how SEND Ghana as a change agent within the Eastern Corridor of Ghana, is challenging factors it believes promotes unequal gender-based power relations, particularly the influence of men's role in sexual and reproductive health.

4.2 Determinants of Gender Inequities in Sexual and Reproductive Health: The SEND Ghana Perspective

Gender-based power inequalities in sexual and reproductive health as discussed in chapter two are manifest in situations where women have less power than men, and men having more sexual freedom and rights. The following factors have been identified by SEND Ghana as affecting women's sexual and reproductive health outcomes in the Eastern Corridor.

4.2.1 Dominant Notions of Masculinity and Virility

Cultural Beliefs

Cultural beliefs in the Eastern Corridor of Ghana detract from women's ability to negotiate sexual relations, determine the number of children they want, and the use of contraceptives including condoms. This is evident in the high fertility levels in the area. Large family sizes are a social asset and proof of a man's virility and social standing (SEND Ghana, 2007). Cultural norms accept polygyny and promote extramarital affairs for men. A man's ability to have many wives and children is proof of his manhood. These two statements from a SEND Ghana staff and a program beneficiary illustrate the situation in the Eastern Corridor.

> Having a large family size, many wives and engaging in extra marital affairs is show of power for men. Men would want to show this by the number of wives or girlfriends and children they have in the community. Men would want to have more children and so they decide when to produce them. To men the aim of marriage is to produce children to show their strength (virility). Men would resist attempts to reduce births or space births because of the fear that society and their fellow men would make fun of them. To them, it is part of their culture to produce all the children they need and nothing should stop them from deciding the number of children to be born even if it is to the detriment of the woman's health (SEND Ghana Staff).

Men in the north think having more children would raise their social status and power in society. It is hard for men to allow thier wives to use condoms. Once they marry a woman, they understand that it is her duty and she must give birth till all the babies in her womb are finished. They would not accept to use condoms to protect their wives from pregnancy as they feel people would make fun of them and say they are women. In this situation the women are often affected most because it affects their health and work. She has no say and if she attempts the man might beat her up. Most of the men act out of ignorance (Woman Program Beneficiary).

According to Heise et al (1995), this situation has been used in many cultures to justify men's dominance of the public sphere, particularly in the realm of sexuality, where male sexuality is seen as inherently predatory with men seen to be in need of frequent sex with preferably multiple sexual partners while women are essentially passive. They would therefore strive to 'prove to themselves and others that they qualify for inclusion in the esteemed category of male' virility and power by dominating women and fathering many children (ibid). Men would even control women's sexuality and childbearing capacity by preventing and not cooperating in women's use of family planning methods because of fear of losing their role as head of the family or being ridiculed by members of the community (Blanc, 2001:196).

This state of affairs from my perspective puts both men and women at an unequal risk to sexual and reproductive health related issues like STI and HIV transmission and unwanted pregnancies, among others. It also does not enable communication among partners on such matters and thus works against the promotion of safe sexual and reproductive health practices among both men and women.

Social Structure

The social structure of the Eastern Corridor is highly patriarchal and defines who heads and takes decisions in the family. Men are seen as the only ones capable to inherit family property, become chiefs and head a family unit. The head, who is a man, is seen as knowledgeable and has the capability to manage, control and make decisions on resources within the family and in the community. Society has therefore bestowed on men the role of decision makers as

it is the man who matters in the family and decisions are made by him. Whatever the woman does only compliments the man's decisions. The woman is expected to be less knowledgeable, obey orders and remain passive. This plays out strongly and whether intended or not, consciously or unconsciously relegates women to a subordinate position even if they are capabable. Men are more privileged in society and take decisions for themselves and their wives to exercise their powerful role as the head of the family. Men decide the number of children to have, when to have them and women have no right to refuse men's advance (SEND Ghana Staff).

This was corroborated by a community opinion leader who stated that

When it comes to decision making with regards to fertility and birth it is the man who does that in a relationship. This is because they say that women

can't contribute to taking decisions on matters of sex. Women have no say; it is men who decide. Women have grown to accept this and therefore rely on men to take the decisions that concern the family level and more importantly women's health, sexual health (Male Opinion Leader).

This situation from my point of view has contributed to limiting women's control over their sexuality and reproductive health rights and well-being. They have no power to decide or discuss who to marry, when to marry, the number of children they want, when to have them and most particularly when they can decide to have sex since *'when a woman feels like having sex to meet her sexual desires the man would never get close to her and would brand her as spoilt (promiscuous). But when he feels like that he would get close to her to have sex and the woman has no right to refuse'* (Woman Program Beneficiary). This according to SEND Ghana (2007:8) does not open up space for women to openly discuss and communicate issues of sex and reproductive health with their partners. Women who are seen discussing issues of sex openly with their husbands are considered socially inept, as it is a taboo area for them, thereby making it difficult for them to negotiate for safer sex with their male partners.

As Heise, et al (2002:S9) notes, women in such cultures are often afraid to discuss issues of sex and protection against pregnancy with their husbands because of the fear of being branded unfaithful or that it would be an affront to their husband's masculinity. Additionally, as Blanc (2001:194 notes, 'women are not supposed to be knowledgeable about sex, are expected to be passive in sexual matters, and may be less comfortable than men with discussing sexual matters, especially their own satisfaction'. This state of affairs in my view promotes unsafe sexual behaviours among partners because people are reluctant to discuss and address their sexual needs.

Socialisation Process

The socialisation of children has been noted as a factor that has profoundly influenced, deepened, and reinforced the gender inequalities that exist between men and women in the Eastern Corridor of Ghana. Family preferences for male children to be heirs of the family are very predominant in the area. The heir in this regard is defined as a boy. As such, families strive to have a male son to continue the family heritage and to place the family in high social standing within the community. Apart from the fact that women are under pressure to give birth to a son and to legitimise their position within the marriage and the community, the male children are also nurtured to grow and behave according to the society's expectation of how men ought to behave. As such, male and female children, as they grow, do not relate with one another and are kept apart because their roles are defined differently. This influences the lives of children as they grow and become adults. A member of SEND Ghana staff notes that,

> this is seen in many ways, even how and when the girl is supposed to be inside the house with the mother in the kitchen while the boy stays outside with the men and hold conferences in front of the house. It is when there is something to consult that they go to the women, particularly the old ladies, after a lot has been considered (SEND Ghana Staff).

This implies, that, boys are socialised to be heirs to the family and take control as decision makers while girls from birth are to be with their mothers and grow to learn their mothers' trade and be submissive. Boys learn from their fathers what the community expects of men, which includes being authoritative, taking control of decision making, risk taking and having extra-marital affairs. Female autonomy is undermined, particularly in the area of sexual and reproductive health behaviours and fertility outcomes through gendered socialisation in the community.

These gender stereotype roles that boys and girls are socialised into, according to Mensch et al (2000:7), have their roots in socially accepted conceptions of gender in which males are seen as authoritarian in their relations with women, take control of fertility decisions and also maintain a distance from their wives and children while women are expected to be submissive and conform to social norms that confine them to roles within the family. Blanc (2001:196) also notes that in societies where there is preference for sons, with a woman's position dependent on her ability to give birth to a son to continue the heritage of the family, she would go to all lengths to continue childbirth until she has many sons to ensure the survival of at least one. The situation is even worse off in polygynous settings where a 'woman's failure to produce a son can lead her husband to marry another wife or abandonment' (ibid). Women in such circumstances fear to raise and discuss such issues with men since it would be regarded as usurping their authority as heads and as decision makers in the family.

4.2.2 Socio-Economic Factors

Restricted Mobility of Women

Women's access to and use of reproductive health services in the Eastern Corridor of Ghana has been restricted due to men's control over women's mobility. This according to SEND Ghana can be traced back in history, during which slave raids and inter-ethnic conflicts called for the protection of women by men in their daily activities. Accordingly, for fear of losing their wives through capture by the enemy, *'there is no way men from ethnic groups in the area would let the woman go to the market or travel long distances to seek medical attention alone, they would have to be accompanied citing enemy territory as an excuse'* (SEND Ghana Staff). This has become part of the social system and as a way of protecting women *'men have said women can't do this, they can't go out, and they can't have their own organisation because they would be travelling out alone'* (SEND Ghana Staff). This from my perspective has given men the power to decide for women when and where they go, deny women the autonomy of taking decisions to seek medical care including reproductive health services without the explicit permission of the man.

Women have to depend on men to decide on issues that affect their sexual and reproductive health. This implies that women are at the mercy of men and seeking sexual health is at the convenience of men. The situation has been compounded in the Eastern Corridor where sexual and reproductive

health service provision by health care institutions is limited and women have to travel long distances to access them. Women's inability to travel alone and to decide when to access sexual and reproductive health services has been noted to act as a barrier to improving their health, and that women's ability to move alone promotes their health by allowing them to access health services (Cleland, Kamal & Sloggett cited in Mumtaz & Salway, 2005: 1751). In such situations where women cannot move alone, they and the health care providers would require the permission and approval of the man before seeking treatment or services are provided (Blanc, 2001:197). I therefore agree with Cleland et al (cited in Mumtaz and Salway, 2005:1751), that women's unrestricted and independent mobility improves health outcomes indirectly via increased exposure to information, the development of interpersonal skills, and greater self-confidence.

Low Economic Status of Women

Men control and make decisions with regards to family resources in the Eastern Corridor of Ghana. This is because *'headship of the family is the preserve of the man and headship also means power, control of resources which also means power and ability to take decisions for the family'* (SEND Staff). As such women have limited control over productive resources such as land, credit and improved technologies to use to enhance their economic status. Male members of the family, irrespective of their age, are landowners. Women whether they are wives, single parents, household heads or grandmothers cannot own land. They can only have access to this through a male relative or husband.

Women however contribute immensely towards the generation of family resources, particularly their participation in farm work. Despite their immense contribution, they have little say on the resources that they support to generate for the family. They therefore rely solely on the man to make decisions on their needs and therefore make them dependent on men in these communities. SEND Ghana sees this as a demonstration of the power dynamics that plays down women's role and their ability to take their own decisions, respond to their needs, and gain control over resources, including financial resources (SEND Ghana, 2006:16). This clearly has an impact on women's ability to make decisions affecting their sexuality and reproductive health and to access reproductive health services, particularly when they would have to travel to access and pay for such services.

Evidence from a study conducted by Bawah et al (1999:58) in northern Ghana shows that resource constraints have been an obstacle to women's ability to access contraceptives and that 'procuring money for the fee from one's husband can also provoke conflict'. Beegle et al (2001:143) therefore notes that a woman's access to resources is a good indicator of whether or not she would use modern reproductive health services and that 'women who own no assets are systemically less likely to use those services than are women who own some assets'. Additionally, women with few resources and no opportunities for alternative livelihood and economic survival 'are likely to fear abandonment and, therefore, will hesitate to leave a risky relationship' or even

fear to negotiate with their partner for sex or the use of condoms (Blanc, 2001:199).

High Levels of Illiteracy

Illiteracy levels are generally high in the northern part of Ghana, with the situation worse for rural women. Educational opportunities in the Eastern Corridor, whether formal or informal, favours men. The result is an extremely high illiteracy level among women in the area (SEND Ghana, 2005:6). The traditional preference to send the boy child to school rather than the girl child has been identified as a major factor that has exacerbated this situation. The girl child would be the first to be withdrawn from school when the financial condition of the parents cannot support all the children in school (SEND Ghana, 2001:13-14). Women therefore receive less education than their male counterparts.

Another factor that prevents girls from attending school is the high incidence of early marriages in the area. The majority of ethnic groups in the Eastern Corridor marry their girls out early. This situation, coupled with the 'low volume of information streaming into the communities' about family planning has resulted in 'the low adoption of family planning practices' among women in their child bearing age (SEND Ghana, 2007:9).

Castro-Martin (1995:188) corroborates this by indicating in a study that the historical neglect of women's education has resulted in high illiteracy rates among older, poor and rural women with this having an influence on fertility outcomes. She notes that 'fertility levels are seen to be substantially lower among the better educated' with the 'pattern of lowest fertility among the highly educated strata holds for all societies'. This is because 'better educated women are more likely than others to desire smaller families and hence have a stronger motivation to practice contraception' (ibid). Women's educational background therefore enhances their capabilities to engage in new patterns of behaviour, enhances their position within the family, improves their control over reproductive choices, enhances their familiarity with formal institutions and health providers, better informed about available contraceptive options and sources, effective use and lower rates of discontinuation and failure of contraceptives (Castro-Martin, 1995:189-194). Greene (2008:5) also confirms that early childbearing negatively affects a woman's ability to obtain the highest possible education and therefore 'ruptures girls' connections to mentoring adults and peers who could provide connections to useful information and institutions'. This in my opinion could include information on sources and options on contraceptives and health care providers.

4.3   Program Reponses and Interventions

It is obvious from the above discussion that there is unequal gender relation in the Eastern Corridor which has an effect on women's ability to take control of decisions regarding their sexuality and reproductive health. According to SEND Ghana its program response has always been to

encourage negotiation among married couples and sexual partners. SEND Ghana was open about this. The focus was therefore not only on women. Clearly we knew this, and that unless men are effectively on board, there was no way you could get women alone making decisions (SEND Ghana Staff).

These program responses and interventions are discussed in this section.

4.3.1 Gender Awareness Education

The gender awareness education component of SEND Ghana's Eastern Corridor program is one that was designed as a first measure to create opportunities aimed at re-orienting, reshaping and changing people's attitudes and mentalities towards being gender aware and accepting the need for change from the existing practices. One of the ways that gender awareness education is undertaken by SEND Ghana in the Eastern Corridor is through the targeting and training of community opinion leaders on gender issues and their impact on women's sexuality and reproductive health outcomes. These include youth leaders, traditional leaders and religious leaders. These categories of people, according to SEND Ghana, hold the power to support, facilitate and spread the benefits of equitable sharing of resources and to encourage balanced decision making in sexual and reproductive health.

During training sessions, the leaders, particularly the chiefs, affirm their resolve to ensure that men in their respective communities get committed to supporting women in addressing their needs. The chiefs, with the support of SEND Ghana, hold community durbars and meetings where they communicate their resolve to support change practices that affect women's sexual and reproductive health. Drama is used during durbars to convey these messages, after which the community members are engaged in an open discussion on the issues raised in the drama. The aim of these discussion sessions is to give community members the opportunity to ask questions and speak freely about the issues and come to a consensus to support the chief on the need for a change in the community. This is what a woman beneficiary of SEND Ghana's program had to say:

> Look, the fact that the chief comes out during community durbars to speak for the need for our husbands to change, support us, and listen to our needs is very good for me. It would make the men ready to change and support us. We have been suffering and the chief has become our saviour as he knows what we are suffering from. The drama that the young people act exactly tells the people what we (women) have been going through and I am happy it makes people talk about it after the program. These things about sex and the need to use condoms were initially not spoken about but this is changing (Woman Program Beneficiary).

According to Bawah et al (1999:62), the active involvement of local leaders provides the 'early opportunities for confronting the potential for gender conflict for explaining family planning within the context of traditional values'. This I think is a good start to break into and change a society where issues of gender imbalance are culturally entrenched. It is a way to get men to understand issues that affect women and to be willing and involved, and gives women the space to address their sexual and reproductive health needs.

4.3.2 Gender Model Family Approach

The Gender Model Family approach is another strategy SEND Ghana is implementing in the Eastern Corridor as a way of *'creating a culture or giving opportunity where people, men and women would be willing to confront or challenge the status quo, not confront it in a violent way but to say that we don't mind to be different'* (SEND Ghana Staff). This approach involved the identification and training of couples (husbands and wives) committed to working towards improving gender relationships within their households. These couples are expected to return home and live positive gender roles within their families by 'discussing issues of sex and sharing gender roles in their own families, while devising strategies for shared responsibilities in order to reduce the heavy workload that women have in the Eastern Corridor' (SEND Ghana, 2006:23).

A SEND Ghana staff in each of the communities makes follow-up monitoring visits to these families not only to ascertain that progress is made by these families with regards to the sharing of gender roles and domestic tasks among family members, but also to observe how relationships are being improved within the families in terms of the family commitment to openly discuss and make mutual decisions for the well-being of the family.

This approach of SEND Ghana in my opinion has the potential to enhance communication between partners and for them to make shared decisions regarding fertility, contraceptive use and accessing reproductive health services. According to Lasee & Becker (1997:18), studies have shown that 'husband and wife communication has been found to be the most significant indicator of contraceptive use'. Speizer, Whittle & Carter (2005:137) therefore conclude in their study that 'programs need to target men directly with strategies that encourage them to communicate with their wives about reproductive decisions'.

The gender model family approach is therefore an attempt at working with men to overcome the notions of masculinity that are deeply entrenched within the cultural norms of the community. These norms do not encourage men to communicate with their spouses but rather give them the power to dominate, control, and have greater influence than their partners over the decision making process (Maharaj, 2001:151 and Speizer, Whittle & Carter, 2005). Also the fact that the approach aims at ensuring the sharing of roles and responsibilities among boys and girls in the family at the early stage in life is indicative of SEND Ghana 'intervene(ing) early to influence the socialisation of young boys to foster gender equitable attitudes and behaviours' (Gupta, 2000:5).

4.3.3 Stepping Stones Approach

The Stepping Stones approach is a participatory method designed to foster communication and behaviour change, particularly in areas where issues of sexual and reproductive health are a taboo topic to be openly discussed. This method also 'looks at the broader context of reproductive health and HIV and AIDS in local communities, such as the gender dynamics governing sexual relationships' (SEND Ghana, 2007:17). SEND Ghana introduced this method in its ECLSPP in 2004 after a sexual and reproductive health and HIV and

AIDS survey acknowledged that its program beneficiaries scored high knowledge in HIV/AIDS and sexual and reproductive health issues and low in terms of positive attitudes and safer reproductive health behaviours.

The main purpose for the introduction of the Stepping Stones method was aimed at encouraging the open discussion of HIV/AIDS and sexual reproductive health issues among partners through improving their communication skills. Communicating effectively and peacefully and adopting better behaviours to protect the individual, family and community well-being in sexual and reproductive health is promoted.

SEND Ghana trains facilitators to provide training on sexual and reproductive health issues to their respective peer groups. These facilitators are selected from within the communities with the support of community members. These facilitators are supposed to be community members who have influence and are respected by their peers. These peer groups are separated into younger women, younger men, older women and older men's groups. The purpose of this separation is to ensure that people are comfortable to discuss issues that affect them with their peers.

The Stepping Stones process runs for 16 weeks after which each peer group comes up with issues that they think they need the support of the community to address. These issues are enacted in the form of role playing at community durbars to convey the issues across to the other community members. A collective decision is then reached as to how to support these groups to handle their sexual and reproductive health needs.

This approach can be seen as one that has the potential to transform sexual relationships and enhance communication among partners in the community. This is because it recognises that gender concerns influence sexual and reproductive health outcomes and thus attempts to modify community norms that perpetuate these using a community-based and participatory approach to 'foster constructive roles of men in sexual and reproductive health' (Blanc, 2001:204 & Gupta, 2000:5). The fact that the approach targets and works with men and women to identify strategies that would redefine gender norms and encourage healthy sexuality and sustained behavioural change from their own situation makes it transformative (Gupta, 2000).

4.3.4 Micro Credit with Education Approach

Providing micro-credit with education has been recognised by SEND Ghana as an approach to empowering women in the Eastern Corridor of Ghana. This scheme was seen as the 'perfect stepping stone to give women the confidence, knowledge and resources to expand businesses, save funds, gain control over their financial resources, and eventually to join a cooperative credit union in their community' (SEND Ghana, 2006:16). Under this scheme, women are organised into small Credit and Savings Association (CSAs) and provided with micro-credit which is combined with the provision of sexual and reproductive health, gender, and peace education. The women are also given 'training in leadership and business management skills through a variety of technical and social skills training sessions' to improve their livelihood security situation (ibid). These CSAs,

provided women the platform for the first time to meet regularly and discuss and address their problems together, and to benefit from capacity building trainings. This was whether consciously or unconsciously a real shift of power away from men and that the women can meet and gossip and share their own ideas. This new form of social capital for the women should not be underestimated (SEND Ghana Staff).

The micro-credit with education approach was not only meant to improve women's economic status but was also to address the socio-cultural inequities in their communities and to equip them with the knowledge that would enhance their decision making abilities with regards to safe reproductive health practices and rights. According to Gill, Pande & Malhotra (2007:1350-1351), women's education and economic status are 'instrumental in enabling women to gain knowledge, confidence, skills, and opportunities that they need to increase their social and economic status and power in the household and in society'. This is where I see SEND Ghana's micro credit with education as appropriate in empowering women to challenge the status quo and to be able to take their own decisions. The approach not only seeks to improve women's economic status, access to information, skills and, services but also goes further to encourage their

> participation in decision-making and create a group identity that becomes a source of power—a group identity separate from that of the family because for many women the family is often the social institution that enforces strict adherence to existing gender norms (Gupta, 2000:6)

This empowerment approach of SEND Ghana deals with addressing both women's control over resources and building their self-confidence and political participation. This is consistent with Sen and Batliwala (2000:18-19) who note that programs aimed at empowering women should not only 'emphasize exclusively on the provision of services or access to external resources' but should also 'create space for women to build their self-confidence in order to manage or control those services'.

4.4 Conclusion

In Conclusion, one can tentatively say that SEND Ghana has a program response that seeks to create an enabling environment to empower women and get men involved. The aim has been to challenge the traditional gender-based stereotypes that promote men's power to undermine and determine women's sexual and reproductive health outcomes. What remains to be seen is whether these responses are meeting the needs of the community, particularly of its women. The next chapter seeks to gauge the perspectives of beneficiaries on their views of SEND Ghana's work in the area.

Chapter 5   Beneficiaries' Views, Lessons and Challenges on SEND Ghana's Strategy

5.1   Introduction

In this chapter an analysis of the views of project beneficiaries and community members on SEND Ghana's program are discussed to gauge whether program responses are meeting the sexual and reproductive health needs of the community, particularly women. The chapter also discusses the lessons and challenges that the organisation is confronted with in its program responses.

5.2   Beneficiaries' Views on SEND Ghana's Program Response

An examination of the in-depth interviews revealed that program beneficiaries and community opinion leaders view SEND Ghana's program intervention as empowering women, and challenging existing socio-cultural norms through the involvement of opinion leaders and men. These are explored in detail below.

5.2.1 The Empowerment of Women

As has already been noted in earlier chapters, the empowerment of women is crucial to ensuring that they have greater autonomy, decision-making power, control and access to resources, and the ability to exercise power in their sexual and reproductive relations. This according to Sen and Batliwala (2000:26) enables women to 'make decisions which result in delaying marriage, having fewer children, spacing pregnancies, and even remaining unmarried or childless by choice'. The pattern that emerged from the responses of project beneficiaries and community opinion leaders on SEND Ghana's empowerment model was one of mixed reaction. While some agreed that the micro credit with education program had improved the economic status of women, enabling them to make decisions related to their welfare and built their self-confidence to discuss issues of sex with their husbands, others were of the opinion that it had made women proud and difficult to handle. A male opinion leader had this to say on the positive impact of the program;

> Women no longer rely on men to give them money to buy what they want or go to the hospital. They are bold and talk about their sexual rights and reproductive health. Before SEND came we did not see this happening. This is good for me and I think for the community (Male Opinion Leader).

This point was buttressed by a woman beneficiary who noted that

> We are now respected by our men. We do not depend on them now. The micro finance has helped to grow our businesses. The trainings and meetings we always hold have given us the chance to discuss and share our problems about sex and family planning and how to talk to our husbands. These have

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improved our ability to take decisions and we support the family finances (Women Program Beneficiary).

On the contrary, some men in the community have felt threatened because women are gaining greater control of their lives due to the fact that the improvement in women's economic status has made them less dependent on men, given them the autonomy to control and make decisions and able to demand their sexual rights. The opinions of two community leaders on the subject are expressed below;

The micro finance that SEND gave to the women has made them rich and some men feel women are proud because they have something equal to men. The men think women can do what men can do, so they feel the women can leave them at anytime and take care of themselves (Woman Opinion Leader).

Some of the women got money from SEND and their businesses have improved. This is good. However, the bad side of it is that some of them got money and built their own houses and decided to go against the men. When the men talk hard to them they threaten to leave. This is because once she gets to build a house as soon as there is a small problem in the house she is moving out so that is the problem. When such a thing happens you can't control her. That is the bad side of it. So right now even if I am allocating a plot to someone to build I don't allocate to the woman straight (Male Opinion Leader).

Even though women's circumstances have been noted to have improved in the community, the threat of conflict and an increase in men's feeling of alienation is evident. This might be because the education component of the program did not involve men and as Sternberg & Hubley (2004:389-390) notes a women's empowerment strategy without male involvement is a partial solution. According to Sen and Batliwala (2000) the process should involve a package that involves men and women so they are both empowered to have equal gender relations.

The fact that women were noticed to have decided or threatened to vacate their matrimonial homes to houses which they had built could also imply that the micro credit had improved their economic status and the means to make decisions for themselves. Economic power has given them power in other realms, including the choice of whether or not they stay with their partner. It therefore meant that the economic factor of women was dealt with and so if women did not like it, they would move out.

In an interview to find out what SEND Ghana was doing about the threat the approach had for men, a staff member had this to say;

This should be noted and its worth observing and looking at how that impacts on the whole relationship dynamics in the community. If the residual effect at the community level of women being empowered is a threat to men it should be picked and looked at how it can be addressed. In terms of sexual and reproductive health rights I can see women taking greater responsibility in deciding whether they want to have more children or not and if they do have children they can decide to look after their children. It has however had some negative effects because the women are empowered and they are

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looking after their children then men can have more children with other women and then say I don't care (SEND Ghana Staff).

5.2.2 Challenging Socio-Cultural Norms

Socio-cultural norms within communities have been noted to promote male dominance and thus serve as a barrier to women's ability to take independent decisions and to discuss with their partners the need to negotiate for sex or regulate fertility and to seek reproductive health information or services. As a result, interventions aimed at addressing gender concerns in sexual and reproductive health need to modify community socio-cultural norms (Blanc, 2001:204).

Data analysed from statements of both program beneficiaries and community opinion leaders from the field interviews revealed that SEND Ghana's program intervention is changing the behaviour of men through its challenge of the existing cultural and traditional norms perpetuating male dominance and preventing women from taking control of their sexual and reproductive health lives. Most have indicated that the involvement of chiefs in the community has created the opportunity for community members, particularly the men, to accept change and to support women in addressing their sexual and reproductive health needs. This, they note is appropriate, because the men listen to the chiefs better since they are the custodians of the traditions and cultures of the area.

A woman opinion leader from Kpandai had this to say about the role of the chief in the community;

> The chief's public pronouncements during gatherings have been very helpful for us. We don't know what would have changed the mind of our partners not to have girlfriends, wanting more children and not to have sex without a condom. The men listen to him and to whatever he says. They are now changing and they listen to women better than before. I think they now know that it is wrong (Woman Opinion Leader)

This finding is consistent with a study of Bawah et al (1999:62) who note that it is important for interventions aimed at improving gender relations in sexual and reproductive health to involve the active participation of community leaders. This provides 'early opportunities for confronting the potential for gender conflict and for explaining family planning within the context of traditional values' (ibid).

Program beneficiaries also noted that the Stepping Stones approach and the Gender Model Family program have helped to create safe conditions which have enhanced the discussion of sexual and reproductive health issues within families. They noted that the Gender Model Family approach has proven to support changing gender roles at the family level and has improved relationships between husband and wife, while the Stepping Stones approach, with the support of the community, has increased the confidence and knowledge of men and women and enhanced communication and open discussion of issues regarding sexual and reproductive health. The statements by these two male program beneficiaries capture the views of beneficiaries;

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My wife and I are part of the Gender Model Family. The training we received has changed me. Interaction between us has improved. We sit and discuss family matters. I listen to my wife. I have time for her. When she says I can't have sex with her or that we can't have a child or that I should use a condom I understand her. She is able to talk to me now more than before. I have learnt that women have their needs and if you don't listen to them what you do can affect their health especially if you want sex and they say no and you refuse. I have been able to do this because the community is behind us. My friends don't make fun of me (Male Program Beneficiary).

The Stepping Stones classes have been very good for me. It has taught me that men should not allow their wives to give birth plenty since it can affect their health. It is important for men to support their wives in this. Also because the community is involved at some point, we are relieved since no one would make fun of us (Male Program Beneficiary).

This is consistent with studies by Blanc (2001) and Bawah et al (1999) that interventions that involve the community have the potential of challenging cultural norms and therefore enhances men's ability to cooperate and support their partners to address sexual and reproductive health issues. Gupta (2000) also affirms that there is the need to use community-based approaches to intervene in issues of sexual and reproductive health and particularly the spread of AIDS because barriers to achieving sexual and reproductive health are deeply entrenched within cultural, social, economic and political structures of the community.

It however came up during the interviews that changing the unequal gender relations and men's sexual and reproductive health behaviours within the community is not an easy task. Community members note that high levels of ignorance and illiteracy coupled with entrenched socio-cultural practices would continue to be barriers to men's ability to change their behaviours. The statement below echoes their sentiments on the issue;

It is not easy to change gender relations. More training and education should go on to address the high levels of ignorance and illiteracy. Education should be continuous to change issues of culture. We need to continue because if you say something today and tomorrow you stop, the next season people would try to forget (Woman Community Opinion Leader)

5.3   Lessons and Challenges Encountered by SEND Ghana

Interviews with staff and a study of reports and documents of SEND Ghana has revealed some lessons and challenges that the organisation thinks it has learned and has fed into interventions to ensure effective implementation of programs.

5.3.1 Lessons Learned

The community-based approach, which involved community members in the change process, has been seen as *'very essential to ensure that they lead in the process of*

development for the desired change to be achieved' (SEND Ghana Staff). Wegner et al (1998:40), in a report on strategies to involve men, note that when an intervention like male involvement in reproductive health is perceived as new, community ownership is crucial for its success. SEND Ghana's catalytic role of heightening awareness about gender and sexual and reproductive health issues and providing resources and skills for the community to handle the issues has proved positive. The Gender Model Family and Stepping Stones approaches are two community-based strategies that involve the participation of community members in discussing and devising of strategies to address issues of gender and sexual and reproductive health. The Stepping Stones program particularly allows for group level discussions while the Gender Model Family allows for family-based discussions of sensitive issues. It also instils in young boys gender equitable attitudes and behaviours at an early age to address the traditional expectation of masculinity.

The involvement of traditional authorities has been noticed to be crucial in facilitating and sustaining SEND Ghana's program in the Eastern Corridor where traditional and cultural practices are valued and held in high esteem. Recognising and equipping local leaders with information on gender and sexual and reproductive health at the onset of the program might have enhanced the mobilisation, participation and acceptance of the efforts to address gender inequality and sexual and reproductive health issues by community members.

5.3.2 Challenges

According to SEND Ghana staff, even though changes have been observed among family members in terms of gender relations and reproductive health decisions, they note that programs aimed at changing traditional norms and attitudes of people with regards to issues of sex and gender requires time. A staff of SEND Ghana notes; *'it takes time for people to change, as it is not easy for them to change easily from their lives they used to practice'.* He further notes that *'organisations have to work with the people for a longer period if they seek to actually change their attitudes'.* In acknowledging the fact that change is a gradual process, SEND Ghana for example first piloted the Stepping Stones approach in two communities to understand the implementation difficulties so the program could be effective (SEND Ghana, 2007:34-35).

5.4 Conclusion

The views of the community in this chapter revealed a number of issues concerning SEND Ghana's strategy in the communities. The interviews have shown that even though the organisation's empowerment approach has improved the economic status of women and increased their self-confidence and ability to make decisions, men perceive the change as a threat, as they have felt increasingly alienated. Women who have improved their economic well-being have been noted to have increased their self-confidence and ability to negotiate and either threatened to or moved out from their marriages.

It is worthy to note that the Gender Model Family and Stepping Stones approach has reinforced women's self-confidence and their ability to negotiate and communicate with their partners. They are also able to challenge the

existing notions of masculinity at the family and community levels. Both community members and SEND Ghana staff members note that working with community leaders and involving men has been helpful in this regard. They also agree that changing existing cultural norms needs continuous and sustained education.

Chapter 6   Conclusion

This study used SEND Ghana as a case to explore the extent to which organisations' programs work to promote gender equity in sexual and reproductive health. This concluding chapter provides a recap of the key findings and reflects on lessons learned for future programming and further research.

The study revealed that dominant notions of masculinity and virility were identified by SEND Ghana as predominant in the Eastern Corridor of northern Ghana, giving men the power to determine women's sexual and reproductive health outcomes. These influences of masculinity result from and are reinforced by socio-cultural norms and practices, the highly patriarchal social structure and the socialisation of children in the area. Also identified as barriers to women's ability to determine their own sexuality was, access to sexual and reproductive health information and services, the restricted mobility of women, their low economic status, and the high levels of illiteracy in the area.

It emerged from the study that SEND Ghana's ECLSPP is playing a catalytic role in the Eastern Corridor by way of empowering women and involving men to challenge traditional gender-based stereotypes that affect women's ability to take decisions and negotiate with their partners with regards to their sexuality, fertility and access to reproductive health information and services. It was noticed that the active involvement of local leaders was crucial in the support of programs aimed at challenging existing gender norms and providing women the space to address their sexual and reproductive health needs.

The study revealed further that the Gender Model Family and the Stepping Stones programs have actively involved men to overcome the dominant notions of masculinity and the deeply entrenched socio-cultural norms that hinder communication between partners and women's ability to negotiate and take decisions with regards to their sexuality and reproductive health. While the Gender Model Family strategy was noticed to have played a supportive role in changing men's dominant attitudes and behaviours and improving partner relationships, the Stepping Stones strategy was improving the confidence and knowledge of men and women through the support of the community. The overarching finding for these two strategies was that they were contributing to enhancing communication and open discussion of sexual and reproductive health issues among partners. Findings from the study also revealed that the gender model family was important as it intervened to deal with the masculine norms that boys were socialised into in their early years and as such had the potential of fostering gender equitable attitudes and behaviours in young boys.

The study also found that the micro credit with education program was empowering women to address the socio-economic factors impeding their ability to make decisions and access sexual and reproductive health services. The program had improved the economic status of women and enabled them to make their own decisions regarding their welfare, and built their confidence

to discuss issues with their partners. Also it had created a forum for the women to meet, discuss and share issues *'around sex and family planning and how to talk to our husbands'* (Woman Program Beneficiary). Despite these positives, the study revealed that men felt threatened and increasingly alienated because of the changes occurring in women's well-being. This situation has the potential of non-cooperation from men and stands to exacerbate women's sexual and reproductive health situation.

Based on the findings of the case studied, some lessons have emerged to inform future programming and research. It is apparently clear that programs aimed at empowering women need to be designed such that they involve men. An integrated approach to dealing with unequal gender-based power relations in sexual and reproductive health would enable programs to reinforce each other to prevent a situation where one group is more empowered than the other. This can defeat the purpose of such programs and at worse exacerbate the situation for the powerless.

Also, the fact that the empowerment process has the potential to result in the demand for social services, and in this case sexual and reproductive health services, programs aimed at creating an enabling environment and providing space for women to address their sexual and reproductive health needs, must cater for the provision of these services to meet the potential demand.

Finally, bearing in mind that this paper looked into how NGOs work to challenge unequal gender-based power relations in sexual and reproductive health, there is the need to further research how government organisations and private sector organisations working in the area of providing sexual and reproductive health services are challenging unequal gender-based power relations in their programs.

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Appendices

Open-ended Interview Guides for in-depth interviews on challenging unequal gender-based power relations in sexual and reproductive health decisions.

This interview seeks to collect data from SEND Ghana Staff, Program Beneficiaries and Community Opinion Leaders on how SEND Ghana's Eastern Corridor Livelihood Security Promotion Program (ECLSPP) is responding to factors that promote unequal gender-based power relations in sexual and reproductive health in the Eastern Corridor. Information gathered will be used for writing my research paper for a Master of Arts in Development Studies (Population, Poverty and Social Development). The information provided from this interview will only be used for academic purposes. None of it will be used for any other purpose.

Part A

Interview Guide with SEND Ghana Staff and Management

1. How long have you worked with SEND Ghana?

2. What is your role/responsibility in SEND Ghana?

3. What is the mission of SEND Ghana?

4. What do you know about SEND Ghana's principles and guiding values?

5. What are the program focus areas of SEND Ghana?

6. What projects does SEND Ghana's Eastern Corridor Livelihood Promotion Implement?

7. What strategies are being used in implementing these projects?

8. Who are the target groups, and what criteria are used in selecting them?

9. What are the factors in your opinion that determine men's role in sexual and reproductive health decision making in the Eastern Corridor of Ghana?

10. What factors according to SEND Ghana determine men's role in sexual and reproductive health decision making in the Eastern Corridor?

11. How does SEND Ghana's Eastern Corridor program respond to the factors that influence men's role in sexual and reproductive health decision making?

12. Is SEND Ghana able to respond to all the factors? If no, which factors does it respond to and why?

13. What has been achieved with regards to SEND Ghana's sexual and reproductive health programs in the Eastern Corridor?

14. What has been the response of men and women to these interventions?

15. What is the response of the community members to SEND Ghana's strategy of addressing unequal gender based power relations in reproductive health decisions?

16. Are there any lessons in terms of addressing unequal gender relations and women's reproductive health decision making?

17. Are there any challenges for SEND Ghana's Eastern Corridor program in addressing unequal gender relations and women's reproductive health decision making?

Thank You

Part B

Interview Guide with Community Opinion Members (Indirect Project Beneficiaries)

1. What is your role in this community?
2. Have you heard of SEND Ghana in this community?
3. How long have you heard and known SEND Ghana?
4. Do you know what SEND Ghana does within the community?
5. What activities have they been engaged in since you heard of them?
6. Is a member of you family involved in SEND Ghana Programs?
7. What have you noticed about their work in the community?
8. What do you think about their involvement?
9. Have you heard about their work on gender and reproductive health and HIV/AIDS?
10. What do you know about this?
11. What factors do you think promote men's control over women when it comes to decision making?
12. What is the community's response/perception about the work of SEND Ghana?
13. As an opinion leader what and how do you see SEND Ghana's work around changing gender relations and their reproductive health work in the community?
14. What needs to be continued and what needs to change? And why?

Thank you

Part C

Interview Guide with Program Beneficiaries

1. How long have you known SEND Ghana?

2. Have you been involved with SEND Ghana? In what capacity?

3. Are you a project beneficiary of SEND Ghana's ECLSPP?

4. How did you become a project beneficiary of SEND Ghana?

5. How long have you been a project beneficiary of SEND Ghana?

6. What project activities of SEND Ghana are you involved with?

7. Of what benefit have these activities been to you?

8. What factors do you think give men the ability to control women in the sexual and reproductive health decisions?

9. Are you aware of SEND Ghana's gender promotion activities?

10. What is it all about? How does SEND Ghana do this with you?

11. What do you think about this?

12. How is this assisting in relationship building in the community and family level?

13. What is the reaction of community members on this?

14. Are you aware of SEND Ghana's SRH and HIV/AIDS Program?

15. What do they do in this regard?

16. What has changed in your family and relationship with regards to decision making? Who decides in the family?

17. Do you think the program is good? And Why?

18. Should SEND Ghana make some changes in its programmes around gender and reproductive health?

19. What needs to be continued and what needs to change?

Thank you

Map of Ghana

A map of Ghana showing some of SEND Ghana's Program communities in the Eastern Corridor of Northern Ghana