

8-9-2014

A MULTI-SITED EXAMINATION OF PREGNANCY, BIRTH AND WOMEN'S PERCEPTIONS OF CARE IN GHANA

Jessica M. Posega
University of South Carolina - Columbia

Follow this and additional works at: <https://scholarcommons.sc.edu/etd>



Part of the [Anthropology Commons](#)

Recommended Citation

Posega, J. M.(2014). *A MULTI-SITED EXAMINATION OF PREGNANCY, BIRTH AND WOMEN'S PERCEPTIONS OF CARE IN GHANA*. (Master's thesis). Retrieved from <https://scholarcommons.sc.edu/etd/2869>

This Open Access Thesis is brought to you by Scholar Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Scholar Commons. For more information, please contact digres@mailbox.sc.edu.

A MULTI-SITED EXAMINATION OF PREGNANCY, BIRTH AND WOMEN'S
PERCEPTIONS OF CARE IN GHANA

by

Jessica M. Posega

Bachelor of Science
Michigan Technological University, 2012

Submitted in Partial Fulfillment of the Requirements

For the Degree of Master of Arts in

Anthropology

College of Arts and Sciences

University of South Carolina

2014

Accepted by:

Erica Gibson, Director of Thesis

Sherina Feliciano-Santos, Reader

David Simmons, Reader

Lacy Ford, Vice Provost and Dean of Graduate Studies

Abstract

In Ghana, both governmental and non-governmental agencies have been working to reach the 2015 United Nations Millennium Development Goals (MDGs). The fourth and fifth goals are related to reproductive health, reducing infant and maternal mortality respectively. Through a combination of increasing midwifery and nursing training programs, public awareness programs, and programs designed to retain skilled birth attendants. This paper explores how the policies and practices intended to create better birth outcomes in Ghana are perceived by those targeted for intervention, and by the reproductive health workers. Drawing from in-depth interviews with pregnant women, mothers with children under one year, and health professionals, as well as from participant-observation in Accra, Sunyani, and a small village in the Upper West Region, this thesis argues that programs and initiatives designed to create better birth outcomes are often misunderstood by local women and ignored in practice by some reproductive health workers. Misunderstandings occur due to cultural differences and language barriers. The underdevelopment in the northern regions, and the obstetric violence faced by all Ghanaian women, but especially rural and minority women, contribute to complex and nuanced individual understandings set against the backdrop of the Millennium Development Goals.

Table of Contents

Abstract.....	ii
List of Tables.....	v
List of Figures.....	vi
List of Abbreviations.....	vii
Chapter 1. Introduction.....	1
Chapter 2. Background.....	6
Chapter 3. Theory.....	19
Chapter 4. Research Methods.....	30
Chapter 5. Results.....	45
Chapter 6. Analysis.....	71
Chapter 7. Conclusion.....	96
Works Cited.....	105
Appendix A: Interview Questions for Reproductive Health Practitioners.....	111
Appendix B: Interview Questions for Community Women.....	113

Appendix C: Photograph of Advertisement114

Appendix D: Map of Ghana.....115

List of Tables

Table 5.1 Childbearing Women and Demographic Information.....45

Table 5.2 Practitioners and Demographic Information.....57

List of Figures

Figure C.1 Image of an Advertisement for the Maternal Health Channel.....	114
Figure D.1 Map of Ghana Indicating Fieldwork Locations.....	115

List of Abbreviations

GHS.....Ghana Health Service

MDG.....Mellineum Development Goal

TBA.....Traditional Birth Attendant

UN.....United Nations

Chapter 1. Introduction

The nature of anthropology as a discipline makes it ideal to study reproductive health, which involves some of the most varied social practices surrounding the biological event of childbirth. The Western biomedical system of childbirth has spread throughout the world for the last hundred years and the push to incorporate Western biomedical practices was compounded by the 1991 United Nations Millennium Development Goals (UN MDGs). Countries across the world were challenged to provide primary education, promote gender equality, and reduce maternal and infant mortality rates among other lofty goals. As the 2015 deadline of the UN MDGs draws near, some nations scramble to make up for a lack of hitting projected goals. Ghana has struggled since the setting of the UN MDGs in trying to reduce maternal and infant mortality rates. The use of an anthropological perspective to frame and explore the reasons for this lag in reduced mortality rates is, in part, the point of this project. The individual's perceptions of how these changes affect the reproductive health care they receive is largely what separates an anthropological perspective from other disciplines which rely more on survey and statistical data. Anthropology allows for a multi-scalar interpretation of data collected. The individual women's and reproductive health care practitioner's perspectives are understood within the Ghanaian health care system, and then these perspectives are situated within the global world-system. This provides a new outlook on how global initiatives surrounding human rights such as the UN MDGs affect the

relationship between states and between state governments, healthcare agencies, and individual patients.

For many, the concept of humanitarianism is not a controversial one. For most Westerners, the idea of helping people in countries that are often termed ‘third world’ is a positive step to correct the ills found in that place, no matter the cause. That cause could be what is interpreted to be a maladaptive cultural trait to Westerners, natural disaster, or even an attempt to remedy a problem created by colonial, neocolonial, or other neoliberal influences. However, many of these perceived issues, especially those that are being dealt with by nonlocal organizations are often understood through a Western construction of what is socially, medically, morally, or physically normative and acceptable. Such a perspective fails to take into account local cultural expectations.

I investigate the representation of “the other”, specifically through postcolonial feminisms and in relation to the field of anthropology. I address how human rights and global humanitarianism discourses have the effect of othering women in particular cultural contexts. In the sense that othering creates a separation between groups of people, it is the creation of the other, one that is unknown and often ‘backward’. The United Nations (UN) Millennium Development Goals (MDG) are affecting reproductive health care in Ghana. The concept of superiority of Western thought and the obscuring and othering forces of global humanitarianism and human rights discourses and practices are sites to question and criticize policy and intention. This shows a clear lack of cultural sensitivity and an ethnocentric perspective, which normalizes the practices of global humanitarianism and human rights.

Another understanding of human rights discourse is that it, and movement toward a neoliberal style of governance, are in opposition. The privatizing of many aspects of the government happens to create increasing disparity in wealth and is coupled with the lessening of government social welfare programs. In this processes of neoliberalizing, the government's main concern becomes creating stability to allow the market to function with the fewest hiccups (Speed 2007). The opposition between neoliberal policies and global humanitarianism and human rights is often not the intended outcome of those working within global humanitarianism. The outcome of prosperity could be argued as desired by both, but the effect of neoliberal policies often creates disparity that is often the topic tackled by global humanitarianism and human rights work.

During my preparation for this research I realized that I must be acutely aware of many of my own biases, and minimizing them is of utmost importance. Although it must be clear that a completely objective perspective is never possible and therefore, I will endeavor to state my biases as a means of creating awareness of how they may have affected this project. My position as a white, female, non-mother, American, graduate student in cultural anthropology set up the dynamics of my access to information that influenced not only the interest in this research project as a whole, but also the interpretations of the experiences and observations.

A week before I was supposed to leave for Ghana, my overall research site and plans changed. Considering the rapidity with which the nature of this ethnographic project changed, it became necessary to adjust my research questions in ways that remained similar enough to those of the original project such that massive amounts of

new background research would not be necessary. This research is focused on effects of the Millennium Development Goal 4 and Goal 5 set by The United Nations in 1990. The United Nations' MDGs reduction of child mortality is Goal 4, with the express intent of "reduc[ing] by two thirds, between 1990 and 2015, the under-five mortality rate" (Goal 4 2013). The improvement of maternal health is Goal 5 which consists of "target 4.A: reduce by three quarters the maternal mortality ratio" and "target 5.B: achieve universal access to reproductive health" (Goal 5 2013).

Research Questions

1. What are the impacts of the United Nations Millennium Development Goals four and five on reproductive health care in Ghana?
2. How do Ghanaian reproductive health care practitioners understand the impacts of the United Nations Millennium Development Goals four and five?
3. How are Ghanaian women's perceptions of reproductive health care impacted by the United Nations Millennium Development Goals four and five?
4. What factors are affecting the ways in which women experience reproductive health care in Ghana?
5. In What ways are the Ghanaian government's efforts to meet the Nations Millennium Development Goals four and five working on an individual level?

The relationships between global level policies and individual experiences are not always easily linked. In the case of the UN MDGs the ties are clearer. The efforts made by the government of Ghana to reduce infant and maternal mortality rates are directly impacting Ghanaian women's lives, and not always in the intended ways. The remaining

six chapters of this work focus on framing this research within the larger body of work on reproductive health and the history of birth in Ghana, the process of ethnographic research, and the results and interpretation of the data.

Chapter 2. Background

Childbirth and Reproductive Anthropology

The seminal work of Brigitte Jordan, “Birth in Four Cultures: A Cross Cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States” (1993) demarcates the subfield of critical medical anthropology as it relates to childbirth and reproductive anthropology. This subfield often incorporates the tenets of critical medical anthropology theory and also partly works with disenfranchised and marginalized groups. Jordan relies on the core concept of authoritative knowledge. Authoritative knowledge is knowledge in a given cultural context that, situationally, is considered to be the best possible practice, although it may not actually be. While authoritative knowledge is what counts within any given cultural context, it may not be the knowledge that is best suited for a particular situation to ensure the best outcome. Jordan’s original notion of authoritative knowledge was based on highly technologically dependent births and the distribution of said knowledge in terms of who was in control of the unevenly distributed knowledge (Jordan 1993). The concept of authoritative knowledge has been expanded upon and critiqued by medical anthropologists, specifically those who study childbirth (Sargent 1996).

While Jordan argues that authoritative knowledge is possessed by those who control the artifacts necessary to accomplish the work, we argue that it is also contingent on shared experience and social position. We consider the extent to which authority entails some status ‘or position that, as Starr argues, compels trust or obedience (1982:9). In addition, we debate

whether the knowledge that “participants agree counts” is necessarily generated through social interaction (Jordan 1993[1978]:154) and we consider the forms that such social interaction may take. We also explore the variation in acceptable “ways of knowing” about birth—the validity of women’s personal and experiential knowledge about labor in relation to the growing worldwide legitimacy of biomedical constructs of birth (Sargent 1996: 216).

Jordan discusses a number of theoretical perspectives as influencing the ways in which she interprets her cross-cultural research, although she is clear that none of these theoretical perspectives are ideal for understanding the biosocial (biocultural) process of birth. She uses the foundations of critical medical anthropology, and traditional ethnography to create “a holistic conceptualization of birth that integrates local view and meaning of the event, its associated biobehaviors, and its relevance to cross-system issues regarding the conduct of birth”(Jordan 1993:8). By using immersion, participation in the birth event, and detailed participant observation she was able to overcome the lack of cohesive framework between medicine and anthropology. Rosaldo and Lamphere’s (1974) work on women in anthropology is cited by Jordan as a turning point that allows for a theoretical perspective in which women as social beings can be seen in the multi-positionality of complex cultural processes (Jordan 1993).

From my perspective, notions of Antonio Gramsci’s concept of hegemony are well represented in Jordan’s work. Looking at the acceptance and the proliferation of the cosmopolitan obstetrics as a part of Western biomedical childbirth system clearly shows hegemonic tendencies (Bates 1975). The use of hegemony as a theoretical concept related to childbirth and reproductive health is more directly addressed in the writings of Robbie Davis-Floyd (2003).

Davis-Floyd builds on the work of Jordan, stating more directly other theoretical influences and frameworks that she uses in the construction and interpretations of birth models in the United States (2003). Davis-Floyd uses feminist theories from anthropology and other social sciences. Davis-Floyd furthers this view of gender dynamics through the incorporation of feminist theoretical critiques while having the realization that not all women are seeking a feminist revolution to save them and their birthing process from the patriarchy that is technocratic medicine. She states that by “mov[ing] beyond the perspective that sees women’s choices for birth technology as ‘false-consciousness’ waiting for the feminist conversion, to a perspective that views such choices as embedded in the hegemonic cultural model of reality that most of us to some degree embrace” (Davis-Floyd 2003: 5).

Davis-Floyd also notes that the symbolic anthropology, and ritual as put forward by Geertz, was a necessary theoretical model to be incorporated into the practice of the anthropology of birth. This can be seen in her own work, especially as she looks at the American birth process as a form of ritual lasting approximately one year, with all the aspects of separation, liminality and reintegration. Davis-Floyd additionally notes that George Marcus and Michael Fischer’s argument that multiple voices need to be exposed within a single text that has been designed for multiple readerships should be incorporated into research in this field as a means of being self critical, critical of the discipline, and as a means of advocacy (Davis-Floyd 2003).

The use of Johan Galtung’s interpretation of structural violence is often important for contextualizing the lives of those studied by anthropologists. Structural violence is

violence that is perpetrated by the system that creates the conditions of violence. Violence may be indirect in action and in the effect of the action, and may not be physical, as well as the conditions in which a person can act in a way that is violent. The violence is “built into the structure” (Galtung 1969: 171) and therefore is a form of social injustice.

Through Farmer’s work on the structural violence of poverty, AIDS and tuberculosis we can see the ramifications of concept of structural violence (Farmer 2004). When the reasons that have historically created the structures that affect a modern population are forgotten or omitted it is easy not only to miss the causes, but the nuances of the structural violence as well. Critical medical anthropologists and anthropologists of birth are interested in the historical and contextual dynamics of the social structures that cause and allow for reproductive social injustice. Such scholars are also interested in framing social injustice within the larger system of capitalism and becoming advocates for people who are affected by structural violence.

Importantly, anthropological work in the field of childbirth and reproductive health incorporates perspectives from Western midwifery, ethnomedicine (including biomedicine), biology, and social science in understanding and framing of the biocultural process of childbirth. This multi-sourced, multi-vocal, and ethnographic approach helps give a perspective on birth that incorporates feminist theory with critical medical anthropological theory. Additionally, Marxist notions of production, and a women as reproducers as related to social production are important in the larger context of economic and structural inequalities which cause the failings that create poverty and inequality within the world system that anthropologists such as Paul Farmer wish to

address (Farmer 2004). A focus on embedded observation and participation in ethnographic research allows us to analyze large-scale concerns of economic and structural violence in a way that is grounded in both the biological and cultural process of birth.

Birth in the technocratic model of medicine can be seen through a Marxian perspective if one thinks of, as Jordan and Davis-Floyd suggest, birth as production and not just reproduction (Jordan 1993, Davis-Floyd 2003). In this model, the woman and the embodied knowledge that is stripped from her can be seen as the alienation of the worker, as the woman's job is to reproduce. The product of labor, the infant, is given back to the mother. However, within this analytical framework, the child will forever be under the possession of capitalists and the system that created and held the authoritative knowledge of its birth. In this way, the mother has just socially reproduced the next generation of the proletariat (Davis-Floyd 2003).

Research into birth and perceptions of reproductive health care in Ghana will show the links between the global system and individual experiences related to pregnancy and birth. The technocratic model of medicine in the context of Ghana places the cultural processes of birth in the past as the production of colonial ideals, and in the present the production of Western ideals as stated in the UN MDGs.

Birth in Ghana

The British colony of Gold Coast was the first African colony to gain independence on March 6, 1957, becoming the modern state of Ghana (Historical Context, History of Ghana, History Timeline). The name Ghana comes from the king's

title from the Empire of Wagadugu, a medieval kingdom about 500 miles North of the present day state (History of Ghana). Present-day Ghana is composed of ten regions, the boundaries of which in part represent the four original polities that made up the newly independent state, Gold Coast, the Kingdom of Ashanti, the Northern Territories, and the Trans-Volta Togoland (Historical Context). A multilingual nation, the official language of Ghana is English and the national lingua franca is Twi: all government documents must be in Twi and English. The language of primary education in Ghana is English.

Depending on the source Ghana has between nine and eleven government-sponsored languages: Twi, Dagaare, Waale, Dangbe, Dagbane, Ewe, Ga, Gonja, Kasem, and Nzema. There are as many as 26 other major language groups in Ghana that are not government-sponsored (Historical Context). The north of Ghana is considered locally to be vastly different than the south. The south is highly populated and has many urban areas, while the north is sparsely populated and often very rural. The south has higher levels of basic education, while the north consistently has the lowest levels of basic education completion (Ghana Web).

The current health care system in Ghana is the “Ghana Health Service (GHS) is a Public Service body established [in] 1996 as required by the 1992 constitution [and]... is an autonomous Executive Agency responsible for implementation of national policies under the control of the Minister for Health” (Ghana Health Service n.p.). As of 2006 only fifty percent of births in Ghana were attended by a skilled health professional.

Reforms decentralizing the GHS at the regional level have left the Brong Ahafo Region,

consisting of 19 districts, with only 86 doctors, and 220 medical facilities for a population of approximately 1.9 million (Salisu and Prinz 2009).

As stated earlier, the United Nations' MDGs reduction of child mortality is Goal 4, with the express intent of “reduc[ing] by two thirds, between 1990 and 2015, the under-five mortality rate” (Goal 4 2013). The improvement of maternal health is Goal 5 which consists of “target 4.A: reduce by three quarters the maternal mortality ratio” and “target 5.B: achieve universal access to reproductive health” (Goal 5 2013). With only two years until these goals should be met, there has been an increase in Ghanaian programs geared toward meeting these goals, including an increase in midwifery-based care programs. Although Ghana is making strides toward meeting Millennium Development Goals 4 and 5, and it is believed that they are within reach of these goals for 2015, there is still the problem that many maternal deaths in rural areas go unreported (Report by Ghana Statistical Service and the Ghana Health Service 2008). The use of midwifery-based care for pregnancy and birth is believed to be beneficial for meeting both Millennium Development Goals 4 and 5.

Rural regions of Ghana are the farthest from meeting Millennium Development Goal five of improving women's health. According to the World Health Organization “a woman giving birth in an urban area is twice as likely to be delivered by a health professional as a woman giving birth in a rural area (84 percent versus 43 percent)” and that “professional assistance at birth increases steadily with the mother's level of education and wealth” (WHO 2008:16). In Ghana there is prestige surrounding the use of Western biomedicine. This prestige system favors those women in urban areas, and those

with higher levels of education and socioeconomic status as it is more readily available to them. The Ghana Registered Midwives' Association has been a part of the International Confederation of Midwives since 1954, prior to Ghanaian independence from the United Kingdom (News 2006). In 2006, USAID noted that there was a shortage of midwives in Ghana and that the population of Ghanaian midwives were aging (The Emerging Midwifery 2006). The Ghanaian government, and nongovernmental organizations such as the World Health Organization have also supported midwifery-training programs in Ghana. With the added support of the WHO, twenty midwifery and nursing programs throughout Ghana have received extra funds and materials. The express intent of this aid is to help Ghana meet the Millennium Development Goals 4 and 5 (WHO 2008).

For the Ashanti, the largest ethnic group in Ghana, pregnancy is a time of vulnerability. This vulnerability can be seen in the culture bound syndrome *sunsumyare*. *Sunsumyare* is a spiritual sickness that manifests itself as physical and is of great concern (Farnes et al. 2011). The majority (88%) of women in Farnes' study felt that some form of biomedical care was good for pregnancy and birth. Among these same women, faith healing and ethnomedical practices had a 90% prevalence. The use of multiple reproductive health strategies is part of the pluralistic dynamic of health care practices within Ghana. The pluralistic system in Ghana is not entirely accepted by everyone, which can be seen in that some women choose not to discuss the simultaneous use of ethnomedical and faith healing with biomedical professionals (Farnes et al. 2011). When these women are asked by biomedical practitioners about their taking of ethnomedicinal herbs 25% did not disclose that they had used herbs. One woman stated that "they

[biomedical practitioners] will advise me not to take it again, but I don't listen to them because I know that sunsumyare exists, and . . . I need to take herbs because the doctor cannot cure that" (Farnes et al. 495: 2011). In this case, there is a perceived tension between the ethnomedical understanding of necessary action during pregnancy and the biomedical system of pregnancy. Within the ethnomedical understanding the taking of herbs is medically necessary for a safe pregnancy. While the biomedical system may find no benefit in the practice, they may find no physiological harm in the taking of herbs themselves. Although the taking of ethnomedical herbs could be seen as undermining the authority of the biomedical system, Biomedicine would consider the taking of prenatal vitamins to be medically necessary during pregnancy but the ethnomedical system may not.

In order to meet the Millennium Development Goals "the World Health Organization [...] has identified a need for 334,000 additional midwives in the world to meet the reproductive needs of all women. To meet this demand, midwifery education programs are growing exponentially in some countries, increasing the workforce by hundreds, and in some cases thousands, of midwives in a country each year" (Lori et al. 2012). Even though Ghana is one of the nations in which midwifery education has been increasing, there is a lack of trained midwives who are willing to work in rural areas. These rural areas have the greatest need for midwifery-assisted care. New midwives feel that they will lack possibilities for professional advancement and that their personal lives will be negatively impacted (Lori et al. 2012). This, in combination with the fact that many of these women are originally from urban areas, and/or they have become

accustomed to the amenities of the urban area in which their training occurred, leads to a continued disparity in placement of midwives in rural areas (Lori et al. 2012).

Nurses and nurse midwives in Ghana have made statements that undercut the localized ethnomedical midwifery practices (WACN 2008:73,74). Many biomedically trained reproductive health care workers in Ghana feel that the local ethnomedical system is dangerous and ‘backward’, and advise women to not seek care from ethnomedical practitioners. Making statements such as “we advocate the scaling down of the training of [traditional birth attendants] TBAs and those already trained should be properly supervised and monitored” (WACN 2008:74). This shows that, at least among some health care professionals, there is a negative bias, which could be seen as representative of the influence of Western biomedical system, toward non-nurse midwives.

In Ghana there is a tendency for health care workers to be very negative toward patients (Witter et al. 2007). For some women, especially those in rural areas, this has become an increasing deterrent from seeking health care of any sort (Witter et al. 2007). Even women who have access to health services during pregnancy do not always seek care, in part to avoid being belittled. This trend could be a continued problem if the midwifery and nurses training programs do not directly address it. This is especially poignant for nursing programs based in the Western biomedical system. Rural Ghanaian women are also less likely to receive postnatal care, and women who do use services are more likely to use health clinics, which “suggests that there is a lot of value placed on the role of the health institutions in pregnancy care” (Adanu 2010: 157).

Some women also avoid health care due to an interest in avoiding spousal violence (Witter et al. 2007, Bawah 1999). In the Northern region of Ghana there has been tension between men and women in part due to “modern means of managing fertility [that] give women a degree of reproductive autonomy that they did not have in the past” (Bawah 1999:54). The availability of birth control methods that can be used without the knowledge or consent of men creates a reproductive autonomy that is a direct result of the influence of Western biomedicine. In this instance, men feel that the power dynamics are upset by women’s access to biomedical birth control that is beyond a man’s control. This perceived lack of control has led some men to become violent as means of dealing with the changes in power dynamics related to fertility (Bawah 1999). Bawah’s research shows some of the ways through which men have been an impediment to women’s interactions with the biomedical health care system in Ghana. In this context, the term “gate-keeping” refers to men who will not allow or heavily impede women’s, and thereby children’s, access to the health care system (Ngom et al. 2003). The role of men in keeping women from health care services in Ghana is relevant to for this data set for several reasons. It has been shown that men influence when women seek out the care of health practitioners and how women choose to interact with health practitioners. Also, women interact with many male practitioners such as male nurses and doctors.

Even with widespread pressure to eradicate local ethnomedical midwives (TBAs), some still practice in rural Ghana. The small number of these TBAs and the large number of rural women who rely on them has necessitated ingenuity in their practice and the adoption of newly available technologies, specifically the cellular phone

(Dabrowski 2011). Ghanaian midwives have begun to use technology to deal with the lack of professionals in comparison to the number of women who require their services. The use of texting via cellular telephones allows midwives to keep in regular contact with clients regarding the progress of their pregnancies and postnatal care. This has allowed for fewer midwives to care for larger populations of women (Dabrowski 2011).

Health Sector in Ghana

The third largest teaching hospital in all of Africa is located in Ghana's capital city Accra, near the Korle Lagoon. Korle Bu teaching hospital was established in 1923. When it opened, it had only 200 beds, while as of the summer of 2013 it had more than 2,000. The hospital was founded under the colonial government of the Gold Coast and it has been associated with the University of Ghana Medical School since 1962. Korle Bu's doctors see over 1,500 patients per day and has many specialty units including plastic surgery, transplants and burn units, as well as the main referral reproductive health clinic in Ghana (Brief 2012). Women may only attend this clinic with prior referral. Public and private hospitals from all regions of Ghana send women to receive care at the Korle Bu antenatal and post-natal clinics.

The region of Brong Ahafo was created in 1959 from a portion of the former Kingdom of Ashanti (Brong Ahafo Region). The policies of the British had favored economic and social improvements in the South near the coast. This led to the migration of many working-age men from the North (Historical Context). The Brong-Ahafo Region has "25 hospitals, 35 health centres, 106 rural clinics, and 54 maternity homes. Government owns more than half of all the health facilities; it totally owns all health

centres, and two-thirds of rural clinics” (Modern Ghana 2013). Three-quarters of hospitals and almost all maternity homes, however, are privately owned. The capital city of the region Sunyani has the lowest fertility rates throughout the region with an average of 2.8 children per family, while the average for the region as a whole is 4.2 children (higher than the national average). This lower fertility rate is due to higher levels of education and easier access to family planning. The rate of infant survival in the region is approximately 82% (Modern Ghana 2013).

The Upper West Region of Ghana was created in 1983, when the Upper Region was split into three regions, the Upper West, the Upper East, and the Northern Region. Here the infant survival rate is approximately 78%, which is nearly 10% lower than the national average. Wa, the capital of the region, is located to the West, near the border with Burkina Faso. The Wa Regional Hospital is located in the city of Wa. Importantly “less than two per cent of the [Upper West] region’s localities have a hospital within the locality and only 11 per cent of localities have a clinic/maternity home facility within the locality” (Modern Ghana 2013). Meaning that very few women in the upper West have access to clinic care and even fewer have access to a hospital.

Chapter 3. Theory

The use of multiple medical anthropology theoretical models allows this research to take a more holistic perspective. The interpretive model is used as a means to elaborate on local explanatory models as found in Ghana, while a critical medical anthropology perspective helps to situate localized articulations of birth and reproductive health care within the larger structures of the world-system, neoliberal economics, capitalism, and global humanitarianism. The concept of authoritative knowledge as used by Brigitte Jordan also influenced the way in which data was collected and analyzed. Jordan's work uses a theoretical perspective that incorporates an interpretive approach and one which could be called critical-interpretive medical anthropology. The theoretical concept of structural violence in relation to the world-systems and their localized manifestations helps to frame the ways in which women in Ghana and health workers interact. The use of feminist intersectional analysis is used to explicitly look at interactions between patients and practitioners and as means of analysis of a photograph. This photograph depicts an advertisement for a maternal health television program produced in Ghana for a Ghanaian audience (Appendix 3). The analysis of this photograph illuminates some of the disjunctures between this attempt to reach out to a presumably broad Ghanaian female audience and the resulting effects of this effort.

Critical Medical Anthropology

In his introduction to a symposium on critical medical anthropology in 1997, Hans Baer, a critical medical anthropologist, concisely quotes his colleague Robert Hahn, stating that:

“while I believe that a comprehensive theory of sickness and healing must consider adaption and culture, my own theory would begin with the position of critical medical anthropology, for several reasons. First, as critical medical anthropologists clearly recognize, events that occur in social settings are powerfully influenced by forces emanating from far beyond those settings.... Second... the understanding that sickness and healing must take into account the local and the global maldistribution of power. Third, theories, including anthropological theories of sickness and healing, are themselves elements of a culture... and fourth, research and theorizing themselves are social acts; they just be made ethical acts. Where injustices and inequality prevail scholars must strife not to rationalize the system... but to unmask and remake it (Hahn, 1995, p.75)”

(Baer 1997: 1563). This epitomizes the foundations and practice of critical medical anthropology. Here, Baer quoting Hahn is significant. Not only does the setting in which Baer quotes Hahn shows the profound contribution Hahn’s writing made to the field of critical medical anthropology, but also as a meaningful way to understand the foundations of the discipline and the research done within its theoretical framework.

The first point Hahn makes is in regards to political economic theory. Here Hahn points out that the individual is seen as have limited agency, and wherein a set of choices within any given context may be due to larger global forces such as the capitalist economy. His second point furthers the idea that the capitalist economy, as understood by Wallerstein, is defined by an unequal distribution of power that insures that the capitalist system works. The third point is critical to what makes the discipline different from other medical anthropologies. By stating that the theories that are used in the interpretation of

ethnographic data are artifacts of culture, anthropologists critical of their field were calling for a reflexive approach, which does not hold anything to be an essential truth. The fourth point made by Hahn is that the work done by critical medical anthropologists is a political and social act; it cannot be separated from the lives of the people that are studied or the context of the capitalist world economy.

Critical medical anthropology is invested in the political aspects of its research, including considering the colonial heritage, power dynamics, and advocacy involved the study of populations (Singer 1995). This area of research considers how the rise of structural adjustment programs and the dynamics of world economic power contribute to the structural inequalities and violence faced by marginal populations.

The concept of structural violence is important within critical medical anthropology as it helps to expand the notion of illness and healing as aspects of a cultural system that is shaped by global capitalist economy.

“Structural violence is the natural expression of a political and economic order that seems as old as slavery. This social web of exploitation, in its many differing historical forms, has long been global, or almost so, in its reach... Our job is to document, as meticulously and as honestly as we can, the complex workings of a vast machinery rooted in a political economy that only a romantic would term fragile. What is fragile is rather our enterprise of creating a more truthful accounting and fighting amnesia” (Farmer 2004: 317).

These webs of exploitation, which are historically based, forgotten or obscured, occur globally. Since structural violence may manifest itself in different ways for distinct groups of oppressed persons, it is important to understand and expose the historical and modern processes that have created and reinforce it.

The use of Johan Galtung's interpretation of structural violence is often important for contextualizing the lives of those studied by anthropologists. Structural violence is perpetrated by the system that creates the conditions of violence. Violence may be indirect in action and in the effect of the action, and may not be physical. The social injustice, and the historical and contextual dynamics of the structure that allow for structural violence and cause structural violence are what critical medical anthropologists and anthropologists of birth are interested in. Anthropologists are also interested in how they can frame structural violence within the larger system of capitalism and become advocates for the people who are affected by structural violence.

Anthropological work in the field of childbirth and reproductive health incorporates perspectives of Western midwifery, ethnomedical, biological, and social science perspectives into the understanding and framing of the biocultural process of childbirth. This multi-sourced, multi-vocal, and ethnographic approach helps to give a perspective on birth that is not solely bound in the bases of critical medical anthropological theory. Marxist notions of production and women's abilities in reproduction as related to social production are important in the larger context of economic and structural inequalities which cause the failings in the system that anthropologists such as Paul Farmer wish to address (Farmer 2004). The focus on embedded observation and participation of the ethnographic research process brings large scale concerns of economic and structural violence into the particular in a way that is grounded in both the biological process of birth that is inseparable from the cultural processes.

Critical medical anthropology advocates for a multi-scalar approach that considers sociocultural phenomena from the perspective of the individual to the global level of social analysis. The highest level is that of the macro-social, which encompasses the capitalist world system (Baer 1997). The next level is the intermediate-social that encompasses the interactions of health care administrators (Baer 1997). The micro-social level looks at interactions between practitioners and patients (Baer 1997). The individual level, the lowest, relates to the person and their sociobiological experiences (Baer 1997).

The focus on capitalism as a means of understanding the plurality of medical systems throughout the world can be considered necessary by social scientists as a foundation of critical medical anthropology. Marxian political economy and dependency theory also influence critical medical anthropology. This influence can be seen when considering structural violence (Hahn 1995, Baer 1997: 1563).

Scholars have argued that a focus on structure and capitalism may problematically leave out the role of individual agency. In order to correct for this, I draw on interpretive and symbolic anthropological theories. Such approaches draw on a framework that uses thick description to account for social actors' cultural meanings (Des Chene 1996). These nesting levels all help to create an interpretation of ethnographic data that incorporate the individual and their interactions, while placing their interactions in sequentially larger frames of social and global systems. Additionally, the informants' voice is necessary for gaining an emic understanding of changes wrought to the localized ethnomedical system of midwifery through the increase in biomedical midwifery in Ghana.

Interpretive Approach

The interpretive theoretical approach to medical anthropology has also been called ethnomedical theory due to its origins (Bear 1997). There is an early link to linguistic anthropology and the use of ethnonyms, in this case the names for indigenous plants and medicinal items. Through this research, anthropologists began to write about pluralistic medical practices, often including locally-based medical/health systems and the Western biomedical system. This early interest in folk medicines is also known as the cultural interpretive theory (Bear 1997). Within this approach, Kleinman's "Explanatory Model" is often used as a means of understanding the medical process (McElroy 2003). A main criticism of this approach is that it is not critical of the power relationships between the anthropologist and community, and among the often-opposing medical systems involved (Baer 1997).

However, an interpretive approach is grounded in the wider cultural system of the people being studied. The perspective that illness and disease are part of and understood within larger networks of cultural meaning helps to situate individual and group experiences within a health event. Within an interpretive framework the reasons for illness and disease, and health events are just as important as the healing and treatment. For example, the reason for a headache is as meaningful as the headache itself. The link between causality and treatment is not necessarily one that a biomedical perspective would accept. In these instances causes could include things such as spiritual sickness, or magic. The aforementioned headache could have been caused by a neighbors use of magic against the person with the headache. The concept of magic is not accepted in the

biomedical system but is paramount to understanding the local interpretation of this health event. The interpretive approach has been more recently called “an alternative theoretical position, one that begins from a recognition of the fundamental epistemological irreconcilability of anthropological and dominant biomedical ways of knowing and seeing” (Johnson and Sargent 1996, 53). This perspective in combination with Kleinman’s “Explanatory Model” helps to illuminate just how people conceive of the medical system as a part of their cultural system. This point is shown through Kleinman’s interview consisting of eight basic questions that elicit personal understandings of a health event. Kleinman’s interview consists of the following questions: What do you think caused your problems? What do you call your problem? Why do you think it started when it did? How does it work? What is going on in your body? What kind of treatment do you think would be the best for this problem? What frightens or concerns you most about this problem or treatment? This explanatory model calls for more than just a list of ethnomedical terms, or individual thoughts on a health event. The interaction of the practitioner, the patient and the medical system within a specific cultural context are all key to gaining a holistic picture of the ethnomedical system. Kleinman found this useful for cross-cultural comparison with other ethnomedical systems including the Western biomedical system. (Kleinman 1978).

World-Systems Theory

Wallerstein’s world systems theory states that the capitalist system is overarching and affects all happenings throughout the world. The system is predicated on the notion of a hierarchy of the unequal system of core and periphery (Shannon 1996, Bernard

2000). This theoretical approach is congruent with that of critical medical anthropology in that it allows for analysis on the local level to be interpreted at the global level (Shannon 1996). World systems theory also allows for a clear linkage between the policies of the Ghanaian government, neoliberal economic policies, and the United Nations Millennium Development Goals. World-systems theory allows for connections to be drawn between reproductive health care of individuals, health care policies and larger global humanitarian and economic policies.

Feminist Theory

Feminist theory is used as a means to avoid falling into heteronormative and androcentric interpretations and assumptions (Geller 2006). This perspective allows one to see more readily that notions of gender are clearly linked to cultural meanings, discourses, and practices that define and reinforce themselves (Geller 2006). This can help to place women and the uniqueness of their experiences more clearly in the larger frameworks of the world system. The use of feminist anthropological perspective to inform the analysis the data collected during research and as a means of understanding the relationship of women to reproductive health care, and perceptions of care, as well as policies directed at women's health.

Intersectional Analysis

Feminist theoretical perspectives often use an intersectional analysis. The closely related social sciences of sociology and anthropology have often been at odds, due to their data sets being highly quantitative and qualitative respectively. Feminist thought and theoretical influences permeate cultural (and other forms of) anthropology. The use of

intersectionality and its links to Patricia Hill Collins, a black feminist sociologist, has lead some anthropologists to be defensive of the anthropological position. Hill Collins feels that knowledge created by those who occupy the intersections of oppression is vastly different than the knowledge created by the majority of the higher educational system. Many anthropologists feel that an anthropological framework already incorporates similar principles. This has lead to a rare explicit use the work of Hill Collins in relation to the framework of intersectionality. The use of intersectional analysis is not rejected outright by anthropologists, but is considered by many to already be a part of the anthropological perspective and need not be explicitly stated.

Several anthropologists have begun to explicitly talk about intersectionality as a framework for research and analysis. The work of Kaaren Haldeman is of particular interest as her work is on pregnancy and experience of intersecting oppressions of black women in the United States. She looks closely at the intersections of race, and particularly perceptions of class and gender as related to stereotypes of race. This intersectional approach helps show how these women understand their own positionality and how others position them (Haldeman 2009).

Anthropologists generally feel that the ethnographic method, and the tenets of holism, and cultural relativism have created, at least since the post-structural turn, space for analysis that was and is already intersectional. That is to say that holism, the anthropological focus on gaining multiple perspectives, including the emic or cultural subject's perspective to work in combination with the etic, or anthropological observer's

perspective, creates a broader understanding of the positionality of a subject within a cultural context.

An intersectional analysis is one that creates a space for understanding multiple dimensions of identity to more fully comprehend the oppression of the persons that inhabit those categories. The most common axes for intersectional analysis are race, social class, gender, age, sexuality, and ethnicity. The main goal of this approach is to move away from a single axis of analysis, which creates disparities between lived experience and cultural reality, and the analytical subject. An intersectional approach can help illuminate multiple perspectives on how a subject is constituted within a specific cultural context and these perspective fit into the larger power structures of society (Cho et al. 2013).

Cho et al. states that there has been debate among feminist scholars and sociologists about “whether there is an essential subject of intersectionality and, if so, whether the subject is statically situated in terms of identity, geography, or temporality or is dynamically constituted within institutions that are neither temporally nor spatially circumscribed” (Cho et al. 2013;785-6). From an anthropological perspective, the historical particularity of individual categories and normalization of race, class, gender sexuality, ethnicity, geography, and all other identities are specific to a location, a cultural group, and a time. The social context in which analysis is done is also a key aspect of understanding research interests and categories for anthropologists. The social context, that is the educational background, cultural norms, and current interests of the society as a whole, and of the researcher create a series of possible areas of interest and

subjectivities. These larger societal interests, subjectivities and biases, as well as those of the researcher are incorporated into the analysis and the audiences interpretation of the analysis. The researcher will always place their bias into their research and therefore it is necessary to state that bias as a means of creating a more extensive image of how the research was conceived, undertaken, and analyzed.

Using a variety of theoretical approaches a more holistic interpretation of reproductive health care can be produced along with perceptions of care by Ghanaians, themselves. Critical medical anthropology is the overarching framework that orients the data collection for this thesis. The incorporation of interpretive anthropology is a means of elaborating emic perspectives and creating thick description from the data. The incorporation of feminist perspectives specifically through the use of intersectional analysis is done to help contextualize observed interactions as well as an advertisement. Together these theoretical orientations help to create a multi-scalar interpretation of the data from the individual to the global.

Chapter 4. Research Methods

The following research was conducted from June to August 2013 for my Master's Thesis in Cultural Anthropology at the University of South Carolina. The ethnographic research conducted as part of this project consisted of interviews, participant observation and policy research. In order to gain a fuller understanding of the state of childbirth and reproductive health care in Ghana the research undertaken during this project incorporated a multi-sited approach. The multi-sited approach allowed for comparison of rural and urban differences in practice, policy, and understanding of reproductive health. Policy and archival research was initially a formidable part of the research plan but proved to be challenging. The semi-structured open-ended interviews were conducted with eleven women who were pregnant, had given birth within the past year, or women that fit both criteria. Semi-structured open-ended interviews were also conducted with nine reproductive health professionals. Interviews with women were conducted at each of the three field sites. Participant observation varied by location and includes the markets and clinic. Grounded theory was used during the analysis of data gathered during fieldwork.

Ghana consists of ten regions with research conducted in the following three: the Greater Accra Region, the Brong-Ahafo Region, and the Upper West Region. Each of Ghana's regional capitals has a Ministry of Health and Maternal and Family Services and the national headquarters in Accra. Initially the background research which would

accompany the ethnographic component of this research included archival and policy research. This proved to be next to impossible while in the field due to the bureaucracy of information storage and availability. Also likely influencing my lack of access to the archives was my position as an American, female graduate student. Archival research on government policies affecting women's health and specifically reproductive health done at the Ghanaian National Archives in Accra, Ghana was impossible. The Archives sent me to the Ministry of Health. The Ministry of Health subsequently sent me to Maternal and Family Services. Throughout the course of this research continual efforts were made to collect policy documents including the Health Sector Development Plans and the accompanying reports on their implementation.

The ethnographic portion of this research was conducted at three main sites. Ghana's capital, Accra; the capital of the Brong-Ahafo Region, Sunyani; and a small village in the Upper West Region approximately a one and a half hour drive from the regional capital of Wa (Appendix 4).

Participant observation consisted of daily visits to markets, riding trotros (privately own shared transportation common throughout Ghana), time spent with my host among friends and family, as well as other social engagements, and time spent at two clinics. Accra is a massive and congested city with infrastructure that at the time of my research seemed unable to handle the daily influx of people hoping to find work and educational opportunities. The city of Accra does not have adequate housing for its ever-growing population, nor does it have enough clean water, or consistent electrical service. The hustle and bustle of several markets in Accra were sites of participant observation

which consisted of walking the markets, buying goods, talking with local women and simple observation. Women make up the majority of market sellers. The majority of these women do not make a substantial income from selling and are expected to work throughout their pregnancies and care for their children in the markets. These occurrences make the markets of Accra a prime location for observing women and speaking with them informally on the subject of reproductive health. Market women in Accra are also more likely to have some command of English, which allowed me some ease of communication. The level of English proficiency held by different members of Ghanaian society varied widely. My hosts and other informants made general statements to me about which groups of people would have different levels of English speaking ability. Largely these generalizations were reflective of my interactions with Ghanians. My ability to speak Twi, improved slightly during my time in Ghana but was limited to making purchases in the market and greetings. My lack of ability to fluently speak any language in use other than English severely limited understanding of some interactions, as well as my ability to conduct interviews.

Observation occurred in the city of Sunyani, but this research was not directly related to the use of reproductive health care. The main market of Sunyani is crowded with narrow paths, and is dimly lit due to being shaded by corrugated metal roofing. This market was also the site of informal conversations with local women regarding pregnancy, birth and care. Here observation was conducted by watching women care for their infants while selling. The village in the Upper West region, due to its small size, only held market every six days. Luckily, my host in the village lived directly across from

where the market was held. This allowed for similar observations through direct contact and informal conversations as was done in Accra and Sunyani and also allowed for prolonged yet unobtrusive observation from my host's home.

Observations, and informal conversations can help create an awareness of reliability or lack of reliability of interview data. Informants may also misunderstand questions asked by researchers or health personnel leading to answers perceived as untruthful. Some informants may simply be worried about how the information they give the researcher will be used and therefore are guarded when answering questions. Given the multitude of reasons a researcher may receive information that does not reflect the actual practice of informants it is important to use a mixture of interview and observation data as a constant validity check (Bernard 2000: 395).

Participant observation was not limited to the market places. Other observational data is from two locations, an urban teaching clinic in Ghana's capital Accra, and the rural Upper West Clinic. The analysis of interactions is largely concerned with the ways in which an intersectional analysis of individual interactions can be placed into the larger framework of structural suffering as understood in critical medical anthropology. A large portion of time was spent in the two clinics. No data was collected from a clinic or other health facility while in Sunyani, in large part due to time constraints.

The clinic in Accra is part of a large teaching hospital complex on the edge of the city. The clinic specializes in maternal and reproductive health. Women may only attend this clinic by referral. This does limit the population of women represented at the clinic to only include those who are having some problem with their pregnancy, emergencies in

labor, and those that had problems during childbirth. Seven days total were spent observing this clinic. The first day of observation included a guided tour of the clinic, which lasted for approximately an hour. This tour was provided by one of the senior nurses. The majority of observation in the referral clinic was direct observation of the sitting area in the center of the clinic. Informal conversations with women waiting to see a health professional occurred and informed the later semi-structured interviews that occurred at this clinic.

The health clinic located at the Western edge of the village in the Upper West Region was a site of similar observation. This clinic is a general health clinic, which also offers the services of a midwife. The clinic is open 24 hours for emergencies although the majority of the patients are seen during the morning. Observation of the village clinic included observing patients and health professionals. Informal conversations were conducted only with the health staff as the majority of patients did not speak English. The small size of the clinic and limited number of staff allowed for an ease in building rapport. The participant observation at this clinic included helping the midwife with patients, helping in the consulting room and shadowing the midwife. The midwife had me feel for contraction of the uterus, weigh infants, and take other noninvasive measurements from mothers and infants. In the consulting room I took down patient information from the patients personal record book into the clinic log and noted the tests and diagnosis for each patient. The help provided in the consulting room was intended as a way of making my presence less obtrusive but also allowed for prolonged observation

of individual contact between patient and health professionals. Interviews of health professionals also occurred at the clinic.

The observation of women, specifically those pregnant or with infants, occurred everyday and in nearly every social setting. Riding in the cramped quarters of a trotro allows for conversations about reproductive health through commenting on the cuteness of a baby. These same cramped quarters also provide transportation for women to clinics and other health services. Several social functions of note provided opportunities for further participant observation and informal interviews and conversations regarding birth, pregnancy and women's health. In Sunyani several meetings with the Queen of Sunyani allowed for the development of a conversation on the state of women's health care. A meeting with the chief and another with local businessmen in the village also provided some insight into the local understandings of women's reproductive health. Informal conversations informed the direction of the formal semi-structured interviews and contributed to dropping the free listing activity on midwifery planned as part of the formal interviews. The free listing activity was initially intended to help develop my understanding of culturally salient ideas surrounding midwifery but from informal conversations it appeared that many women did not differentiate when talking about biomedical midwives, doctors, nurses, and other health personnel.

The conducting of formal semi-structured, open-ended interviews occurred in the clinic in Accra, the village clinic, and in women's homes. Interviews in Accra were limited to only those women and health service providers attending and working at the referral clinic at the teaching hospital. A total of six women were interviewed at the

clinic, two pregnant women, their receiving services, and four health care professionals. The women, while given the choice to do the interview in a locale of their choosing, wanted to do the interview immediately in the busy clinic. Refer to Appendix 1 for a list of interview questions for the childbearing women. The health care professionals interviewed included the DDN or head nurse, a health worker, a senior midwife, and a nursing student doing work in the clinic for educational credit. Refer to Appendix 2 for a list of interview questions for the health care professionals.

A total of five interviews were conducted in the Brong-Ahafo Region. Four of these interviews were done with pregnant women or recent mothers in Sunyani. The fifth interview took place approximately thirty kilometers away in a village with a former traditional birth attendant. The interviews of the childbearing women in Sunyani took place in three locations, the home of one woman, and the work places of the three remaining women; a local primary school for special needs children, and a local municipal building. The interview with the traditional birth attendant took place in the common courtyard outside of her home that was shared with her adult children. The traditional birth attendant spoke only Twi, and my host translated the interview with several interjections from her family members who spoke English. The interview schedule used for the traditional birth attendant was a slightly modified version of that used in the interviews with all other health care professionals. All research participants were given pseudonyms to protect their identities and privacy.

Formal interviews in the Upper West village total nine. Four of these interviews were conducted at the local health clinic with health care professionals. The midwife, two

public health nurses, and a nurse were interviewed. The midwife's interview was conducted in the waiting and records area of the clinic, while all others were private being held in the consulting room or the antenatal consultation room. The five local childbearing women were interviewed in their compounds throughout the north side of the village. Family, friends and children were present during these interviews and on a number of occasions interjected and/or were deferred to in order to answer the interview questions. Also present at these interviews was my host in the village, a Peace Corps volunteer. None of the local women with infants or that were currently pregnant spoke English. The husband of the first woman interviewed of these women was used as a translator for all five of the interviews. The use of a man, and specifically a local man, to conduct the interviews may have lead women to be cautious about how they answered questions about the sensitive and gendered topics of pregnancy and birth. From my observations Ghanaian women to some extent expected to discuss these topics with male medical personnel but not with other men including their spouses.

As a matter of course all interviews included demographic data including age, ethnicity, highest level of education, religion and location of birth. The interview questions for the childbearing women and for the health service providers changed slightly through the course of the research. The addition of questions regarding local issues, and other areas of interest related to reproductive health which were of concern to Ghanaian women was informed by earlier formal semi-structured open ended interviews, informal conversations, and participant observation.

Notes were taken during each interview including initial impressions, mannerisms, and the demeanor of the woman being interviewed. These notes are used as a means of providing greater insight into each woman's responses. Any interactions with any of her children or other persons during the course of the interview, directly before or after were also noted.

Prior to each interview oral consent was gained from each person being interviewed. As part of the consent process forms were given to everyone to read, although for each interview the form was explained orally and the informants were given the option to keep the form or return it. The expressed verbal consent was used as a matter of keeping the anonymity of the informants. After consent was given, to be interviewed the informants were asked directly if the interview could be recorded, with the provision that the recordings would not be made public. All informants except the head nurse at the Accra clinic gave consent to be recorded. All interviews were recorded with a handheld voice recorder and/or alternatively with the recording function of an iPhone 4s. Interview transcriptions were accomplished on a MacBook Pro using Pages, iTunes and Dragon Dictate. All interviews, field notes, and other documents have been analyzed using Atlas.ti qualitative coding software.

The initial intent was to make informant selections based on snowball sampling for the childbearing women. In the Accra clinic this was not possible due to the busy nature of the clinic. While women were given the choice of location to be interviewed, they chose the clinic as many of them were not local and therefore were also not able to recommend other locales for interviewing. The selection of women in the clinic was not

entirely random. Based on casual conversations and pleasantries, I became aware that a large portion of the women did not speak English. Therefore selection was limited as no translator was available. Nurses and other health professionals used as informants in both the Accra and village clinic were selected largely based on the workload of the individual. It should be noted that the midwife at the village clinic was often away when I was at the clinic and so we devised a schedule for her interview and for my observation of her with her patients.

Informant selection in Sunyani began through a meeting with my host's friend from university. The wife of this friend was the first local childbearing woman to be interviewed in Sunyani. Following a modified snowball sampling methodology she recommended a fellow teacher and two women that worked with her husband. Due to the limited amount of time in the Brong-Ahafo Region all three of her informant recommendations were taken. This is distinct from more common snowball sampling methodologies in which one recommendation would have been taken and then the recommended person would suggest the next possible informant. I purposefully selected the traditional birth attendant for an interview. My host mentioned that there were several traditional birth attendants in his home village just outside of Sunyani. Of the three TBAs recommended, only one was still alive and living in the village.

The formal interviewing process and the selection of informants was more complex in the Upper West village. The small size of the village, and the lack of English speakers were the two main factors in determining whom to interview. The limited number of health service professionals available at the health clinic and their busy

schedules determined who would be interviewed. Due to the size of the village and its proximity to the clinic, interviewing women at the clinic was not an option. If these women were to be overheard by the clinic staff it could affect the treatment they receive. Many of the women at the clinic came from villages that were six or more hours walk away. Therefore, interviewing them at their homes was not a viable alternative to interviews in the clinic itself. While serving a large area, the clinic did not have more than one to three antenatal or post-natal patients per day.

Language Barrier

The language barrier between many of the women and myself caused a multitude of difficulties that should be explored as a means of full disclosure of the data collected. Two aspects of language use are often referred to in this research are the use of a translator and non-verbal communication. My inability to speak any of the local languages lead to interviews that did not require translators, which in turn lead to me interviewing more highly educated women. The women interviewed in the Accra clinic were the most highly educated and tended to have the greatest amount to say regarding the care they wanted. It is difficult to say if this is due to being able to communicate more readily with me, or having greater access to information related to reproductive health care.

The language barrier was also a determining factor in the selection of women to interview. No women in the village spoke enough English to be interviewed by me and I did not know how to say more than a basic greeting in the local language. This lead to my reliance on a male translator for interviews. He was fluent in English as well as Wali, the

local language. The language barrier also prevented me from finding women to interview without the help of several local men who spoke English. One man went through the village records and produced a list of women who had given birth in the last year. This list of approximately ten women included the wife of the man who was selected to be my translator based on his high level of fluency in English. Interviews started with this man's wife, then another woman whose house connected to the same courtyard. The selection process for the next three women was based on proximity to the translators compound. If the woman was not home, we went to the next woman on the list whose home was closest in proximity to our location.

Field notes were taken daily. Many field notes in the form of jottings were taken during daily activities, including market visits, trotto rides, and informal conversations. The jottings were expanded upon each evening. More extensive notes were taken during and directly following interviews, and in the course of observation. Notes of detailed interactions of health services providers with women were also taken. Detailed layouts of the clinic in Accra and the health clinic in the Upper West were created in the form of hand drawn maps. These maps help me recall details of interactions and events that occurred in these spaces.

Other forms of data were collected throughout the course of the research including photographs and notes on local and regional literature. The use of literature passages to exemplify local interpretations and awareness of subjects will be used throughout the results and analysis chapters to reinforce occurrences and ideas. The main form of data collected outside of narrative and text sources are photographs. These

images vary in content and impact, but they did help me to understand the kinds of reproductive health care Ghanaian women are exposed to. Photos of women and babies predominate in the photos. Many of these images show women working while carrying their infants. Another category of photographs are those of signs. These photographs are of the signs for birth related services and businesses throughout Accra, Sunyani, and Kumasi (the second largest city in Ghana which was a stop on the bus routes north), and for advertisements or public service announcements.

Grounded theory was used as a means of data analysis and influenced data collection through the modification of interview questions. Grounded theory consists of the identification of categories and concepts that emerge from the text of interviews, field notes, and participant observation (Bernard 2000). This theoretical approach is used to link identified categories and concepts to more formalized theories. Coding for themes with an inductive approach will also be done during the analysis of the data (Bernard 2000). The grounded theory approach has been useful in understanding how women perceive the care they are receiving through reproductive health care programs. A grounded theory perspective has also been useful in answering many other questions and creating new and surprising questions and answers. This approach has also been helpful in bringing out important concepts that were new to me and that I was unaware were important for Ghanaian women and reproductive health care providers.

There are a number of ethical concerns that had to be addressed in the during the course of the research. An application to the University of South Carolina Institutional

Review Board (IRB) was submitted and approved as this research involves human subjects. Oral consent was obtained from each informant, following a detailed discussion of the information available on the written consent form that was also provided. The use of oral consent was to insure the anonymity of the informants and to protect them from repercussions within their community and/or from the health service providers. Women and health service providers were only interviewed if they expressly gave consent. The names of informants were not used in the notes taken during interviews, and were avoided during the course of the interview so as to prevent the recording of the name. The copies and photographs of all handwritten and hard copies of typed notes, transcripts and flash drive containing backups of all information related to this research is kept in a locked desk. The computer on which these files exist is protected with a password, as are the individual file folders. The original versions of the audio files, on the voice recorder and iPhone 4s, have been deleted. Every effort to protect the privacy and security of the interviewees continues to be taken. The name of the village in the Upper West region have been replaced by pseudonyms in order to minimize any repercussions from statements made during interviews. The name of the clinic in Accra will also not be used explicitly, nor will the name of the village in Brong-Ahafo in which the traditional birth attendant lives.

The data for this thesis was collected through interviews and participant observation. The interviews consisting of health care practitioners and local Ghanaian women are situated through the use of field notes, photographs and observation. The limitations of my language ability and my use of male translators for some of the

interviews is discussed in detail. Due to reproductive health being a topic largely comprised of sensitive subject matter, pseudonyms and oral consent were used to protect informants. Chapter 5 contains details on the organization of data collected during this research.

Chapter 5. Results

The interviews for this project were conducted in the homes of the women, in the clinic, and at their place of employment. I was able to see the environment in which the women lived or worked through participant observation of them and their children. This helped me to gain insight into their personalities. The interviews shed light on the similarities across all births as well as those that were centered in each group of women. A number of themes became apparent as important factors in the women's access to information and in their decision making process.

Women (Patients)

For all of the women interviewed basic demographic information was gathered during the course of the interview. Table 5.1 shows this information and informs many of the themes discussed in following section.

Table 5.1: Childbearing Women and Demographic Information

Arranged by location, and order in which interviews were conducted at each location.

Location	Name	Religion	Socio-economic status	Language	Children	Marital Status	Birth Location	Cesarean
Sunyani	Ama	Christian	Middle class	Twi/ English	1	Married	Clinic	No
Sunyani	Akosiwa	Christian	Middle class	Twi/ English	1	Married	Clinic	Yes

Location	Name	Religion	Socio-economic status	Language	Children	Marital Status	Birth Location	Cesarean
Sunyani	Aba	Christian	Middle class	Twi/English	Pregnant	Married	Clinic	-
Sunyani	Adwoa	Christian	Middle class	Twi/English	1	Married	Clinic	No
Accra	Esi	Christian	Upper Middle	Twi/English	1/pregnant	Married	Clinic	No
Accra	Abenaa	Christian	Middle class	Twi/English	2/pregnant	Married	Clinic	No
Upper West	Rayyan	Muslim	Middle class	Wali	1/pregnant	Married	Clinic	No
Upper West	Nazira	Muslim	Middle class	Wali	1	Married	Clinic	No
Upper West	Marowa	Muslim	Middle class	Wali	3 (twins)	Married	Clinic/Home	No
Upper West	Fahimeh	Muslim	Middle class	Wali	2	Married	Clinic/Home	No
Upper West	Abia	Muslim	Middle class	Wali	2	Married	Clinic/Home	No

Accra

Only two women were interviewed in Accra about their experiences and perceptions of care. This was largely due to the busy nature of clinic in which the participants were selected. The clinic is a referral clinic for women who are having difficult pregnancies or those who have had difficult pregnancies, labors, or problems with miscarriages in the past. The women at this clinic are from every region of Ghana and from a wide variety of socioeconomic classes. The women interviewed from the Accra clinic were interviewed in the large open waiting room in the center of the clinic. A number of women were approached about being interviewed but due to language barriers only brief exchanges occurred.

Education and Language

Both of the women interviewed in the Accra clinic were highly educated with at least some level of college. The first woman interviewed in Accra, Esi held a Masters degree and a high paying position within the city. She was unwilling to state the exact nature of her profession. The second woman interviewed in Accra, Abenaa had some college education but was not currently employed. The two participants from the Accra clinic are not representative of the general patients in the clinic. The language ability of each of these women determined that they would be interviewed. As stated previously, I did not have any proficiency in any Ghanaian language, causing me to rely on women who could speak English fluently or to use a translator who was fluent in English. After having short and often strained conversations with several women in the clinic it became clear that I needed to look for women who were more likely to speak English to obtain a full interview. Women who have lower levels of education were not intentionally left out of this research but it was necessary due to my lack of ability to speak their language. The higher levels of education in Ghana are conducted largely in English, therefore women with more education would have higher levels of English proficiency allowing them to communicate with me. The two women were both dressed in western-style clothing, that appeared to be new, and could be considered to be business casual which locally is often understood as a sign of being highly educated and therefore having a high degree of English proficiency.

Religion

Two of the women interviewed in the Accra portion of this study were both Christian. Both of these women also made it clear that they were not Catholic but did not clarify further as to the specific Christian denomination.

Similarities and Differences Across Accra Women's Experiences

The two participants from Accra also shared other similarities including both being married, currently pregnant, and having only given birth in clinics or hospitals in the past. For both women this was not their first pregnancy. This was the second pregnancy for Esi. She was sent to the referral clinic from a private hospital. Esi was the only woman in the study to use a private facility, and she also appeared to be the wealthiest of all the women interviewed. Conversely Abenaa was having her third child but her seventh pregnancy. She was referred to the clinic by a smaller clinic in Accra after having four miscarriages in a row. Abenaa had not heard of the United Nations Millennium Development Goals while, Esi had heard of the UN MDGs. Abenaa discussed why she used a public clinic “the women who use private hospital are showing off. Public clinics are equal to private. These women want status. They send them to this clinic if they are having trouble. You see, I was sent here. I didn't need to spend more money to have them just send me here.” When asked if women have more options at private clinic she stated that only some clinics had more options, but the quality of equipment and safety were on par with the public hospitals. Abenaa's statements show that the prestige of using private services affect some women's choices for care. Esi also

stated that she preferred the care of male doctors to midwives, a sentiment echoed by Abenaa. Additionally, both women were of the Akan ethnic group - the largest ethnic group located largely in the South of Ghana. This proximity to more highly developed infrastructure may have contributed to why both women with higher levels of education were of the Akan ethnicity.

Sunyani

A total of four women were interviewed while in Sunyani, other than the TBA. These women were interviewed in three different locations. The first woman interviewed, Ama, was in her home while her young son and husband were outside talking with my host. I met Ama through my host, Kofi. I was introduced to a friend of his, who informed me that his wife had recently given birth after asking about my research. Ama and her husband helped in snowball sampling to find the three subsequent women to be interviewed in Sunyani. The third participant, Akosiwa worked with Ama and was interviewed at the school where the two women worked. Ama's husband suggested the third (Aba) and fourth (Adwoa) participants, both of whom were secretaries at his place of employment. Both of these women were interviewed at the government offices where they worked.

Education and Language

All four women from Sunyani had at least a secondary school education. Each woman also either had tertiary education or other vocational training. Ama and Akosiwa shared similar educational backgrounds as they shared the same position within the school where they were employed. Their tertiary education gave them a high proficiency

in English, and allowed them to work with special need children. Aba and Adwoa both had training in secretarial work, and worked in a Governmental office. In Ghana all government business is conducted in both English and Twi, as they are the two official languages. This led to the conclusion that English fluency was a requirement of the positions held by Aba and Adwoa. Each of the women also spoke Twi while Adwoa also spoke another language but she did not mention what it was.

Religion

All of the women interviewed in Sunyani were Christian. Both sets of women who worked together self-identified as practicing the same religion. Ama and Akosiwa who work in the school identified themselves only as Christians, while Aba and Adwoa who work in the office identified themselves as Catholic. Those who identified themselves as Catholic felt the need to differentiate themselves from other Christian denominations. This self-identification may be in part due to the smaller number of Catholics in Ghana as compared to Protestant and Pentecostal Christians.

Similarities and Differences Across Sunyani Women's Experiences

The women interviewed in Sunyani shared other similarities including being married. Ama, Akosiwa, and Adwoa all had one child under the age of one and were not currently pregnant. Aba was currently pregnant with her first child and is the only woman interviewed who had yet to give birth. Aba was pregnant with her first child and stated that “yes, I am going to antenatal. Clinic is where you learn about things... they say eat fruit. My husband makes sure we have fruit. He wants a son.” Aba was nervous about labor and delivery. She also stated that the nurses at the regional hospital were the best.

“My husband wants me to go there [the regional hospital in Sunyani]. There is a clinic much closer but I don’t go, go to antenatal. I am happy to go to the hospital.” Aba’s statements made it clear that her husband had a great deal of influence over the reproductive care she received.

Adwoa’s birth experience was the most different from the other interviewees. Adwoa was originally from the Northern Region of Ghana, and had had her child in the hospital there. She had a difficult labor and required a C-section. Aba and Akosiwa had no knowledge of the UN MDGs, but Ama and Akosiwa had heard of the UN MGDs. This lack of knowledge related to the UN MDGs is not necessarily reflective of a complete lack of knowledge of the impacts resulting from the UN MGDs. Akosiwa stated that trying to meet the goals had made birth safer for women in Ghana. She also stated that this helped to put more information about birth out in the public for women who wanted it. Both Ama and Akosiwa stated they had seen television programs on childbirth that had given them very good information. Akosiwa specifically stated that when she told her doctor that she did not want to give birth in ‘normal’ position (lithotomy) and wanted to squat as she had seen on the television program. She was told by her doctor this that was not an option and was in fact very unsafe. In response Akosiwa said “I just kept quiet after that. Did as doctor, as nurses told me. I did not want to make things hard.”

Upper West

A total of five women were interviewed in a small village in the Upper West Region of Ghana. Each of these women was interviewed within the walls of her family

compound. Their children and other family members surrounded them during the interviews, which were conducted with the help of a male translator.

Education

The women of the Upper West village all had very low levels of education in comparison to the participants in Sunyani and Accra. Of the five women interviewed in the Upper West Village only two of them had any formal education. Three of the women, Marowa, Fahimeh and Abia had non-religious education. The other two women, Rayyan and Nazira were sister-in-laws and had both finished primary school. Only one of the women interviewed had finished primary school and had attained some secondary schooling. This greater level of education allowed Nazira some English competence, but she was not proficient enough to be able to adequately conduct the interview in English. She was able to greet me, but she did not feel comfortable enough with her English ability to have me interview her in English. It appeared more that she wanted to greet me in English because it made me aware of her education. Nazira had a higher level of English language ability than many of the women in the village, which her husband had mentioned to me prior to the start of the interview. During the interview Nazira made it clear that her English ability was a source of pride for her and her husband.

Language

Each of the interviews conducted with local women about their birth experiences required a translator. Each of these women spoke Wali. Nazira had an extremely limited knowledge of English. Nazira's husband was the translator for her interview as well as my interviews with Rayyan, Nazira, Marowa, Fahimeh, and Abia. The use of a male

translator had an impact on the way women would speak about pregnancy and birth. The use of a male translator created some tension between the female specific processes I was asking about and the man translating their answers. While the use of a male translator was unavoidable it was also detrimental. If a female translator would have been used the women interviewed would have likely been more comfortable discussing the sensitive subject matter. All of the village women were hesitant to answer questions, and often simply nodded their assent to questions related directly to labor and delivery.

Abdula, the translator seemed very proud of his wife's limited English ability. Perhaps this was because it set her apart from not only the other women interviewed but nearly all women in the village, save for the nurses at the clinic and several of the girls currently at the local primary school. The girls in the primary school also had limited English ability. They would often follow me as I passed the schoolyard, but were often at a loss for how to express themselves in English, other than saying that we were friends. Again, my lack of ability to speak Wali limited nearly all my interactions in the village. Although my host in the village, a peace-corps volunteer often translated basic questions from the community, her ability in Wali was also limited even after eight months of speaking it. Most of her interactions were with male community members who spoke fluent English.

Religion

The women interviewed in the Upper West were all Muslim. The village they live in is predominately Muslim, having at least ten mosques. The village also had one

Christian church but it was outside the limits of the village, as the chief would not allow it into the village proper.

Similarities and Differences Across Upper West Women's Experiences

The women I interviewed in the Upper West village shared both similarities and differences in their experiences. All of the participants considered themselves to be of middle class socioeconomic status. What Ghanaians consider socioeconomic class varies by location. In urban areas the middle class has access to more amenities, such as indoor cooking areas, television, etc. From my observations, and discussions with my host a middle class status within the village meant that one had a brick or mud-brick home with a shared courtyard, enough to eat, money to send the male children to school, and a small piece of land to farm. The majority of people in the village fit this description. Only a few people including the chief, and several men who owned large farms or other businesses would consider themselves upper class. The only people that appeared to fit into a lower socioeconomic status, as described by my host, were those without a home, or who had a mental or physical disability.

All of the women spoke Wali as their native language and each of them already had at least one child. Rayyan was the only one of the women currently pregnant. She had only one child, as did her sister-in-law Nazira. Fahimeh and Abia both had two children each. The remaining woman, Marowa had three children but only two pregnancies. Marowa's most recent pregnancy had been twins. Multiple births are not uncommon in the community. The local midwife, Adofo, mentioned several other multiple births. Marowa was unaware of her option to go to the clinic in the evening

when she was in labor. She expressed this through her translator with the statement “she was alone... No, no one was here with her. She labored alone. She said her husband was in the fields and it was almost night. She said, “you go to clinic in the morning. Morning.” When asked about taking the newly born twins into the clinic she stated with the help of her translator “nurses were angry with her. But, she, she says she could not wait. The babies came. They, then it was the night.” Marowa was chastised by the nurses about not coming to the clinic when she was in labor. The nurses had not explained to her that she could come to the clinic at anytime if she was in labor. In expressing her frustration Marowa stated through her translator “Don’t like to go clinic now. She says she will go to hospital in Wa next time.” Marowa’s experience would have likely been different had she not faced a language barrier with the clinic staff who largely spoke English and Twi.

Rayyan and Nazira had only given birth at the local clinic, while the other three women I interviewed, Marowa, Fahimeh and Abia, had given birth once at the local clinic and once in their homes. Abia was very vocal about not being offered instruction on antenatal care by the staff of the clinic. This is in contrast to the other four women, who stated that the staff had given them some amount of instruction related to antenatal care. Additionally, each of these women were married and had no formal employment, several of the women stated that at times they would help their husbands on the farms.

Data from all interviews

As stated above all of the women interviewed spoke at least one language other than English. The women in The Upper West being the only women who did not also

speak English fluently. All of the interviewed women considered themselves to be of a middle class socioeconomic standing except for the woman with the Master's degree who felt that she was of an upper middle class socioeconomic status. Each of the women interviewed considered themselves to be religious. The women interviewed in both Sunyani and Accra were of different Christian denominations and the women in the Village were all Muslim. Of the eleven women interviewed only three of them stated they had no formal education. All three of these women were from the Village. All eleven of the interviewed women had given birth in a clinic or hospital, but three had also given birth at home. The three that had given birth at home were alone or unattended by any form of birth practitioner. These same three women were those who stated they had no formal education. Only one woman stated she had received a cesarean section; this occurred in Ghana's Northern Region prior to her moving to Sunyani where she was interviewed.

All of the women reported that they were treated respectfully by nurses and doctors when asked directly. Each of the women also expressed concern for their treatment when responding to other questions during the interview. One woman made a statement to the effect that midwives treat women poorly and this is why she will only see a doctor. Another woman stated that she was not instructed on antenatal care but given the government issued antenatal care book and told to find someone who could read it to her. Ten of the eleven women had at least one living child, while the other interviewed woman was in the midst of her first pregnancy.

All of the women interviewed were married. Each of the five women in the village stated that they did not have a job, but would at times help in their husband's farming. In contrast the remaining six women were holding jobs in the formal economy. Only one of the eleven women used a private doctor, this was the woman who held a Master's degree and considers herself upper middle class. The remaining ten women used public clinics or hospitals for antenatal care and birthing services.

Practitioners

Table 5.2: Practitioners and Demographic Information

Arranged by location, and order in which interviews were conducted at each location.

Location	Name	Title	Education	Religion	UN MDG	Language	Gender	Ethnicity	Views on TBA
Sunyani	Nana	TBA	No formal education	Christian	No (awareness of)	Twɛ	Female	Akan	-
Accra	Yawo	Head Nurse	Nursing/midwifery school	Christian	Yes	Twɛ/English	Female	Akan	Negative
Accra	Kodjɔ	Senior Midwife	Nursing/midwifery school	Christian	Yes	Twɛ/English	Female	Akan	Negative
Accra	Efia	Nurse	Nursing school	Christian	Yes	Twɛ/English/Ga	Female	Ga	Positive and Negative
Accra	Fiifi	Nursing Student	Vocational nursing school	Christian	Yes	Twɛ/English	Female	Akan	Positive and Negative
Upper West	Joseph	Nurse	Nursing school	Christian	Yes	Twɛ/English/Dagbani	Male	Dagambura	Positive and Negative
Upper West	Adofo	Midwife	Nursing/midwifery school	Christian	Yes	Twɛ/English	Female	Akan	Positive and Negative
Upper West	Kaakyire	Community Health Nurse	Nursing school	Christian	Yes	Twɛ/English	Female	Akan	Positive and Negative
Upper West	Nkrɔmo	Community Health Nurse	Nursing school	Christian	Yes	Twɛ/English	Female	Akan	Positive and Negative

Reproductive health care providers were interviewed in all three locations. Table 5.2 lists the basic demographic information of care providers interviewed. Initially, I intended that all providers interviewed would be women and currently working in reproductive health in some capacity. However, in the process of conducting research I included one male in the study. The incorporation of a male nurse was due to my working closely with this him during my time volunteering at the clinic. Joseph was a male nurse working in the local clinic on the outskirts of the village in the Upper West Region. The first participant interviewed for the study, Nana, was a traditional birth attendant from Sunyani and was currently not practicing midwifery. Nana was the only health care provider interviewed in Sunyani due to time constraints. Four women, Yawo, Kodj6, Efia, and Fiifi, are reproductive health care workers interviewed who work at the referral clinic located in Accra. Other than Joseph all the health care professionals working at the clinic in the Upper West were women: Adofo, Kaakyire, and Nn6ma.

Accra

Each of the four health care practitioners interviewed in Accra were clear that they felt that birth was now the safest it had ever been in Ghana. They also felt that the UN MGD's were the root cause of the positive changes in the system.

The first interview in the referral clinic Accra was with the head nurse who was also a senior midwife, Yawo. Yawo is in charge of the daily running of the clinic, but the full extent of her duties was not clear to me. She was the only participant who outright refused to be recorded for her interview. She is a heavy-set older woman of Akan ethnicity and was distinguished as a licensed nurse and senior midwife based on her

uniform. She was admittedly Christian, but stated that churches sometimes offered women birthing services and that this was very dangerous. Yawo mentioned that Pentecostal churches were often those that offered birthing services. These churches were not affiliated with biomedical health care providers or TBAs. The churches that offer these services promote their services in favor of other options for their congregations. Yawo made it clear that many women had died or lost infants due to the practice of these churches.

Head nurse Yawo was also wholeheartedly against the idea of incorporation of traditional birth attendants (TBAs) into the biomedical system of reproductive health care. She felt as though this would have a detrimental effect on how women viewed the health care system and the quality of care that would be associated with it. She felt that the largest impacts of the UN MGD's were twofold; (1) in that more women were now going into midwifery and nursing (as opposed to all other occupations) and (2) that clinics were opening up in areas where better birth outcomes were most needed.

The next interview in the bustling referral clinic was with Kodjó, a nurse and senior midwife. She shared many of the characteristics of the head nurse Yawo, in that she was Christian, and made note of the unsafe birth practices occurring at churches. She also echoed the negative sentiment about TBAs that Yawo had made. This sentiment is largely in contrast to the views of the two remaining health care practitioners interviewed in the Accra clinic. Efia and Fiifi both felt that there needed to be collaboration among biomedical nurses, midwives, doctors and traditional birth attendants. Efia was a young nurse who had attended nursing school within the past few years and was hesitant about

how collaboration between TBAs and the biomedical system would work, but felt that it would be key to meeting the United Nations Millennium Development Goals 4 and 5 by 2015 deadline. Fiifi was a vocational nursing student at the local technical college who unlike nurse Efia did not want to end up working with birth or pregnancy. Her opinion on the use of TBAs within the biomedical system was the most favorable of those at the Accra clinic. Nursing student Fiifi felt as though a collaboration was not only possible but would be beneficial to the biomedical system, as well as to the populations of women they would serve.

The ethnic background of the practitioners interviewed in the Accra clinic was Akan, except for Efia. She stated that she was Ga, but that she was raised as an Akan. Her physical features were notably different than those of the other nurses who stated they were Akan. Efia herself had pointed out to me that her features were indicative of Ga ancestry. She noted her wide face and also mentioned “when people think of a Ga women, they think they are fat and loud.” This sentiment is also reflective of my host Kofi’s description of the Ga. He used a locally made television program with a large Ga women being belligerent on a trotro as an example of stereotypical Ga features and behavior.

All of these practitioners stated they did not feel that the ethnicity of a woman bore much on her decision-making and thought process regarding antenatal care and childbirth. Although, interestingly they each did make note that in the past ethnicity would have been more of a factor in the way women perceived birth and birthing services. Access to primary education through schools was cited as the reason that

women in Ghana now view birth in relatively the same way. Yawo stated that “all women now know it is safest to come to clinic for antenatal care” and when asked about ethnic differences she stated “no, ethnic group does not matter now, as when I was young.” Similarly, the much younger Efia stated “we now have education for everyone and this means all women, Ghanaian women, Akan, Ga, we see birth the same.”

Contrasting her own statement Efia did additionally say that it was possible that some very rural women may still be viewing birth differently based on their ethnic background. Perhaps in contradicting her own statement Efia realized that while education has lessened some of the perceived past differences related to birth that not all Ghanaian women have the same education. Her awareness of her ethnic background and how people perceive her may have lead her to remark upon rural and urban differences in access to care.

Health care practitioners in Accra held similar beliefs about the UN MDGs were improving women’s access to care. All of these women felt that the UN MDGs were influencing policies that lead to better training for reproductive health care professionals and more education for pregnant women. They nearly all repeated the same phrases. Efia indicate that “things are safest now, with education and training. Antenatal care is much more important now”. Fiifi similarly stated “antenatal care, yes, that is what the Development Goals have helped with... it is much better now”. The practitioners all stated that more general education for women and new nursing and midwifery training programs were the result of the UN MGDs. The similarities in their responses to these

direct questions seem to indicate that the UN MDGs are part of the discourse of the health care profession.

Sunyani

The first interview conducted in this area was with Nana who is a traditional birth attendant. While she was no longer attending births due to pressure from the local hospital, she was still relied upon by local women for her specialized reproductive ethnobotanical knowledge. Nana still provided local women with plants that were said to provide relief from menstrual cramps or keep women from having spontaneous abortions. This interview was done in the compound of her home with her family nearby. The interview with Nana, who was in her late seventies or early eighties, was conducted with a translator. My host, Kofi, offered to translate. He was from the area and fluently spoke both English and Twi (his native language).

Nana had never heard of the UN MGD's but felt that the prospect of helping women and babies survive was a good thing. She stated that she had become a midwife after falling ill. Nana stated that God told her it was her calling. Never having lost a mother or baby during delivery she was very proud of her work and felt that the nearby hospital had created undue stress on her and the women and babies she cared for. Nana stated through her translator that "she said, when they came [the hospital] they came to her. Asked her to stop, send her women to hospital, clinic... She says, they wanted her secrets, what she used. She refused. Take the woman from her home when it was time, they would send them by taxi." Nana also expressed her distrust in the doctors from the hospital. She stated, "women came home with no babies. None lost babies with me.

Never lost any babies, God wanted me to do my work.” Eventually the pressure from the hospital in Sunyani was too great and Nana said she stopped delivering babies.

Upper West

The first interview conducted in the Upper West Village Clinic was with the male nurse, Joseph. The three remaining interviews with Adofo, Kaakyire, and Nkróma were conducted over the next several days while I was volunteering in the clinic’s consultation room. They were also all conducted in the clinic during slow points of regular clinic hours. Nurse Joseph is from the Dagomba ethnic group. While the Dagomba are largely Muslim, Joseph is fervently Christian. He was from the Northern Region that is the most heavily populated with people of the Dagomba ethnicity. All of the other nurses interviewed in the Upper West were from the Akan ethnic group. Each of the four nurses including the midwife also reported that they were Christian of differing denominations. Nurse Joseph was very open and forceful with his religious beliefs in contrast to the other nurses who were substantially less forward with their beliefs. Both men and women proselytized in the streets of Accra, and Sunyani but Joseph was the most vocal of anyone I met in the village. While several other men in the village asked me to come to Mosque, none were so forceful as Joseph when he insisted on my attending a Christian Church. He was known to hand out religious booklets and pamphlets to the patients he saw. Nurse Joseph stated on one occasion outside of his formal interview that people only get sick because they do not truly believe in God. He also stated that his ultimate goal was not nursing or healthcare but instead to be a preacher in the United States.

Nurse Joseph stated on several occasions that he believed that Islam was a hindrance to getting information and care to women about pregnancy and childbirth. The other two nurses and the midwife made similar but less harsh comments about ethnicity and religion playing a role in women's understanding and lack of concern regarding antenatal and birth care. Adofo, the midwife stated that Muslim women are uneducated and "they don't listen to me. They listen to their husbands. What do those men know of antenatal?" Nkróma mentioned that she had a hard time working with the Fulani women, as they did not learn English, or Wali. Kaakyrie when asked about religion's effect on birth stated "Muslim's don't care for educating the girls. They just want wives and mothers. If they had more education this would be easier".

All of the health care practitioners interviewed at the Upper West Clinic had a nursing school education save for the Adofo. She started out as a community health nurse but returned to school to become certified as a midwife. Adofo serves as the midwife for the entire area serviced by the clinic. The last two people I interviewed, Kaakyrie and Nkróma were both community health nurses. This means that their job entailed them traveling to the different villages that the clinic was intended to serve. They would treat patients and teach the communities about hygiene, sanitation, and other medical issues. Nurse Kaakyrie and nurse Nkróma and the midwife Adofo were all very adamant about the need to incorporate traditional birth attendants into the system in which they worked. Nurse Joseph was the lowest educated of the nursing staff but was often regarded with the highest title of doctor due to his gender. He only held a 'basic nursing certificate' and stated his education was not as long as that of a community health nurse or a midwife.

Simply by being male he was assumed to be a doctor, while the female nurses higher in rank to him were often second-guessed by him and other men at the clinic. Kaakyire during her interview remarked in frustration that patients, especially male patients ignore her in favor of Joseph.

Observations

Provider-Patient Interactions

As a means of describing the social interactions between patients and practitioners the following vignette is of an interaction I observed first hand in the Upper West Village.

A young woman sits quietly with her daughter in her lap in the consulting room waiting for the male nurse clad in white to look at them. Her thin facial features, vibrantly-colored clothing, hairstyle, ear and septum piercings indicate that she is probably Fulani. Joseph the nurse mentioned these features as being distinctively Fulani aloud to the visitor in the room. He then made several comments about how the Fulani were a drain on resources and difficult to work with. The Fulani camp where she lives is several hours walk or a very bumpy and crowded moto ride away from the rural clinic in Ghana's Upper West Region where she and her young daughter have come for treatment. The nurse speaks to her initially in English, then in French, and finally in what little Wali he knows, the language of the majority of people in the local town. It's hard to tell if he does this for the amusement of the visitor or because he is required to. In other interactions with Fulani he spoke very little with them, simply grabbing hands or taking paper work from them. The Fulani woman clearly understood very little if any of what the nurse was asking, and based on his exasperated look while speaking with her, he assumed this would be the case.

He proceeded to look over the small girl who greatly resembled her mother, thin features mirrored on her small face. Taking the malaria test kit out of the individual packaging, opening the baggy with the blue sterile gloves and the lancet, he picks out the small green plastic cased lancet leaving the gloves in the baggy as he throws it into the pile of other baggies. Quickly snapping the top off the lancet after opening the second baggy that held the malaria test strip, he proceeds to wrench the girls arm around while trying to motion to her young mother to hold her still with her thumb facing up at him. Pricking the child's thumb he squeezes it to produce a deep red drop of blood. Mortified the girl stares

at her hand, the source of pain and begins to wail and cry. After getting the blood onto the test strip the nurse turns to throw away the other materials, but the child continues to cry, clearly irking him. He quickly turns back around and grabs her hand where her mother was holding a small piece of sterile cotton and threatens in English to prick the girl again, brandishing the green lancet. The child begins to cry further, looking to her mothers blank expression for sympathy, and finding none, she quiets down but looks as though she could burst out again as the tears continue to stream silently down her small face.

The preceding vignette shows the power dynamics between a male health care practitioner and a Fulani woman. Ethnicity, religion, language barriers, stereotypes, power dynamics of the medical profession, and gendered hierarchies are among the many factors that influenced the above interaction between the male nurse with the young mother and child. Initially, I thought that these dynamics of health practitioner-patient interactions might have an effect on patient experiences and perceptions of biomedical health care clinics, which, in turn, could affect a patient's likelihood to trust and seek out such care in the future. However, upon further observation these interactions were complicated by local interactional dynamics observed outside of the clinical context in Ghana.

Health practitioner-patient interactions have been the focus of many studies of the health system in Ghana. In trying to be reflexive I realize that my interest in patient-practitioner interactions has stemmed largely from the available literature on Ghana and health care (see Chapter 2 for an overview of this literature). This awareness of negative patient-practitioner interactions made me more generally turn an analytically critical eye to the health practitioner-patient interactions that I observed.

While in the Village in the Upper West Region, I observed a pattern of interpersonal interaction that influenced my view of health practitioner-patient

interactions. My host in the Village, a Peace Corps volunteer who was well-liked by the local people often jokingly said 'I will beat you' to her friends and children. I noticed this sort of interaction in a number of other locations including the bus back to Accra, trotro stations in Accra, at the Ministry of Health office building, and at the clinics in Accra, and the Village. These threats of violence, while done somewhat jokingly, often lead to people getting punched in the arm or chest. My village host, said that Aalam, a male friend from the Village often hit her so hard that he left bruises. From this I began to question what was the difference between my expectations of violence and the expectations of the Ghanaian's making these statements and creating these acts. Being hit hard enough to leave a bruise is a form of abuse from my outsider's perspective. My host in Accra, Kofi assured me that this was playful and while sometimes people are hurt it is not thought of as violent by most Ghanaians. Similarly, in analyzing health practitioner-patient interactions, I became aware of a need to disentangle how patients perceive their interactions with health care professionals and my own perceptions of their interactions.

In my observations I noted the different types of interactions observed and where each interaction took place. As previously mentioned, I collected no data on patient-practitioner interaction in Sunyani. In Accra, patient-practitioner interaction was observed almost entirely from the waiting area in the center of the referral, infant and antenatal clinics. This means that interactions with the specialist doctors and midwives are not part of the data set as those interactions occur in the consultation rooms, always with closed doors. The types of interactions observed are largely of midwives and nurses in the emergency intake area at the front of the clinic, the nursing and health students assisting

nurses and public health nurses with vaccinations of newborns, blood pressure, urine, weight and medical history tables. The occasional senior midwife or head nurse (who by all accounts runs the majority of clinic) would interact with the waiting women as a group or individual women in the waiting area.

In contrast to the observations in Accra, the patient-practitioner interactions in the Village clinic were more varied. These interactions were not limited to antenatal or post-natal visits. Working in the consulting room of the clinic was a means for me to give back and be useful, rather than in the way, while I observed patient-practitioner interactions and the day-to-day workings of the clinic. Also, the midwife was often out of the clinic or in the nurses' quarters sleeping during the morning hours. This was related to her duties, as my week spent in working in the clinic started with a birth a few hours before my arrival. Observed interactions between the midwife and antenatal and post-natal patients was limited save for one experience helping the midwife do the second day post-natal check on the woman and her infant born in the early morning prior to clinic opening on my first day. The majority of the other interactions I observed were not related directly to patients who were seeking reproductive or infant care. These patient-practitioner interactions mostly took place in the consultation room. The majority of people who attended the clinic were there due to symptoms of malaria. Other observed interactions were between the receptionist (who was also a nurse) and women waiting to be seen in the consultation room or after they had been seen while they were returning their files and getting prescriptions. The health workers and nurses also interacted with people in the intake area on the semi-open front of the clinic. Other observed interactions between

patients and practitioners were similar to those already detailed. Not all patient-practitioner interactions were negative. The largest portion of interactions could be described as neutral. Most nurses were not friendly with patients nor were they overtly rude. Although nurse Joseph was an exception; he was usually forceful and rude to patients.

Photo Advertisement

Through window of the trotro I notice the cardboard cutout of a heavily pregnant young woman wearing a floral dress with a piece of local Akan cloth wrapped around her stomach. Next to the life-size female figure are the words “pregnancy is not a disease or death sentence”. I quickly snapped a photograph of this advertisement (Appendix 3). Luckily, the trotro was moving very slowly due to heavy traffic, typical of Accra central. With approximately seventy percent of the Ghanaian commuter population using this cheap, yet somewhat inefficient, transport method in the clogged streets of Accra, a great deal of people would be exposed to the sidewalk advertisement. Any form of motorized transport other than a moto takes hours to get around Accra, but the trotros take much longer due to limited routes and constant stops. People often complain about traffic, and the cramped and often deteriorated conditions of the trotros.

The woman in the advertisement may be intended to be a representative Ghanaian woman or she may have been chosen because she is a well-known singer. Kaakie is a Ghanaian Dancehall singer and has had musical success in Ghana with several hit songs and music videos (Abotsi 2013). I asked my Ghanaian host, Kofi, and his brother about the advertisement. They both knew Kaakie and felt that she was a very public Ghanaian

figure. Kofi's brother stated that even if a Ghanaian did not know her, they would know she is Akan. He stated that she looks Akan and that even his friends from the north knew Kaakie before coming to university in Accra. These northern friends of Kofi's brother were likely privileged through education and perhaps had access to more media than the average northern Ghanaian. She is well-known for being Christian, similar to the majority of Ghanaians. This majority also consists of Southern populations and the main ethnic group, the Akan. Kaakie's religious affiliation has been in the Ghanaian tabloid news as of late, with rumors of her being banned from church activities due to her Dancehall stage performances (Abotsi 2013). Therefore, based on the sign, those who do not recognize the woman in the advertisement assume that she is Christian, Akan, and that she speaks English.

In Chapter 6, I begin my data analysis by discussion of the photograph described above. This analysis of the photograph is done through an intersectional framework. The analysis stems from Kofi's comments made about the image in conjunction with data related to the demographics of Ghana.

Chapter 6. Analysis

Intersectional Analysis of Photo

The advertisement in the photograph I encountered was for the Maternal Health Channel. Advertisements for this television series that airs on several Ghanaian television channels, circulate on the radio, television, and through physical advertisements. The launch of the Maternal Health Channel in the spring of 2013 was part of the government of Ghana in combination with non-governmental organizations' mass effort to increase awareness of maternal health issues among Ghanaian women (Maternal Health Channel 2013). Through this increased awareness, the government and NGOs goal is to meet the standards set by the United Nations' Millennium Development Goals. The launch of the Maternal Health Channel caused a stir in the press, even international media including CNN, The Guardian, and Women's Media Center.

Those behind the Maternal Health Channel know that the highest infant and maternal mortality rates are in and around rural areas and among the poorest populations. This awareness is reflected in a video advertisement for the Maternal Health Channel that can be accessed from several websites, including the website for the British newspaper *The Guardian*. *The Guardian* considers itself to be a politically independent and ethical source of information for those in the UK and the Commonwealth (which includes Ghana). This video advertisement depicts a rural woman in labor who is being transported approximately one and a half hours to a hospital, presumably by her husband,

on the back of a motorcycle. The use of a video by the Maternal Health Channel, a medium that is not available largely to these communities that are most in need of the message may be ineffective.

In their Global Development section, The Guardian UK describes this advertisement:

“Ghana has high maternal mortality rates and is set to miss its millennium development goal. But a new TV series, Maternal Health Channel, is launching to provide drama, information and discussion about ways the country can improve the health of mothers, particularly in rural areas where access to healthcare is limited” (Guardian 2013).

The Guardian’s reporting on what most would perceive as a positive story about Africa, does not fit the usual paradigm of negative sensationalization of Africa in the media.

The intersection of ethnicity, class, gender, and location does not create an effect of simple addition of discrimination. Instead these intersections create a nuanced dynamic that is more than the sum of its parts. Seventy-six percent of the total urban population has a working television in their homes, while only forty-six percent of homes have them in rural areas (Audience Scapes 2010). Nearly equal numbers of rural and urban dwellers have a working radio in their homes, eighty-four and eighty-nine percent respectively.

Therefore, radio broadcasts may have been a more effective tool to reach rural populations if the program had been translated into one of nine government-sponsored languages, based on the language of population in the area where it was broadcast. This, of course, would not be a perfect means of reaching the women most in need of the

information being shared by the Maternal Health Channel, as many women in rural areas speak one of the dozens of other local languages not formally recognized by the government. The lack of communication with women most in need of better birth outcome is also representative of a large portion of interviews conducted for this project. The majority of women in Ghana do speak English or Twi with some fluency, these are the easiest women to reach with either an advertisement or as a researcher. This does limit the amount of data collected and how representative it is of Ghanaian women.

One intention of the advertisement is to promote the Maternal Health Channel, in order to create a greater awareness among Ghanaian women of reproductive health issues, such as the necessity of access to care. For those who have direct access to the sidewalk advertisement, the woman looking back at them is familiar. The majority of Ghanaian women are also of Akan descent, and therefore English speaking (to some level of proficiency), from the southern part of the country, and young (Ministry of Health 2013, 4). Ethnicity, and location in the southern part of Ghana also indicate that she is likely Christian and a city dweller. From my perspective as an outsider's in combination with commentary from Kofi, and my village host, the clothing on the woman may indicate a woman who lives in a rural setting. Based on my observations and conformation from several Ghanaian informants rural women are more likely to wear non-tailored clothing, including wrap skirts. However, it is common in Ghana for women to wear both local style dress and Western style clothing in the cities. For most Ghanaians I spoke with they easily discerned the ethnicity of those around them based on phenotypic expression. Even in my short time in Ghana, I became aware of the

differences in facial features and body types that indicate some of the majority ethnic groups. This was in large part due to Kofi showing me around Accra, and Sunyani and describing the people of different ethnic groups we encountered. I also discussed specific people and photographs with him. The assumptions about ethnicity used herein are based on Kofi's assessments. Many of these descriptions of groups were also mentioned explicitly or in passing with other informants. It is highly probable that a Ghanaian looking at the advertisement would see her face shape and build and assume she was Akan.

As stated in Chapter 2, English is the official language in Ghana. English is used starting after the first years of primary school, and on through secondary education in the country. Persons who live in rural areas generally have more limited English competencies than the majority of those who live in urban areas due to a lack of education and regulation of those educational systems. Those who are not of the Akan ethnicity, the majority ethnic group, are further limited in their access to television, and radio due to language barriers. The vast majority of Ghanaian television programs include two languages, English, and Twi, the main Akan dialect. Individuals with higher levels of education are more likely to use English in their work and daily life. The use of code switching between English and Twi also limits access to information broadcast on television and radio. Importantly, in rural communities, education may be available for boys and girls, but boys are encouraged and many girls are not. If a woman lives in a rural area, she is less likely to receive an education. If this same woman is not of Akan descent and has not been exposed to the Twi language, then she is further

disenfranchised. She will have less access to information and opportunities that require the use of English or Twi. Not surprisingly, non-Akan, rural, and non-English and non-Twi speaking women have the highest infant and maternal mortality rates in Ghana. In part, this is related to their linguistic disenfranchisement. Also, because of their location they have limited access to medical facilities (Ministry of Health).

This linguistic disenfranchisement is in part linked to gendered ideas about and practices of education, as non-Akan rural women often have limited access to schooling, which would be the channel through which they could learn English. Additionally, most health professionals are trained in the Southern part of Ghana and many are from the Akan majority who fluently speak Twi and English. This differential access to the official language of English and to national languages other than Twi furthers a linguistic rift between health practitioners in the medical system and patients who do not speak these two languages.. Patients not only have trouble communicating with health care professionals but often they also have differing expectations of health care. The rural areas are also more likely continue to use local practices that have not been pushed aside by the Western Biomedical system. Health professionals, however, often delegitimize these ethnomedical understandings of birth. These understandings include spiritual sickness, and the use of ethnobotanical knowledge (WACN 2008). Media, in the form of the advertisement under analysis, also contribute to the delegitimizing of ethnomedical practices. Created in the south for the majority ethnic groups, such advertisements reinforce the value of the Western biomedical practices that southern Ghanaians are more

likely to have access to. Likewise, health care practitioners may understand this advertisement as further delegitimizing the ethnomedical practices they encounter in rural areas.

An intersectional approach to the analysis of the advertisement allows for a holistic understanding of the assumptions of its creators, the likely interpretations of the target audiences, as well as a sense of the women who are excluded from its reach. The likely intention of this advertisement and the stated intent of the Maternal Health Channel is to reach a predominantly female audience and create awareness of reproductive health issues, but, more importantly, they are doing this as a means to meet the UN MGD's (Maternal Health Channel 2013). It is not clear if the advertisement intentionally ignores or simply does not explicitly include those women in northern, rural and ethnic minority groups. There is also the possibility that the creators did not consider the limitations of language, location and ethnicity when creating the advertisement and the series. Whether or not the creators realized the limitations of language, location, and ethnicity they are still reinforcing the normalization of a specific type of Ghanaian woman. The intersectional analysis of this advertisement shows the failure to include the subjects of Ghanaian society who are most in need of the possible benefits of the advertisement. The intersection of location, with women in the North being more rural; religion with many being Muslim; and language with many non-English or non-Twi speaking, in combination with the historical lack of infrastructure, have intersected to create oppression and repression. Highlighting these axes of oppression helps to illuminate the particularities of ethnicity, language, religion, gender, and location that have been

obscured through their lack of inclusion in the advertisement. The Ghanaian women who fit the ideal portrayed in the advertisement are those who already have access to the image and its message in a way the women in most need of this message do not. These women may feel empowered and as though the advertisement is creating solidarity among all Ghanaian women, when it is actually obscuring difference and othering those who do not fit the portrayed ideal. A more inclusive portrayal of Ghanaian women would be complicated to construct due to the dozens of languages and ethnic groups, but similar advertisements that incorporate the nine government sponsored languages and perhaps women of different ethnicities would be a starting point.

Intersectional Analysis of Patient Practitioner Interactions

When using an intersectional framework to understand the situation of rural Ghanaian women, one must look at the intersections of location, ethnicity, gender, religion, and language ability. The assumptions made here are based on conversations with Ghanaians, specially my host, Kofi and his brother. This has lead to the incorporation of a bias based on a male, Akan, educated and Christian perspective. Many of the generalizations about religion, ethnicity, location, language, and gender were also reflected in conversations I had informally with many of the female nurses, and my host in the Village, the Peace Corps volunteer. Based on a number of informal conversations with many Ghanaians, stereotypes regarding physical descriptions of people, styles of dress, language use and ability, and personality types were all commonly used ways of determining the ethnic background of other Ghanaians, and West Africans more generally. In my own observations, such stereotypes circulated widely and to some

extent affected the institutional health care experiences of patients. Of course some of the Ghanaian informants mentioned that not all people fit the ethnic stereotypes. It was also made clear that many people use these stereotypes to discriminate against non-majority groups. The interpretations of ethnicity and class in the following section are mostly based on interpretations by my host Kofi. These interpretations are not intended to reify stereotypes but simply to help describe interaction and categorize them in a way that is not solely based on my white, American, female perspective. This discussion also helps understand how the patient experiences of many women are affected by the stereotypes attached to their perceived ethnicity.

In Ghana women who are urban but speak a language other than English or Twi have a different intersectional disadvantage than rural women with the same linguistic barriers. Urban women are more likely to have access to a television, and other individuals who may speak either English or Twi, thereby giving them greater exposure to mass media. Locally, language is related to ethnicity. Likely, if a person is of Akan descent they will speak Twi or one of the closely related mutually intelligible languages. In practice, this means that rural women who are of Akan descent have a different interaction with access to resources than those rural women who are a different ethnicity and/or speak a different language. Access to education is also a key factor in women's lives in Ghana. The location of rural women and the distance to schools, in combination with the cost of education make it less likely that girls will receive even a primary education during which they would learn English. The data gathered during this research reflects this dynamic in that only educated women who spoke English were interviewed

due to my lack of language ability in any of the national languages. My research suffers from a similar language bias due to my inability to speak with women who did not speak English, when a translator was not available. Religion also plays a part in the intersections of education, gender, and language. A large proportion of the population of the northern three regions of Ghana is Muslim. When girls do have access to schools they are often Qur'anic schools where English is not taught. In some cases these schools teach Arabic, but it is often only used to read from the Qur'an. This religious education is important in local communities but furthers the gap between the rural northern populations and the urban southern populations.

For rural Ghanaian women the particularity of the intersections of ethnicity, religion, language and gender create an intricately laced oppression. Due to gendered expectations relating to their religion and their ethnicity these women have limited access to transportation other than their own feet. Due to their ethnicity, they have greater language barriers in terms of institutional access to healthcare and other public services than those experienced by the majority Akan ethnic group. Due to their gender, they also have limited access to education, which furthers the language barriers even more. The intersections of the axes of analysis for women in rural areas in part apply to women in the Accra clinic. The fact that the clinic where observations were made in Accra is a referral clinic means that women from all over the country were sent there. Many of the women are Akan, Christian, and educated and therefore speak at least Akan and English. There are also women who face the same and more varied particularities of intersections of oppressive subjectivities. Some Southern women who attend the clinic are not able to

attend school due to financial constraints, or familial obligations. This puts them in the position of not speaking English, and perhaps not Akan, depending on the ethnic group in which they were raised.

The following four interactions between patient and practitioner from both the Accra and the Village clinic will be discussed in relation to aforementioned axes of intersectional analysis. For the clinic in Accra, the patient-practitioner interactions include an interaction between the head nurse and two pregnant women arguing in the main waiting area, and an interaction between a pregnant woman and the nurse and nursing student at the blood pressure table. The patient-practitioner interactions discussed for the clinic in the Upper West Village include the interaction between the male nurse, Joseph and a woman and her child in the consultation room, and the interaction between the midwife and the woman and child at the day one post-natal visit.

One interaction recorded in my field notes was based on participant-observation with the head nurse, Yawo and two pregnant women arguing in the main waiting area. After returning to my host Kofi's house later that day I discussed the incident with him and his brother. The assumptions about class and status of the two pregnant women come largely from Kofi's commentary on my descriptions of the women. That day Yawo happened to be standing outside her door on the right side of the main waiting area, her figure imposing and a grimace on her face visible. The younger nurses, including Fiifi and Efiia had remarked on what they considered her usual bad mood. When I had interviewed Yawo, I assumed that her demeanor was because she did not like me, a white American, in her clinic. Fiifi and Efiia stated that she made most people feel

uncomfortable. Whenever she stood with her arms folded and looking from side to side it was as though she was surveying her domain. Across the hall of the seating area a disagreement between two pregnant women began. The commotion was between a standing woman wearing a pink floral dress and a seated woman in a brown kaba, a type of local dress with a gold head wrap. The standing woman's attire indicated she may have been of a lower socioeconomic status. The seated woman's kaba and head wrap, while common among Ghanaian women, likely indicated that the woman has some wealth. The woman in the pink floral dress was heavy set, with a round face, which made Kofi think she was of Ga descent. According to Kofi, the woman in the brown kaba was likely Akan. Even with my limited understanding of Twi, I recognized it as the language of their argument. When the argument escalated to yelling, one of the midwives and the head nurse began to intervene. The head nurse quickly walked toward the arguing pair and forcefully moved the standing woman in pink to the other side of the aisle of the waiting area.

The head nurse spoke to the women in English, but the woman in pink refused to speak English to her. If the woman in pink was of Ga descent then it was likely that she spoke English as she would have been from Accra or near Accra. Women in and from Accra were more likely to speak English than those from rural areas as it was used more frequently in the capital and education was more widely available. The head nurse became visibly angry with both women but it was clear her anger was directed more at the woman in pink. Perhaps the dynamics of class, ethnicity, and language all played a role in the interaction between the women and the head nurse. It was difficult for me as

an outsider to tell the nuances of this interaction. It is possible that Ghanaian ethnic stereotypes were placed onto my description of this event by Kofi. I do not want to reify these stereotypes, but my position makes it difficult for me to make my own determinations about ethnicity, class, and intent. I must rely on the interpretations of my informants, and hosts, and try to problematize the stereotypes employed when making sense of the world around them. I need to be aware of male, Akan, educated, Christian biases when interpreting this data.

The second case in the Accra clinic is of the interaction between a pregnant woman and the nurse and nursing student at the blood pressure and urine sample table. This patient-practitioner interaction included two practitioners and a very confused patient, based on her fearful and inquisitive look. It is possible that I am interpreting this look incorrectly based on my American biases but Kofi seemed to agree with my assessment of the patient's state based on my description. The woman, who was holding her medical records in a Pixar Cars folder, appeared to have traveled to the clinic from a rural area. Her printed wrap skirt was not tailored to her pregnant body, as I noticed on many women in Accra. The woman looked confused as she walked up to the station where the Akan nurse and the Ga nursing student sat. They motioned for her to come over, hand her folder over, and sit. She also made several audible utterances which I learned from my host are indicative of being inquisitive and frustrated. The woman's face showed a mixture of fright and stress as the nurse took her blood pressure.

The nursing student handed her the urine sample cup and asked her in English to go to the restroom and fill the cup. This was the normal procedure for this station at the

clinic. From observation at the clinic I noticed that nearly all initial interactions between nurses and patients were in English and initiated by the nurse. This was not always the case, I noted several occasions in my field notes in which nurses spoke exclusively in Twi, or other languages with women in the clinic. The woman clearly did not understand enough English to comply with the nurse. The nurse began to look exasperated, and made a sound that, based on my description, Kofi stated often meant frustration. She then spoke in Twi to the women who seemed to understand more of the nurse's instructions. As she continued to sit holding the cup, the nurse became frustrated and tried to mime what she wanted the woman to do with the sample cup. The use of hand gestures to indicate wanted behaviors was discussed in the interviews of several women and nurses from the Upper West. This implied that in the instances when nurses were frustrated with the language barrier they used hand gestures as a last resort to communicate with the women they treated.

The nursing student appeared to be more patient, as she did not make similar vocalizations to those of the nurse and her face appeared to be more relaxed. My perception of her patience could be related to a number of things. She had only been working at the clinic for four weeks so perhaps she is not as worn out or as easily annoyed by the confused woman, or it could have been only my interpretation of her reaction based on our previous interview. When discussing this interaction with Kofi he was unable to make any assumptions about the patient's ethnicity from my description though he seemed fairly certain that she was not Ga, Akan, or Fulani due to her apparent inability to speak Twi or English. The intersection of her vulnerable position as a

pregnant woman with complications, her ethnicity, and language ability structured the way she was able to navigate the health system in Ghana.

The last interaction that I observed between a patient and practitioner was that of the midwife, a woman and her child at the one-day post-natal visit. The religion of the two women was different as the midwife was Christian and the new mother was Muslim as was noted in her chart. The ethnic background of the mother was not the same as that of the midwife but both women are of minority ethnicity in Ghana, but majority ethnicities in the Upper West Region. The mother's ethnicity was unknown to me but my host in the village stated that she was from one of the larger ethnic groups in the community. The ethnic background of the midwife is complex, she stated separately in her interview that she was of Akan descent but also that she was of a northern Ghanaian majority ethnicity but did not state explicitly which one. Perhaps each of her parents represents one of the two ethnicities she claimed. It is also possible that she is of Akan ancestry but was raised in the north of Ghana and assumed the ethnic identity of the community she lived and worked in, similar to Efia.

In this interaction, the midwife called both the woman with her newborn and myself into the post-natal examination room. The midwife motioned for the new mother to sit on the bed after she took the infant who was wrapped in a white cloth. The midwife did not explain why I was in the room. The midwife laid the infant on the bed next to her mother and unwrapped her. First, she checked her umbilical cord. The midwife commented on the fact that it had been bleeding and she asked the mother if she had retied the string on the umbilical stump. The baby was then weighed. As I looked back at

the mother I noticed that she was trying to see what was happening with her newborn baby. The baby was then rewrapped and set on a nearby table. Turning to me, the midwife asked if I have ever felt a contracting uterus, which I had not. She then proceeds to have the woman take off her shirt and we checked her uterus and made sure she was expressing milk properly. The midwife expected me to have experience with post-natal care due to my interest in her work. My position as an American and a graduate student, or 'big woman' as I was regularly referred to by nurses at the Village clinic impacted the ways in which they treated me and the patients they were treating. The nurses and midwife felt no need to ask the patients if my presence was bothersome. Those visiting the clinic did not question the authority of the midwife and the nurses. My right to be at the clinic was not questioned by the patients likely due to my position as a white American. Even the nurses did not question my right to be at the clinic.

Throughout the course of this interaction between the midwife, the mother, her infant and myself, the midwife spoke English with the woman. The mother appeared to understand some of what was asked of her, but also seemed confused by the interaction. I assume she was confused based on the way she continued to look in my direction, but did not ask about my presence. It may have been that my presence in this space led to the use of English in the interaction, which led to a language barrier between the new mother and the midwife. The midwife was from the Upper West and spoke Wali, English and several other languages. Because of my presence it was possible that the midwife spoke only English to accommodate my inability to speak the local language. Since the midwife had

delivered the infant the previous night the mother would likely have spoken with the midwife at least on that occasion.

The interactions between the midwife and the mother intersect and interact in a way that does not necessarily meet the patterns of the previously discussed patient-practitioner interactions. The particularity of this interaction is complicated further by my active participation in the interaction in ways that cannot entirely be understood by me. The other interactions did not include a white American, such as myself. My participation in the interaction between the mother and the midwife may have given the midwife more authority. On several occasions Kofi, and my host in the village stated that the presence of a white person can be understood to lend prestige to those around them, in this case the midwife.

Racism, Gender Violence, Obstetric Violence

An awareness of the negative treatment of patients and an oft-discussed lack of standardized work ethic on the part of northern-stationed nurses according to the standards set by the government of Ghana has not necessarily lead to changes being made to correct these issues. In the north of Ghana it is well known to the Ghanaian government that not all maternal and infant deaths are reported (Ministry of Health). This is due to a number of reasons that include the lack of facilities, lack of interest on the part of health care practitioners, and shame of those who have lost family members (Ministry of Health). The few facilities that are designed to service the populations in the north are spread out and are often simply too far for some women to travel to. This, combined with gate keeping behaviors, the mistreatment of patients by nurses and other practitioners,

and the admonishment the women may receive for not coming to the clinic or following the orders of the staff often lead to underreporting. Abia, the mother from ?, felt that the nurses had mistreated her by not helping her to understand antenatal care. Other women mentioned that nurses were rude to them. Although I did not see any gatekeeping behaviors first hand, I often heard from clinic staff about men keeping their wives away from the Village clinic and women whose husbands refused to provide transport to the clinic. The system used for reporting infant and maternal death by clinic staff is not fool proof and the government of Ghana is aware of the flaws in the reporting systems (Ministry of Health).

Many Ghanaians I spoke with felt that the government had an overall lack of concern for the Northern regions of Ghana, that is The Upper West Region, The Upper East Region and The Northern Region. A number of informal conversations mentioned the lack of concern over the north was in part due to the colonial lack of infrastructure, lack of resources in the north, and the lower population of the northern part of Ghana. This lack of concern could be seen as reflected in the poor outcomes of maternal and infant health found in these places. The north of Ghana has long been ignored by both colonial and postcolonial governments (Ministry of Health). The Ghanaian government often notes the binaries between north and south in Ghana. The south is home to the majority ethnic group the Akan, while the north is home to a large number of very small minority ethnic groups including the Wala, Hausa, Fulani, and Dagambura.

The southern part of Ghana largely speaks languages in the Kwa family including Twi, the main language of the Akan, while in the north most languages are part of the Gur

language family. English and Twi are spoken widely as the languages of commerce and education through primary school, while the languages of the north are not used in countrywide commerce and are rarely spoken on television. Speaking Twi while code-switching with English is common in the south of Ghana, especially among the affluent and well educated. On Ghanaian television many of the announcers will exhibit this type of code-switching when not speaking solely in English. Those with higher levels of education often code-switch between Twi and English and this can be a barrier to those who only speak Twi. This became apparent while watching Ghanaian political television and the television news. The programs would be primarily in Twi but would code-switch to English for words, phrases, or even whole conversations. This became even more problematic for people who spoke Twi as their second or third language and did not speak English. When Twi is so widely intermixed with English it may become a communicative barrier for those who are not competent in both languages, a competence that is often related to social class, education, gender and location.

The notion of a barrier related to language is complex in a country such as Ghana. Ghana has dozens of spoken languages, therefore it may be very difficult for the government to incorporate all of these languages into advertisements and programs designed to help reduce infant and maternal mortality. Furthering the spread of use of English and Twi as official languages is also likely to be problematic. This might lead to linguistic shift away from minority languages toward the use of majority languages. It is not ideal for the Ghanaian to push majority language use, but it is also not ideal for

portions of the population of Ghana to not have the opportunities afforded to those who do speak majority languages.

As exposed in Chapter 5, negative ethnic stereotypes of minority northern groups persist, as do those of some southern groups. The means by which many of the Ghanaians I spoke with framed those around them was in terms of ethnic differences. These differences in some instances were based on negative attributes associated with certain ethnicities by majority groups. Examples of these stereotypes include that the Ga like to argue, or the Fulani are draining resources meant for “real” Ghanaians. Nurses such as Joseph made comments related to ethnic or religious stereotypes. Joseph stated that “Christianity brought education. That is just the way it is. They don’t come. They are still using their grandfather’s knowledge. They don’t conform to today’s knowledge. They don’t... The Muslim’s are backward. They only want our knowledge when they are sick. Then they want it.” Here we can see that these prejudices are not just related to one axis of oppression. The relationship between gender, religion, education, language, and location are complex and oppression that each of these marginalized groups must navigate daily. This oppression may not always be apparent to the people who face it. Women such as Abia and Marowa were aware of the poor treatment they received by the clinic staff. They both indicated that they wanted to talk with me about their misunderstandings and ill-treatment as a way of stating their unhappiness with the way the clinic staff treated them. According to these interviews, the nurses and staff meant to care for the reproductive health needs of local women, often thought them to be stupid, uncaring, or unworthy of proper treatment. Most of these women were unaware of their

options or the clinic services available to them because of the historic and current social relationships between them and the reproductive health practitioners that they seek care from. The example of Abia being told to find someone to explain the antenatal care book to her is a means of looking at how these different axes of oppression interact to create the circumstances of her daily life and particularly her experience with clinic staff.

Perceptions of Care

The women in this study generally spoke positively about the care they received and the options they had within the health care system for antenatal and birth care. Women's opinions did differ based on location, as did the experiences of care the women described. Speaking broadly, the women interviewed in Sunyani were aware of birthing options from viewing reproductive health programs on television such as the Maternal Health Channel discussed in the intersectional analysis of the photograph. Akosiwa stated "my birth was ideal" but this contrasts with her later statement "they tried to give you some drugs, they gave me the drip. It was to force the labor to come. I was told to stay in the position" indicating that her awareness of birthing in a position other than the lithotomy position was circumvented by the authoritative knowledge of the hospital staff.

Sunyani

Interestingly Akosiwa, Aba, Adwoa and Ama, all of the birthing or pregnant women from Sunyani expressed that they felt the care given to them was good, that nurses and doctors respected them and that they were not treated poorly by clinic or hospital staff. A disparity can also be seen in Ama's statements that "they treat me well in hospital... Nurses are respectful" and her later statement that "they did not let me, let me

move around. I wanted to get up, saw [on television] That they let you stand and walk during [labor]. They [nurses] yelled and me stay.”

What appears on its surface to be an odd contrast of positive feelings toward nurses even though they yelled, and the positive feelings women have about their treatment and the stories of specific experiences that negate them create an interesting dynamic when taken in consideration of the UN MDG's on reducing infant and maternal mortality. Programs that encourage women to seek medical care from reproductive health care practitioners reinforce the notion that lack of care within the Western biomedical system is dangerous and the cause of most maternal and infant deaths. Through these initiatives women become aware of the dangers of pregnancy and birth. This is reinforced by the constant rhetoric surrounding the dangers of not seeking care and in combination with the ad campaign stating that “pregnancy is not a disease or a death sentence” if care is sought from proper sources such as biomedically trained clinic or hospital staff. However, in the context of individual interactions with healthcare practitioners the idea that pregnancy is a dangerous time that requires particular forms of care does not seem to permeate healthcare practitioner's treatment of patients. When these women live through pregnancy and birth and having a healthy baby they often do not see the negative ways in which they were treated. It has been shown that women in other settings that face similar and more horrific obstetric violence, such as manual dilation or unnecessary cesarean section also feel similarly about their experiences (Jordan 1993).

Village, Upper West

Perceptions of care for the women interviewed in the village in the Upper West Region in some ways mirror the perceptions of care held by the women interviewed in Sunyani. Even though they described situations which were very negative, such as being scared and giving birth alone at home, overall they held the clinic and its staff in very high regard. Abia, Marowa and Fahimeh all had at least one of their children at home because they did not understand that the clinic was open twenty-four hours.

Practitioners

The only reproductive health care practitioner interviewed near Sunyani was Nana the traditional birth attendant. She gives a stark contrast to the voices of the biomedically-trained nurses and midwives. Nana's story reflects the larger practices and policies that have affected Ghanaian women's access to various forms of antenatal and birth care. Even after the hospital arrived in Sunyani and affiliated personnel tried to halt her practice she continued to serve the women of her community. This continued for some time due to demand from the community but eventually the hospital wore her down. Nana stated through her translator that "She began her practice when there was no clinic of health care center in the town. But later when there was one there was a conflict. Women, pregnant women should not come to her, or to go anywhere outside the clinic. So that brought some conflict between her and the health care facility in the town. So at a point she was frustrated and then angry about the fact that she did not get the cooperation and support of the hospital. So there was that kind of hostility. So she decided to abandon the practice all together." The doctors at the hospital trained in Western biomedicine were

looking to her ethnobotanical knowledge at the same time they were trying to end her services to the women of her community.

These women who used to receive her services were expected by the hospital to travel what is approximately a twenty-minute drive to Sunyani to receive antenatal care and to deliver their babies. This at a time when most women did not have access to the resources or funds for travel, which would have left many of the women in Nana's community without any antenatal or birth care if she had heeded the warnings of the hospital. This is reflective of Ghanaian Government policies that further discounted ethnomedical reproductive health knowledge while privileging Western biomedical knowledge as a means of modernizing the state (Ministry of Health). The Ministry of Health development plan lays out approaches to eliminating ethnomedical practice, and improving reporting on mortality. These types of policies rarely take into consideration the effects on the poorest and most rural women. The women who rely on community members such as Nana and her skills as a TBA to care for their pregnancies and deliver their babies are not considered as the Ministry of Health creates policies which do not replace the TBAs they try to eradicate (Ministry of Health). Policies such as these have continued the colonial legacy of modernization on a western trajectory, the incorporation of western biomedical knowledge and facilities as those where authoritative knowledge is held, and perhaps most importantly these are policies that fail to take into consideration the complex relationships women have in their communities and the diverse obstacles these women face.

There does not appear to be any consideration of the fact that the Western biomedical system is perhaps not the best system for antenatal and childbirth care for the women and infants of Ghana. The northern regions of Ghana while underdeveloped by colonial and post-colonial policies of modernization did face the same crackdowns on TBAs and other ethnomedical practitioners (Ministry of Health). This has also been reinforced by Ghanaians such as Kofi who feel that the underdevelopment of the north has been intentional neglect by the Ghanaian government. One cannot simply seek to return to the pre-colonial system of localized ethnomedical midwifery in Ghana. As of 2013, the Ghanaian government has endorsed programs such as the Maternal Health Channel to compensate for the higher rates of maternal and infant death in the northern regions, while obscuring the particularities of northern women's experiences with pregnancy and reproductive health care.

The Government of Ghana hopes that increases in midwifery and nurse training programs will help to curb the high maternal and infant death rates in the northern regions but these policies do little to train people from these regions, ethnic groups, religions, nor do they teach the local languages to reproductive health care practitioners who are to be stationed in the northern regions. Similarly they do not hire translators (Ministry of Health). The government is likewise aware of the deplorable state of care in these regions. The continued negative treatment of women (and men) who seek health care services is well known, and the Ministry of Health has reported in the Health Sector Development plan that "Distribution of health workforce... remains a challenge. Distribution of medical officers, pharmacists, and professional nurses is skewed in favor

of urban areas particularly in the southern sector of the country” (Ministry of Health 2013, 10). The Ministry of Health also reports “a viable solution is yet to be found for the perennial problem of staff failing to take up postings” and that “there is no effective staffing norm in place and the levels of staff commitment, productivity and attitude to work has been questioned in several reviews”(Ministry of Health 2013, 10).

Chapter 7. Conclusion

Global level institutions like the United Nations affect the lives of women all over the world. Specifically, the UN MDGs related to reproductive health have affected pregnancy and birth all over the world. Women in Ghana have recently seen increasing changes to the reproductive health care system supported by the government of Ghana. This research has considered the experiences of eleven Ghanaian women who have recently dealt with this changing system and nine Ghanaian reproductive health care practitioners. The intricacies of their individual experiences with the health system are nuanced with historic and cultural dynamics particular to each location, and each woman's positionality. The effects of the UN MDGs are far reaching for these women, even if they are unaware of the MDGs or how the MDGs have influenced policy and practice of reproductive health care practitioners.

The types of conclusions that can be drawn from the intersectional portion of this analysis are not necessarily ones that give solid answers but in fact complicate the questions I posed at the outset of this project . My own biases, and those of my informants and my host, Kofi clearly affected my perception of interactions between patients and practitioners. The Western biomedically-based system in practice in Ghana in many ways reinforces power dynamics strengthened by the colonial system and local practices. Those who are part of this system may abuse their power when interacting with women who are in vulnerable positions. The intersections of subjected positions create

particularities that are important for understanding interactions between patient-practitioners and create a possible space for change. By looking at the historically particular nature of individual interactions recorded during this research and placing them into a global framework the analysis of this data is not only relevant and beneficial to individuals who patronize the two studied clinics but possibly any practitioner-patient interaction. The use of an anthropological framework and perspective for analysis of this data helps to contextualize the interactions between practitioners and patients in Ghana.

The original research questions that guided this research were found to be relevant to the reproductive health care system in Ghana and the way women experience the health care system. The impacts of the UN MDGs 4 and 5 can be seen in a number of ways. There is an increasing awareness of laywomen, specifically those with some formal education, about the UN MDGs and reproductive health more generally. All of the health care practitioners interviewed were of the UN MDGs. They each noted that there has been an increase in nurse and midwife training programs and that birth is now much safer in Ghana than in the past. Healthcare practitioners stated that one of the most notable impacts of the MDGs was the increase in the importance of antenatal care. For some in Ghana, such as Marowa, the MDGs do not affect all of their births, as they may happen while they are alone at home. The awareness of the UN MDGs by the local clinic staff did not influence Marowa's experience directly. Instead her clinic experience, similar to that of other interviewed women, created distrust between patients and clinic staff. The ways staff treated patients, the role of husband's wishes, the effects of linguistic, ethnic, and social prestige, as well as a woman's proximity to reproductive care all affected the

way the interviewed women experienced their pregnancies and births. The efforts of the government of Ghana to implement programs that improve reproductive health care outcomes are not affecting all Ghanaian women in the same way. Based on reports by the Ministry of Health the government realizes it will not likely meet the UN MDGs by the 2015 deadline, and that the efforts it has made to meet them are not affecting women equally across the country. The government of Ghana has implemented programs that have increased the number of reproductive health care practitioners but has not dealt with the disparities in quality and access to care between the north and south of the country. The UN MDGs are affecting Ghanaian women on an individual level, through the policies and practices of the Ghanaian government. How each woman experiences the effects of the UN MDG 4 and 5 varies based on location, ethnicity, language ability and religion.

Suggestions

Perhaps an important step for the Ghanaian government in their training regimens for nurses and midwives would be to include a sort of cultural sensitivity/awareness training. The number of ethnic groups encountered by birth practitioners (and other health workers) is as great as the number of stereotypes associated with each ethnicity. While many women do not feel that their ethnicities or religions affect the ways in which they give birth or receive care, some medical professionals' views seem to oppose this.

Does the combination of all these factors consciously affect the way practitioners interact with patients? In some cases yes, in other cases perhaps not on a conscious level, and in other cases no. The ways in which practitioners perceive the different factors

cannot be entirely known from observation alone, or even in combination with interview data, but a more comprehensive understanding of the dynamic can be gained.

The dynamic of global humanitarianism and human rights discourses and practice are changing. While linking the work of NGOs and the impact of UN MDGs on the Ghanaian government's policies to larger neoliberal economic policies that further the oppression of people and groups within the capitalist world-system may be possible, the positive effects and intentions complicate critiques. Importantly, local practice was not occurring in a vacuum, the colonial past and policies limited and modified the practice of those termed traditional birth attendants. The UN MDGs call to lessen maternal and infant mortality may be an admirable goal, but it causes an erasure of ethnomedical practices.

The government of Ghana and NGOs that work to reduce mortality rates do not always consider what local women want, only what they are perceived to need by the West in order to meet the goals set by the UN. For many, these goals are undisputedly for the common good and which leaves no room to question the groups that try to accomplish the UN MDGs. Sometimes, the goals themselves are often futile. Good or bad, at their core, human rights and global humanitarianism work do two things: (1) create or reify an "other," and (2) obscure differences. To work, human rights and global humanitarianism highlight perceived differences by othering groups in ways that create justification for intervention, and they obscure differences of practice, understanding, and perceptions of need.

Other than wanting to survive pregnancy and childbirth with a healthy baby, Ghanaian women's perceptions of desired and deserved antenatal and delivery care differ widely. Drawing from the data discussed in the preceding chapters, location seems to be one of the best means for organizing women's experiences, perceptions, and needs into locally meaningful categories. The loss of local ethnomedical knowledge may leave biomedical reproductive health care as the only option for care. If the biomedical system is not to be questioned by the UN, NGOs, or the Government of Ghana in the near future then the method by which biomedical reproductive health care is distributed to women needs to be reevaluated on all levels from Ghanaian communities, to the Ghanaian Government. The Ministry of Health is aware that it is nearly impossible to meet the UN MDGs by 2015 (Ministry of Health).

One possible intervention that could possibly make a dramatic difference in care received by women in the northern regions of Ghana would be to ensure that health workers and specifically reproductive health practitioners are from the areas they are sent to work in. This would hopefully curb mistreatment of patients due to ethnic prejudice or racist ideas, religious differences, language barriers, and/or lack of interest in the community. While the problem of lack of oversight may still be an issue for these far-flung clinics perhaps the interest in communal wellbeing will create a more positive and accountable work environment. An environment in which nurses want to work with local people and feel as though they are part of the community could lead to more positive experiences for patients and practitioners.

This repetition of the colonial focus on the south of what is now Ghana furthers the structural violence that also translates into personal, obstetric and gender violence experienced by the women of reproductive age in the north of Ghana (Ministry of Health). As the UN MDGs' 2015 deadline approaches the measures taken by the Ghanaian government are ignoring the problems that are found in the north of the country such as lack of oversight, lack of practitioners who want to practice there, etc. The Government of Ghana recognizes the problems it has with forcing nurses and reproductive health care practitioners to work in the north when they do not want to, but they have no policies to change this. The government's policies are not having the desired positive effects on maternal and infant mortality rates in the north.

The Northern regions of Ghana were almost entirely ignored since 1991 when the UN MDGs were set, and they continue to be ignored. This is contributing to the extremely high maternal and infant mortality rates facing the country. A number of factors contribute to the continuing high rates including lack of will work by practitioners in the North (Ministry of Health). This is largely due to the fact that many would prefer to be in the cities and they are also not of the same racial, ethnic, religious, geographic or educational backgrounds of the people in these areas. Therefore health care practitioners cannot find reason to connect and often times uphold long-held prejudices and stereotypes for the communities that they are serving. This seems to be in contrast to the perspectives of many of the health practitioners that provide care in the cities. These practitioners often see larger numbers of women from the Southern ethnic groups including the Akan. As shown in this research nurses in Accra such as Fiifi and Efi

expressed their belief in a lack of ethnic differences related to birth, while those nurses such as Joseph and Kaakyire who worked in the northern regions expressed negative stereotypes they held for groups such as the Fulani.

Limitations

This research just begins to scratch the surface of complexities of women's experiences with the reproductive health care system in Ghana. The nearly six weeks of conducting research allowed little time for rapport building, at least to a level that would help to create a more emic perspective of women's experiences. English is the official language of Ghana but with disparities in education not all people speak it proficiently, according to the health care practitioners interviewed, and based on my interactions. My inability to speak Twi limited my interactions with local women in the south of Ghana when I was away from my host. This time allowed me to interact with women and observe. While this limited me to interviewing only women with a higher level of education it also allowed for them to not be concerned with having a man translate. The interviews in the Upper West village being translated by a man lead to what appeared to be somewhat uncomfortable moments for many of the Muslim women. In order to answer my questions about pregnancy and birth these women had to discuss topic reserved for females in the presence of a man.

Due to the limited time and language complications there are many ways that further research would help to create a more holistic representation of women's experiences with reproductive health care in Ghana. In the wake of the push to meet the UN MDGs there are still disparities in care and treatment of women from differing

religions, ethnicities, and locations. Further research investigating the variation in class-based experiences of reproductive health care in each location would be beneficial. Expanding the research locations within each region would be a fruitful endeavor for further research as it would allow for a fuller picture of how geographic differences factor into experiences of care.

Contributions of Research

This research helps to illuminate some of the complexities of women's experiences in Ghana with the reproductive health care system. How women navigate the system has long been a concern in for anthropologists interested in reproductive health. While Ghana may train large numbers of midwives in comparison to the United States, they still employ what Davis-Floyd calls a technocratic model of birth (Davis-Floyd 2003). An increase in medicalization of childbirth has been the result of the push to meet the UN MDGs. As this research has shown not all women are receiving this type of birth care, but it is seen by the government of Ghana as being the best, if not only means, of meeting the UN MGDs. The data and interpretations of this ethnographic research may only be preliminary but they can be used in the cross-cultural comparison of childbirth practices. Another contribution this research makes is to the anthropology of development in that it links the global initiative of the UN MDGs to individual women's experiences.

The outcome and trajectory of anthropological research is not always obvious at the start of a project. With the changes this project underwent the goals of understanding the Ghanaian reproductive health system, its relationship to the UN MDGs and women's perceptions of care became less about specific place and more about how these vary by

location. Women in Ghana may for the most part see their care as being quality care. This perception of good care does not accurately reflect my own interpretations of the interactions and specific experiences of the women who participated in this research. Health care practitioners in Ghana are well aware of the UN MDGs and the ways in which their training and government programs are meant to meet the goals. Largely, this translates into a rhetoric from the health care practitioners that differs greatly from their own actions and the policies of the hospitals and clinics. As a whole, access to reproductive health care has been improved by the push to meet the UN MDGs in Ghana but the improved access to care and newly trained practitioners is based on geography. The women in the northern regions of Ghana have long been those with the highest rates of maternal and infant death and this continues to be true. The focus of the Ghanaian governments efforts have been in the south, and many of the initiatives such as Maternal Health Channel confront women with the 'ideal' of a women from the south of Ghana. This obscures varied experiences of Ghanaian women related to reproductive health care and leads to further disparities among regions and rural populations. Each Ghanaian woman experiences the effects of the UN MDGs 4 and 5 in different ways. Women with greater access to education are the most likely to benefit from the programs and policies implemented by the Ghanaian government. The individual experiences of women with reproductive health care practitioners are affected by the global level UN MDGs. By looking at these experiences and how they relate to policy helps our understanding of the reproductive consequences related to global decision making processes.

Works Cited

Abotsi, Maureen

2013 Kaakie - I've Not Been Banned From Church Activities. <http://www.ghananation.com/news/15619-i've-not-been-banned-from-church-activities-kaakie.html>, accessed October 2014.

Adanu, Richard MK

2010 Utilization of Obstetric Services in Ghana between 1999 and 2003. *African Journal of Reproductive Health* 14(3):153-158.

Audience Scapes: The InterMedia Knowledge Center

2010 The Urban-Rural Communication Comparison in Ghana. <http://www.audiencescapes.org/country-profiles-ghana-demographic-profiles-comparing-urban-rural-divide-urban-rural-communication>, accessed October 2014.

Bernard, Russell H.

2000 *Social Research Methods: Qualitative and Quantitative Approaches*. Thousand Oaks, California: Sage Publications.

Cho, Sumi, Kimberly Williams Crenshaw and Leslie McCall

2013 *Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis*. *Signs: Journal of Women in Culture and Society* 38(4):785-810.

Davis-Floyd, Robbie

2003 *Birth as an American Rite of Passage*. Berkeley: University of California.

Farnes, Beckstrand, and L.C. Callister

2011 Help-seeking Behaviours in Childbearing Women in Ghana, West Africa.

International Nursing Review 58: 491–497.

Guardian, The

2013 Maternal Health Channel: Drama of Childbirth in Rural Ghana – Video. [http://](http://www.theguardian.com/global-development/video/2013/feb/13/maternal-health-channel-childbirth-ghana-video)

www.theguardian.com/global-development/video/2013/feb/13/maternal-health-channel-childbirth-ghana-video, accessed October 2014.

Ghana Health Services

N.d. About Us: Background. [http://www.ghanahealthservice.org/aboutus.php?](http://www.ghanahealthservice.org/aboutus.php?inf=Background)

[inf=Background](http://www.ghanahealthservice.org/aboutus.php?inf=Background), accessed March 2013.

Ghana Web

N.d. Trotro Station. <http://www.ghanaweb.com/GhanaHomePage/fun/trotro.php>,

accessed October 2014.

Ghana Web

2012 Trainee Nurses and Midwives Kick Against Fee Hikes. [http://](http://www.Ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=246832)

www.Ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=246832, accessed February 2013.

Goal 4

2013 Millennium Development Goals: Child Health. United Nations. [http://](http://www.un.org/millenniumgoals/childhealth.shtml)

www.un.org/millenniumgoals/childhealth.shtml, accessed February 2013.

Goal 5

2013 Millennium Development Goals: Maternal Health. United Nations. <http://www.un.org/millenniumgoals/maternal.shtml>, accessed February 2013.

Government of Ghana

2012 'We Need Midwives Today More Than Ever'. <http://www.Ghana.gov.gh/index.php/news/features/12715-we-need-midwives-today-more-than-ever>, accessed February 2013.

Haldeman, Kaaren

2009 The "Burden and Blessing" of Being a Black Woman: Engaging Intersectionality Through an Anthropology of Pregnancy and Motherhood among African American Women. *In The Intersectional Approach: Transforming the Academy Through Race, Class and Gender*. Berger and Guidroz eds. Pp.210-228. Chapel Hill: The University of North Carolina Press.

Historical Context

N.d. The Historical Context. <http://www.ghana.gov.gh/index.php/information/reports/144-the-historical-context>, accessed March 2013.

History of Ghana

N.d. History of Ghana. <http://www.ghanaweb.com/GhanaHomePage/history/>, accessed March 2013.

History Timeline

N.d. History Timeline -Chronology of Important Events. <http://www.ghanaweb.com/GhanaHomePage/history/timeline.php>, accessed March 2013.

Johnson, T. M. and Carolyn F. Sargent

1996 *Medical Anthropology: Contemporary Theory and Method*. Westport, Connecticut: Praeger.

Jordan, Brigitte

1993 *Birth in Four Cultures: a Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Prospect Heights, Illinois: Waveland.

Hahn, Robert A.

1995 *Sickness and Healing: An Anthropological Perspective*. Chelsea, Michigan: BookCrafters.

Hill Collins, Patricia

2010 *Black Feminist Thought in the Matrix of Domination*. *In Social Theory: The Multicultural and Classic Readings*. Charles Lemert ed. Pp.541-552. Boulder: Westview Press.

Kleinman, Arthur

1978 *Concepts and a Model for the Comparison of Medical Systems as Cultural Systems*. *Social Science and Medicine* 12: 85-93.

Lori, Jody R., Sarah D. Rominski, Mawuli Gyakobo, Eunice W Muriu, and Peter Agyei-Baffour

2012 *Perceived Barriers and Motivating Factors Influencing Student Midwives' Acceptance of Rural Postings in Ghana*. *Human Resources for Health* 10:17.

Maternal Health Channel, The

2013 About: The Maternal Health Channel Ghana. <http://www.mhcghana.com/about>, accessed October 2014.

Ministry of Health

2013 The Health Development Sector Medium Development Plan (HSMTDP).
Republic of Ghana.

Modern Ghana

2012 College of Nursing and Midwifery to be Established in Accra. <http://www.modernGhana.com/news/414747/1/college-of-nursing-and-midwifery-to-be-established.html>, accessed February 2013.

Report by Ghana Statistical Service and the Ghana Health Service

2008 Millennium Development Goals in Ghana A new look at data from the 2008
Ghana Demographic and Health Survey. <http://www.measuredhs.com/pubs/pdf/OD60/OD60.pdf>, accessed February 2013.

WHO

2012 Atlas of Birth: Turing Promises into Action with ARHR; Saving the Lives of
Mothers and NewBorns in Ghana.
Alliance for Reproductive Health Rights

Salisu, Abdallah and Vanessa Prinz

2009 Health Care in Ghana March 2009. ACCORD: Austrian Centre for Country of
Origin & Asylum Research and Documentation. www.ecoi.net, accessed March
2009.

Shannon, Thomas

1996 An Introduction to the World-System Perspective. New York:Westview Press.

WACN Sub-regional workshop

2008 "Obstetric Emergencies: The concern of the Community Nurse/Midwife Practitioners" Accra, Ghana. West African Journal of Nursing 19 (1).

Witter, Sophie, Daniel Kojo Arhinful, Anthony Kusi and Sawudatu Zakariah-Akotod

2007 The Experience of Ghana in Implementing a User Fee Exemption Policy to Provide Free Delivery Care. Reproductive Health Matters 15(30) :61-71.

2006 News from Ghana midwives International Midwifery19 (4).

2006 The Emerging Midwifery Crisis in Ghana: Mapping of Midwives and Service Availability Highlights Gaps in Maternal Care.

Appendix A: Interview Questions for Reproductive Health Practitioners

Questions may change based on responses from the women interviewed.

1. Why did you start working as a nurse/midwife/with midwives?
2. Why did you decided to work with/as a nurse/midwife?
3. Tell me about what you feel are women's options for childbirth in Ghana. What are the differences between urban and rural access?
4. When during their pregnancies should women begin seeing you (nurse/midwife) for care?
5. When during their pregnancies do most women in the community seek care?
6. What type of information do you (or someone who works with/for you) provide to women about their options for birth?
7. Do you recommend some sort of childbirth education course for the women you are seeing? If yes, what and why?
8. Have you noticed a trend in the type of women you see, or do not see? Age, occupation, education, religion, ethnicity?
9. How many women do you care for at any one time?
10. Do you do any reading or research on childbirth outside of what is required for your profession?
11. Who's advice did you think community women seek most often about pregnancy and childbirth?
12. What other influences do you think women have about decisions for giving birth?
13. Do you feel that the women you care for are given all the care/attention they would prefer?
14. Have women come to you after having a bad birth experience with childbirth?
15. How much control do women want during their birthing experience?
16. How much control do you allow them?
17. Do you have children? If so can you tell me about your birth experience?
18. What are your intended impacts on the community of women you work with?
19. Are there other options for childbirth in this community?
20. Do you feel any tension with other birth facilitators in the region?
21. What do you think is the ideal for childbirth in this community?
22. What is the role of the government in women's options for childbirth in Ghana?
23. Are there rituals/rights/practices that are related to pregnancy, birth or babies?
24. Are you from this region? If yes/no, where?
 - a. If no, what brought you here to work?
25. What ethnic group do you belong to?

26. What ethnic group do the women you work with belong to?
- a. Does this effect the type of care they need?
 - b. Does it effect your relationship with the women you work with?
 - c. Do different ethnic groups give birth differently?

Appendix B: Interview Questions for Community Women

Questions may change based on responses from the women interviewed.

1. What do you consider your level of income, not in dollars but standard of living, your socioeconomic level?
2. Was the father of your child, or a partner part of the process?
3. Have you had more than one child? If so how were these experiences different?
4. Did you attend a childbirth education class, if so can you talk about the experience?
5. What was your reaction when you found out you were pregnant?
6. When did you first seek prenatal care?
6. Whose advice did you seek about pregnancy and childbirth?
7. What other influenced your decisions about giving birth?
8. What do you consider your options for the birth?
9. What do you consider your ideal birthing situation?
10. Do you know anyone who has given birth in a different way?
11. Did you do any reading or research on childbirth after you found out you were pregnant?
12. How do you feel about other ways of giving birth?
13. How do you see your childbirth experience in comparison to others?
14. Please tell me about your birth experience?
15. Were you happy with your childbirth experience?
16. Do you think if you lived in an area with more resources you would have made different decisions about childbirth or prenatal care?
17. How much control do you feel you had in planning the birth of your child?
18. How much control do you feel you had during the actual birth?
19. What do you consider your level of income, not in dollars but standard of living, your socioeconomic level?
20. Do you know what the United Nations' Millennium Development Goals are? And how they affect your life? Or the lives of people in your community?
21. How did women give birth in the past?
22. Are there other rituals/rights/practices that are related to pregnancy, birth or babies?
23. What ethnic group do you belong to?
24. What ethnic groups live in this region?
25. Do different ethnic groups give birth differently?

Appendix C: Photograph of Advertisement



Figure C.1: Image of an Advertisement for the Maternal Health Channel

Appendix D: Map of Ghana



Figure D.1: Map of Ghana Indicating Fieldwork Locations