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Gender Inequality and Lack of Sexual and Reproductive Rights of Women in Ghana: Implications for Social Work Education

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Introduction

Ghana is one of the first African countries to ratify the Convention on the Elimination of All Forms of Discrimination Against Women. In addition, Ghana has enshrined a number of sections (17) and (27) in the current 1992 constitution of the country outlining equal rights to all citizens including women and children. However, twenty years after the international women's decade and the national proclamations and ratification of United Nations conventions, women's reproductive and sexual lives are still being impacted by discrimination, gender-based violence, and high rates of maternal mortality among women in Ghana.

The human rights of women include their right to have control over their bodies and to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health (Beijing Platform for Action, paragraph 96, 1995). However, the reproductive and sexual situation of women is now under threat due to the HIV/AIDS pandemic that has engulfed the continent of Africa, with serious health consequences for all the women there. In addition, power and unequal gender relations between men and women and the cultural silence surrounding sexual habits in general are causes of concern to the general health of women, including their sexual rights. In Ghana, sexual and reproductive rights of women have a "feminist face" because of discrimination against women due to gender inequality and their low educational status. In addition, cultural norms have made it difficult for women to refuse their partners sex or to negotiate for safer sex.

Gender inequality is mentioned as a major driving force behind the lack of reproductive and sexual rights of women in general. According to the Commonwealth Secretariat (2002), patriarchy combined with poverty, illiteracy, and unemployment are all factors that increase women's repro-

ductive and sexual vulnerability. It is assumed that if women had control over their bodies and were able to negotiate safe sex, the disease might not have reached such vast proportions. It is pertinent that any meaningful engagement with sexual and reproductive rights should be addressed in reference to unequal gender relations between men and women.

The Study

This study reports on a qualitative study, which documents the sexual and reproductive experiences and concerns of Ghanaian women. This study's interest is in finding out the experiences of Ghanaian women in relation to their decision-making about child bearing and exercising their rights as women in to use birth control devices and also to demand safe and protected sex from their spouses or other sexual partners. This study took place in two regional capital cities and two rural settings in Ghana. The following factors were taken into account in selecting the study area: the size of the population; the size of the various migrant populations; the diversity of cultural, educational, economic, religious, and ethnic patterns; and the heterogeneity of the people and the groups. The inclusion of both urban and rural communities was meant to create fairness, divergence, and variations of responses that reflect possible differences between rural and urban populations.

Ghana is a former British colony, located on the south coast of West Africa a few degrees north of the equator. Ghana achieved independence on March 6, 1957, and became a pioneering independent state surrounded by colonial territories throughout West Africa. The total population of Ghana in 2000 was 20.2 million, with an annual growth rate of three percent (UNFPA 2004). Seventy percent of the people live in the rural communities of the country. The remaining 30 percent live in the urban areas and are concentrated along

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the coast and in the ten administrative regional capitals of the country. The major local dialects are Akan, Ewe, Ga, Nzema, Dagbane, and Hausa.

Economically, Ghana has diverse and rich natural resources but agriculture is the main economic activity, representing 45.5 percent of the gross domestic product. The economy is open to world markets and the primary products for export are cocoa, gold, diamonds, manganese ore, bauxite, timber products, and non-traditional processed agricultural products.

Historically, women suffered oppression and domination by the patriarchal system in Ghana. Women were taught to accept their position through the socialization process, including their initiation rites. They were taught to be obedient wives and to respect their elders. They were told that a man could marry more than one woman (Manu 1984; Oppong 1973; Nukunya 1969). The inferior position of women in traditional Ghanaian society was reinforced by a number of factors, including social practices, religious beliefs, and the practice of polygamy, child marriage, and widow inheritance. Many of these practices are still found today in some places in the country.

Methodology

A phenomenological qualitative approach was used for this study because this approach facilitates the description of an experience as perceived by the participants who have lived the experience. This approach intends to make visible the essence of the women's experiences and to enrich the understanding of their everyday sexual and reproductive life. The purpose of phenomenological study is to explain the nature and nuances of life experiences and to suggest possible insights about the lived experience from the participants' point of view. Two research questions, the answers to which formed the basis of the findings of this study, were put to the 68 participants, all women aged 18 to 70 years, in six focus group discussions. The participants were asked, 1) "Do you as women have the right or the freedom to use birth

control, or practice family planning without your partners' permission?" and 2) "Do you as women have the right, to demand safe and protected sex, by requesting your spouses or partners to use a condom?" In addition to the six focus group interviews, a demographic survey eliciting socio-economic information was used as a technique for data collection.

Study Participants

Purposive samples of 68 women were recruited through personal and professional contacts through the Department of Community Development and local church women's groups from two regions in Ghana. The composition of participants is from a broad cross-section of the Ghanaian population in terms of ethnicity, age, family situation, economic situation, education, religion, and patterns of residence that is both rural and urban (Table 1).

Seventeen were of the Akan ethnic group comprising Ashanti, Fanti, Kwahu, and Akwampim. Twenty-nine were of the Ewe ethnic group from the south, central, and northern parts of the Volta Region. Sixteen were of the Ga-Adangbe ethnic group made up of Gas from Accra and Krobos from Eastern Region. Six participants were from the northern part of the country consisting of two Kasenas from Upper West, three Dagombas from Northern Region, and one Buli from Upper East Region.

In all the groups, the continuum of family living situations was represented. Forty-eight of the participants were married with children, two were divorced with children, six were widows with children, seven were single women, and five were single parents with children. Forty-four participants lived in urban areas and 24 lived in rural communities. Sixty-one of the participants were practicing Christians of various denominations, namely, Presbyterian, Catholic, Methodist, and Pentecostal.

Five participants practiced Islam. One believed in traditional religion and another practiced

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Table 1. Sample

	Number*	%
<u>AGE</u>		
18-35 years	24	35
36-45 years	21	31
46-60 years	21	31
61-70 years	02	03
<u>MARITAL STATUS</u>		
Married	48	70
Divorced	02	03
Widowed	06	09
Single	12	18
<u>EDUCATION</u>		
Primary/Middle	15	22
Secondary/Post Sec	32	47
University	14	21
No Education	07	10
<u>RESIDENCE</u>		
Urban	44	65
Rural	24	35
<u>OCCUPATION</u>		
Civil/Public Servants	15	22
Teaching	27	40
Self-employed	12	18
University Students	08	12
Farmers	06	08
<u>ETHNICITY</u>		
Akan	17	25
Ewe	29	43
Ga-Adangbe	16	23
Dagomba/Kasenas/Buli	06	09
<u>RELIGION</u>		
Christianity	61	90
Islam	7	10

*Sample (N=68)

the Eckankar or Eastern religion. In terms of education, 15 of the participants had completed pri-

mary or elementary education, eight had completed secondary school education, and 24 of them had completed post-secondary education such as teachers' training education and higher National Diplomas. Fourteen of the participants had university education and seven had no formal education.

The incomes of the various participants ranged from the highest of 834,000 cedis per month, which is approximately \$94, to about the lowest of 62,000 cedis per week, which is about \$7. The average income for participants in civil and public services was 417,000 cedis or \$47 per month. Participants in private and self-business had irregular incomes due to the fluctuation of their businesses and thus could not report their incomes.

Research Procedure

The research team consisted of the author and two local research assistants who were recruited and trained before the fieldwork. The human subjects review committee of the author's university approved the research. Each of the focus groups consisted of ten to twelve participants who were contacted through the regional community development officer responsible for women's activities and the local leaders of women's groups. The group discussions were held in local meeting places and the English language was used mainly for the educated urban participants while two local languages -- Akan and Ewe -- were used with the rural participants. The participants were not paid any money but were provided with refreshments during the discussions. All the group discussions were audio taped and later transcribed verbatim into English.

Analysis

The interpretative phenomenological analysis (IPA) by Smith, Jarman and Osborn (1999) guided the analysis of this data. IPA takes an idiographic approach, which requires the researcher to engage in close textual analysis of transcripts

before moving on to begin to look for commonalities between or among individuals. The analysis began by slowly reading the individual responses to identify significant words, statements, or phrases and these statements and words were later organized into themes that became the claims for the group. The author's commentary and direct quotations from both urban and rural participants offer an overall sense of the experiences. Similarities and differences in themes from both the urban and rural groups were also noted. The analysis of the transcripts paid attention not only to patterns of meaning across transcripts, but also to contradictions, and dilemmas within groups and across the various groups.

Verification of the findings of this study was carried out with member checks from two of the urban focus groups and one rural focus group. The transcripts were read to the participants who were satisfied with the report and readily accepted that it reflected their own ideas or their authentic voices. A peer review process between the author and her two assistants involved comparing the personal reflections from the field with the findings outlined from the transcription.

Findings

Reproductive decision-making is not easy. The findings of this study revealed that women in Ghana do not fully enjoy sexual and reproductive rights. "Reproductive rights" in this context means the right to practice family planning and the use of birth control devices without consulting spouses or partners, and the right to safe and protected sex by demanding the use of a condom by male partners. In describing their experiences of the concept of the right to make personal decisions concerning the use of birth control and family planning services, a majority of the participants mentioned cultural practices -- such as the pressure from extended family members on married women to have children and being a good wife by being sexually available to your spouse -- as some of the obstacles they face. The right to

make the decision as to the number of children one wants to have is easily understood by all participants but the cultural practices make it extremely difficult for most women to exercise that right. An educated urban participant expressed this as:

Culture plays an important role in the choice of family size; the Ghanaian woman cannot kick against her cultural background. For example, she can decide to have a specific number of children but the extended family and the community can put pressure on her or the husband for more children.

Motherhood is seen as the natural state for women, and non-motherhood is defined as deviant in the Ghanaian culture. Women who are involuntarily childless are seen as cursed. Oppong and Abu (1987) recorded field interviews in Ghana that confirmed this traditional view of procreation. Citing figures from the Ghana fertility survey of 1983, the authors concluded that about 60 percent of women in the country preferred to have large families of five or more children. Two urban participants summed it up as:

A woman entertains the fear that if she is not able to give birth to at least another child of the opposite sex, especially a boy, the man will go in for another woman. However, men are now being more understanding with having same sex children such as all girls.

When a woman refuses to have many children, there is the possibility of her husband having an affair outside the marriage.

Another urban participant believed times have changed and women should be able to exercise their rights:

In the past when women were basically housewives and the men provided all the needs

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of the home, the man decided on how many children they should have but now things have changed.

A married rural participant believed since women are now playing effective economic roles in the family they could practice birth control secretly:

Women are also contributing their quota of housekeeping money or even more; therefore, we must make decisions on reproduction of children as well and practise family planning on our own, but we have to do it secretly.

Almost all the participants in both urban and rural settings expressed the belief that they have the right to make personal decisions concerning family planning or the use of birth control and to determine the number of children they have. However, they are faced with male dominance and unequal power relations, a problem exacerbated by poor economic conditions. In order to protect themselves from ill-health and economic problems related to child bearing and child rearing, the issue of practicing birth control or family planning becomes a “personal thing to be done secretly.” Two middle-aged married rural participants expressed it this way:

As women, we carry the pregnancy to full term and at times we are saddled with all the troubles of child rearing and care-giving and hence we have the right to decide the number of children we want to have or we will practice family planning or use birth control secretly.

For instance, pregnancy, childbirth and child upbringing are tasking and financially difficult for the housewife and the career woman; therefore, in the face of all these challenges, the woman has to decide how many children she can comfortably have.

An educated urban participant also expressed his view:

In the past when women were basically housewives and the men provided all the needs of the home, the man decided on how many children they should have but now things have changed.

Demanding Safe Sex Is a Thorny Issue

Another major finding of this study focuses on the right to demand safe and protected sex. “Safe and protected sex” in this context refers to the use of condoms by male partners. The general consensus among the participants was that every woman has the right to demand safe sex, and they viewed the demand for safe sex as very crucial in the fight against the HIV/AIDS and other sexually transmitted diseases. However, all participants, both rural and urban, regarded the issue of demanding safe sex as “culturally sensitive and unacceptable to most men.”

This situation posed a great dilemma and controversy for all the participants in this study because they felt it is the right of women to demand safe or protected sex from their spouses or partners, but at the same time they are faced with the issue of not offending their men, which seems to be a cultural issue. Both married and single participants expressed their awareness of the practice of polygamy and multiple-partners’ relationships involving men in monogamous marriages in Ghana. Demanding safe sex was referred to a “very thorny issue and a difficult problem for women,” one with both cultural and religious implications.

Two educated urban participants explained the issues:

This is a thorny issue because if your husband does not want to practice safe sex and yet he demands sex, then you the wife is torn between giving in to him or allowing him to go outside the marriage for it. And if he goes out-

side, what guarantee do you the woman have that he will not infect you with the virus?

Culture downplays the rights of women as far as women's reproductive life is concerned. Culture denies the woman the right to negotiate on when to have safe sex. The man calls the shots in all these instances. For instance if a woman decides she is not in the mood for sex or insists on the use of condom before sex, the man interprets it as an act of infidelity or even something more serious.

Three married rural participants also expressed their opinions as:

In this age and time, a woman needs to demand safe sex from her husband because most of the husbands are not faithful. We have to stay healthy and therefore we must demand safe sex.

I have a friend whose husband through promiscuity developed the AIDS disease and infected his wife and the newborn baby so we women should wake up and demand safe sex to protect ourselves.

Ghanaian men are not to be trusted. So, safe sex must be demanded to protect us from the HIV/AIDS disease.

Even though most participants affirmed their right to demand safe sex, the main dilemma they faced is the belief that it is wrong for a woman to deny one's spouse or partner sex even if she is aware of the risks involved. In effect, a woman is torn between giving in to unsafe sex or risking an end to her marriage. This dilemma has been expressed by a number of educated, married, urban participants as:

Before marriage, girls are taught about the joys of marriage and motherhood and how to

keep their husbands happy and to accept without question the responsibilities handed down by the culture. These lessons are silent about our rights as women, mothers or wives.

The bible says the man is the head of the family and this makes it difficult for some women to disobey the will of their husbands.

Women have the right to safe sex yet the men will not allow their wives to insist that they wear condoms. Men prefer sex without condom. They want it "flesh to flesh." Should the woman continue to insist on a condom, the man will take offence and sexually abuse the wife or even rape her.

There is nothing known as marital rape in this country. It is a woman's responsibility to have sex with her husband and if she refuses and he forces her, it is not a crime or marital rape.

Most women do not even have the right to decide when they are in the mood to have sex or not to have sex, and left alone, to demand safe sex.

Discussion and Implications

Within any marriage in Africa, men typically have more say than women in the decision to use birth control devices and in the number of children that the couple wants to have. Ghana Statistical Service Report (1997) has indicated that despite the independent nature of some marital relationships, men in Ghana still have the primary decision-making power in issues of family planning. Collumbien & Hawkes (2000) indicate that unequal power relations in sexual relationships can have a detrimental effect on both men's and women's sexual health. According to them, men's concerns about appearing powerful and in control can discourage men from discussing sexual issues with women.

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Women's sexual and reproductive roles have largely determined their social status and economic opportunities. It has shaped their view of themselves and their sense of personal empowerment, yet they have received little support or care in fulfilling this role. For most women in most societies, the reproductive role has been simultaneously over-valued and under-supported (UNFPA, 1997).

It is obvious that Ghanaian women, in view of the findings of this study, are in a subordinate position just like other women in other parts of the world. They are confronted with maintaining their family and marriage relations and facing problems of how to make choices in terms of their reproductive and sexual rights. Among currently married Ghanaian women, contraceptive prevalence is about 30 percent with only 10 percent prevalence of modern methods (Ghana Statistical Service, 1999). Women's reproductive health and rights cannot be fully evaluated without investigating the status women have within their society.

Culturally, values and beliefs regarding the sexual behaviour of men and women influence the balance of power in sexual decision-making. In a national survey conducted in Ghana, it was discovered that in reproductive issues such as when to stop having children and use contraception, 54 percent of respondents said they made a joint decision, 35 percent said the decision was the prerogative of their husbands or partners, and 11 percent said the decision was made by the woman alone. (Gadzekpo, 1999).

This study reveals the problems faced by the participants concerning their sexual and reproductive rights. Sexuality is one area in which almost all the participants found themselves highly controlled even though they expressed the opinion that they know what sexual rights they should have. The issues surrounding sexuality and reproduction have remained a private and a thorny matter in most of the participants' marriages because they are scared to be labelled as promiscuous or prostitutes by their spouses if they are open

about sexuality. The main problem related to power relations between spouses concerns the threat of sexually transmitted diseases, especially HIV/AIDS. The women have heard just enough about these diseases to be worried about the dangers of unprotected sex in view of the recognized infidelity of husbands and partners, but they still continue to put their lives at risk.

Both educated and uneducated participants expressed powerlessness in the face of what they know, assumed, or suspected to be infidelity, but could not introduce the use of condoms to their spouses. Another implication of this situation is that the gender role of women precludes them from making decisions connected with their fertility. In view of this, some participants have to resort to secret family planning, that is, the use of birth control, in order to space childbirth or to avoid frequent pregnancies.

The findings of this study – as explained above -- pose a challenge to professionals committed to gender equality, human rights, and other aspects of gender issues in Ghana. The views of the participants concerning their problems are buttressed by other researches and studies from other developing countries.

A number of other socio-cultural factors also enhance women's vulnerability to sexually transmitted diseases and HIV/AIDS, and these factors are incompatible with the attitudes, knowledge, and skills necessary for women to negotiate and practice safe sexual behaviour. For example, studies carried out in Brazil, India, Mauritius, and Thailand found that young women knew little about their bodies, pregnancy, contraception, and sexually transmitted diseases (Vasconcelos & Neto, 1992, Bhende, 1992, Cash & Anasuchatkul, 1992).

The lack of knowledge among women is supported by norms that dictate that good women should not know about sex or the functioning of their sexual and reproductive organs. In many societies, a "good woman" is defined as one who is naïve about sexual matters and chaste until

marriage, while a “loose” woman is one who knows about topics pertaining to sex and is assertive sexually (Carovano, 1992; Cash & Anasuchatkul, 1992). In a study conducted in Guatemala, about half the women interviewed at prenatal and sexually transmitted disease clinics said that they had never spoken with their husbands about sex. In addition, some Guatemala men reported that they speak about sex more freely with sex workers than with their steady partners (Lundgren, Bezmalinovic, Skidmore & Hirschmann, 1992).

Another socio-cultural factor is the social acceptability of multiple partners for men. In the findings of the study, most of the participants claimed that their spouses or partners are not to be trusted in terms of extra-marital relationships. Results from sexual behaviour studies around the world indicate that men, both single and married, have higher reported rates of partner change than women (Jenkins 1992; Orubuloye, Caldwell & Caldwell, 1992; Sittitrai, Brown, Ohanuphak, Barry, & Sabaiying 1991).

In focus group discussions among Jamaican working women, it was revealed that women were very concerned about the infidelities of their partners but felt that faithfulness on the man’s part was “pie in the sky” (Chambers, 1992). The use of condoms also has some socio-cultural implications for both men and women. According to a study in Uganda, many men are unwilling to use condoms, either because they do not believe in AIDS education messages that advocate the use of condoms, or because they have decided that their sexual pleasure outweighs any health risk (Sewankambo, 1997).

Implications for Social Work Education

The discussion above highlights the ways in which socio-cultural and economic factors influence male and female sexual behaviour and the power imbalance in heterosexual relationships. These factors have unintended consequences of exposing women in Ghana to HIV/AIDS infec-

tion and other sexually transmitted diseases. This indicates the need to examine some alternative discourses, ones that can provide assistance to women in reducing their vulnerability to STDs and HIV infection.

HIV/AIDS is accompanied by psychological, social, cultural, economic, and political consequences. It is, therefore, apparent that if the spread of this epidemic is to be controlled, women’s rights to have control over their reproductive and sexual life must be effectively pursued, developed, and encouraged among various groups of women in Ghana. There is the need to empower adolescent girls and women personally and collectively to increase and effectively use their knowledge, and their skills and rights as women.

According to Simon (1990), empowerment is a series of attacks on subordination of every description -- psychic, physical, cultural, sexual, legal, political, economic, and technological. The process involves the psychological, educational, cultural, and spiritual dimensions involved when individuals are helped to understand their oppression and to take steps to overcome it. Thus empowerment is a process of increasing personal, interpersonal, and political power so that individuals can take action to improve their lives (Gutierrez, 1990).

Girls and women must be given the educational opportunities to improve their skills in advocating the use of condoms and negotiating safe sexual behaviour with their partners. They also need to share personal experiences in group interactions and to develop a critical consciousness about gendered sexual roles. These efforts could facilitate individual behaviour change and might also lead to collective action to change socio-cultural norms in the communities.

There is also the need for effective information, education and communication to raise awareness among men of the reproductive health risks and effects of harmful socio-cultural practices on women and their sexuality. The need to

promote quality communication between spouses concerning all aspects of their sexual life should be encouraged and promoted. Involving men in the sexual and reproductive health of women will increase their awareness, acceptance, and support of their partners' needs, choices, and rights. In terms of contraception, it means encouraging the men to give more support to their partners who use birth control.

Social workers in Ghana need to work in collaboration with women's groups to bring about social change through social and adult education that could lead to change in attitudes that support the subjugation of women. Curriculum development should incorporate culturally appropriate feminist, humanistic, and empowerment theories into social work training programs in social work schools in the country. This will enable social work students to become effective advocates and change agents in fighting against some of the institutional and cultural barriers that hinder the progress and advancement of women in general.

Finally, there is the need for the state machinery to focus resources on making the structural changes necessary to improve the status of women by increasing women's access to education, credit, skill training, and employment. All of these would contribute to furthering the human rights of women. There is also the need for more participatory action researches to examine the cultural, economic, and social factors related to sexuality and gender relations with emphasis on the realities of women's lives. Data from such studies are essential for the design of appropriate and effective interventions, programs, and policies on women's needs and HIV/AIDS prevention in the country.

Conclusion

This study examines gender inequality and the lack of sexual and reproductive rights of women in Ghana. The findings revealed that women in Ghana claimed to have the reproductive and sexual rights as outlined in both international con-

ventions ratified by their country and in the national constitution. However, in practice, women lack the power to negotiate safe and protected sex with their partners, due to unequal gender relations, power and control, and socio-cultural practices. Having the knowledge about one's reproductive and sexual rights is one thing, but using the knowledge freely is another. The freedom for women to have control over their bodies and sexuality has been hampered by socio-cultural myths, silence, economic difficulties, and social exclusion that are deeply embedded in Ghanaian and other societies.

Finally, finding lasting solutions to the sexual and reproductive problems of women involves full participation and social inclusion of women's voices and their experiences in social policy planning and formulation. In addition, broader measures are needed to improve the economic status of women and to empower women personally, socially, and collectively within their marriages and in the society. There is the need for measures to raise awareness among men of the ways in which their sexual behaviours can place them, their families, and sexual partners at risk of HIV infection.

References

- Bhende, A. (1992). Evolving a model for AIDS prevention education among underprivileged adolescent girls in urban India. Washington, DC: International Centre for Research on Women and AIDS Program.
- Caldwell, J. C., Caldwell, P. & Quiggin, P. (1989). The social context of AIDS in Sub-Saharan Africa. *Population and Development Review*, 15, 185-234.
- Carovano, K. (1992). More than mothers and whores: Redefining the AIDS prevention needs of women. *International Journal of Health Services* 21, 131-42.
- Cash, K. & Anasuchatkul, B. (1992). Experimental educational interventions for the prevention of AIDS among Northern Thai single female migratory adolescents. Washington, DC: International Centre for Research on Women and AIDS Program.
- Chambers, C. (1992). Sexual decision-making amongst Jamaicans. Washington, DC: International Centre for Research on Women and AIDS Program.

- Commonwealth Secretariat, (2002). Gender mainstreaming in HIV/AIDS: Taking a multi-sectoral approach. London: Commonwealth Secretariat.
- Gadzekpo, A. (1999). Societal attitudes to violence against women and children. In D. C. Appiah & K. Cusack (eds.), *Violence against women & children in Ghana: A report of a national survey on violence*. Accra: Gender Studies & Human Rights Documentation Centre.
- Gutierrez, L. M. (1990). Working with women of colour: An empowerment perspective. *Social Work*, 35, 149-154.
- Ghana Statistical Service, (1999). *Ghana demographic and health survey*. Accra: Statistical Services.
- Ghana Statistical Service, (1997). *Ghana demographic and health survey*. Accra: Statistical Services.
- Jenkins, C. (1992). Preliminary report on the national sex and reproductive study of Papua New Guinea. Washington, DC: International Centre for Research on Women and AIDS Program.
- Lundgren, R., Bezmalinovic, B., Skidmore, W. & Hirschmann, A. (1992). *Guatemala city women: Empowering a hidden risk group to prevent HIV transmission*. Washington, DC: International Centre for Research on Women and AIDS Program.
- Nukunya, G. K. (1969). *Kinship and marriage among the Anlo-Ewe*. New York: Athlone Press.
- Oppong, C. & Abu, K. (1987). *Seven roles of women: Impact of education, migration and employment on Ghanaian mothers*. Geneva: ILO.
- Orubuloye, I. O., Caldwell, J.C. & Caldwell, P. (1992). Diffusion and focus in sexual networking: Identifying partners and partners' partners. *Studies in Family Planning* 23(6), 342-351.
- Sewankambo, N. (1997). *AIDS in Uganda: Understanding the causes of high-risk sexual behaviour*. Ottawa, Canada: International Development Research Centre.
- Simon, B. (1990). Rethinking empowerment, *Journal of Progressive Human Services*, 1, 27-40.
- Sittitrai, W., Brown, T., Ohanuphak, P., Barry, J. & Sabaiying, M. (1991). *The survey of partner relations and risk of HIV infection in Thailand*. Florence, Italy: Abstracts of the Seventh International Conference on AIDS.
- Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis, In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology: Theories & methods*. London: Sage Publications.
- UNFPA, (2004). *Background on Ghana*. Accra: UNFPA.
- UNFPA, (1997). *Rights for sexual and reproductive health: The right to choose*. New York: The State of the World Population.
- Vasconcelos, A. & Neto, A. (1992). *Research project on AIDS and sexuality among low-income adolescent women in Recife, Brazil*. Washington, DC: International Centre for Research on Women and AIDS Program.