Maternal Mortality: Gender and Access to Health Services – The Case of Ghana

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Abstract

With nearly 600,000 women dying every year from complications arising from pregnancy, maternal mortality is a pressing issue. The majority of these deaths could have been prevented, had an accurate response been formulated. Existing policies tend to assume that physical constraints are the main obstacles to women’s access to health services. This paper challenges that assumption, arguing that gender inequalities and women’s role in society are the root causes of the high levels of maternal mortality in the developing world. The international policy response will be analysed through an examination of the Millennium Development Goals and a case study of Ghana, revealing that the failure to properly include gender is the main reason to why maternal mortality rates remain high.

Keywords: maternal mortality; gender; MDGs; reproductive rights
Introduction

Every minute, somewhere in the world, a woman dies from complications of pregnancy. Complications arising from pregnancy and childbirth are the number one cause of death among young women and girls between the ages of 15-19 years in the developing world. Most of these deaths could have been prevented (Center for Reproductive Rights 2013; WHO 2013). Yet declines in maternal mortality rates are slow, and implemented policies and strategies have not had the desired outcome (UN 2012). The failure of international institutions to include gender in their policies is one of the main reasons for the insufficient progress to improved maternal health.

Maternal health refers to “the health of women during pregnancy, childbirth and the postpartum period” (WHO 2013). Maternal mortality rates are thus based on deaths during pregnancy, childbirth and 42 days from termination of pregnancy. Reproductive causes account for more than 50% of deaths among women in their childbearing years, making it an enormous threat to women’s health and right to life (Koblinsky et al. 1993). It is estimated that almost 600,000 maternal deaths occur each year, most of which can be prevented (Ronsmans and Graham 2006). Reproductive health threats are unique to women, and as such they run the risk of not being properly dealt with due to the inferior position women have in many countries around the world in combination with an underrepresentation of women in higher policy circles. It is also mostly in the past three decades that maternal mortality has even been recognised as a public health concern (Gruskin et al. 2008). Further, 99 per cent of maternal deaths occur in developing countries (WHO 2013) creating an extremely large discrepancy between maternal mortality in developed and developing countries – much larger than for child or neonatal mortality. Maternal mortality rate is therefore a strong indicator of inequality, reflecting the status of women and their access to healthcare (Shen & Williamson 1999: 210). A widely used approach to explain the high number is to point out the weaknesses in medical and health systems, but poverty and lack of health services are not the only explanation for high levels of maternal mortality. More importantly, as Cook and Dickens (2002) argue, the failures of social justice that underlie these systems account for a large part of these preventable maternal deaths. Accordingly, a lot of the current research and literature on maternal mortality focus on the availability of health services in rural areas. However, it often fails to fully consider the social and cultural factors that prevent women
from accessing these services. Even when facilities are available women tend not to make use of them (Koblinsky et al. 1993).

For example in Ghana, where abortion is legal under certain circumstances, many women still have illegal, unsafe abortions because they are not aware of the fact that abortion is legal or they are prevented to access it due to other social constraints. The large falls in maternal mortality levels across the developed world has mostly occurred due to the increased frequency of skilled midwifery care at birth along with universal access to care. The importance of available, professional care is therefore vital when discussing maternal mortality. Nonetheless, there are other reasons behind the low attendance of women at clinics and hospitals than merely the physical constraints to access. This study will thus use a case study of Ghana to illustrate the fact that government policies will not be fully effective if social norms and attitudes regarding women and society are not changed first. As Stromquist (1990) and Albertyn (2003) assert, this approach is necessary because even though practical limitations to women’s access to medical services are important, efforts in improving these problems have not led to the desired reduction of maternal mortality rates. Instead, the root cause of the low utilization of maternal care services, being women’s subordinate role in society, needs to be emphasised so that appropriate actions can be taken.

The following three chapters will analyse and discuss the different aspects affecting gender relations and women’s role in society, and the measures taken by international institutions to reduce maternal deaths. The discussions will be structured around four main themes: women’s role, patriarchy, education and abortion. These themes will be considered in relation to the three different contexts identified in the chapters. The first chapter will discuss the feminist literature on these four topics, creating the theoretical base which the following two chapters will be based upon. The main issues identified in chapter one will then be discussed in the second chapter dealing with policy responses to maternal mortality. This chapter will assess the international policy response to maternal mortality by analysing the United Nations Millennium Development Goals (MDGs), as they represent the largest international effort to reduce poverty and related issues. Finally, the last chapter will use a case study of Ghana to prove the theoretical assumptions provided in the first chapter as well as the effects of the MDGs discussed in chapter two. This chapter will provide country specific evidence on how women’s role and gender affect maternal mortality. Hence, this paper will aim to answer the question: how does women’s role in society affect their access to appropriate services that could reduce maternal mortality?
Methodology
Both primary and secondary sources are used in this paper. Government documents, research studies, statistics, international policy documents and NGO reports have all informed this study. The wide ranges of sources, as well as the analysis of texts produced by both Northern and Southern scholars provide a broad base for the discussion. While the case study of Ghana has benefitted from in-country accounts, the limited amount of Southern academics commenting on the impact of the MDGs means that the second chapter may be slightly biased. However, this paper has sought to reduce this bias by using official statistics to provide a more neutral, accurate ground to the analysis. Further, the difficulties in measuring maternal mortality were also shown in the differing figures produced by different organisations (UN 2012; WHO 2013). However, as this study focuses on the United Nations MDGs, the numbers cited in relation to maternal deaths as well as to the goals in general are those produced by the United Nations.

1. Theoretical Background

1.1. Introduction
Gender inequalities exist in any society and contribute to the subordination of women relative to men in most contexts. Gendered structures place barriers to women’s access to paid labour, education and health services which could provide them with life-saving care. These gender norms and structures are therefore relevant to any analysis of maternal health. This chapter will examine the feminist debate surrounding gender issues by focusing on four themes: women’s role, patriarchy, education and abortion. These themes capture the core issues concerning women’s position in society and how that affects their health, particularly maternal health. There are certainly more aspects of gender divisions and female subordination which affects the lives of women, however these four categories were chosen as they include issues that are crucial for an understanding of how gender is linked to maternal mortality.

Further, the different issues examined in this part of the paper also affect each other and it is crucial to recognise these connections in order to understand how gender creates the root causes of sustained high rates of maternal mortality. Hence, the discussion in this chapter will
provide a base for the argument that gender inequalities prevent women from accessing available health services. This will be done by engaging with feminist literature on the topic to assess the validity of the assumptions surrounding gender and access to resources. Firstly, women’s various roles will be examined with specific attention to women’s reproductive role. Secondly, the concept of patriarchy and the effect patriarchal structures have on gender equality and women’s autonomy will be outlined, followed by a discussion of education. The proven benefits of education should not be ignored, however a gender biased curriculum may be more detrimental than beneficial to women’s autonomy. Both women’s role and patriarchy are important to consider in relation to girls’ education and these themes will be further explored in this chapter. Finally, abortion as an essential mean towards full reproductive rights is examined. Again, all the three previous themes are vital to ensure an understanding of abortion as the contested topic it currently is. The four categories are thus connected in the last section on abortion, proving the value of abortion as an indicator of reproductive rights.

1.2. Women’s role

The role women are given in society is of significant importance to gender inequalities. Women play a large part in the organisation and production of the household, but their involvement in waged labour outside the household is limited. Women are thus seen as the housewife and homemaker, confined to the private sphere while men dominate the public sphere and take part in productive work outside the home (Moser 1989: 1801). This division of labour is problematic as it gives the man full control over all income generating labour and hence also over the resources produced. Women therefore become dependent on men in accessing resources, even such simple decisions as purchasing household items will be made by the man (Allen 1999, in Sesay 2010). However, the fact that women often are confined to the private sphere does not necessarily mean that they only undertake reproductive housework. They may also function as secondary income earners, although this work is often undertaken in the home or immediate neighbourhood meaning that they still remain in the private. Community management is also often performed by women, however the leadership roles are still reserved for men again reflecting the gendered division of labour. These different roles, which Moser calls ‘the triple role of women’, mean that the workload of women is often quite diverse and this is an important factor to consider when assessing women’s position in any community (Moser 1989: 1801). Nevertheless, despite these triple roles women are often viewed primarily as child bearers, their principal duty being to
reproduce. This reproductive role comes of importance from a quite early age and also contributes to the low education and literacy levels of many women (Stromquist 1990). Women’s roles as the housewife and organiser of the household in combination with the reproductive role pose further problems to women’s health. Because pregnancy is seen as the ‘normal’ state, not a as a condition requiring care as it is not an illness, women are discouraged from seeking professional care as they, and the community, believe that they do not need it. The triple role and the amount of work women do often goes unseen by the community as it is perceived as being non-productive (Moser 1989: 1801).

Consequently the fact that the heavy workload can have implications for women’s health and wellbeing may be ignored by both the women themselves and society at large. Additionally, the threshold of illness recognised by society is very high for women and many women will endure a lot of pain before seeking care as they cannot afford to disrupt the household organisation which they have the primary responsibility for (Okojie 1994: 1237). The lack of education and information available to women further increases this problem as they will not be able to read the ‘danger signs’ and hence delay seeking medical care.

Because of the emphasis on fertility and reproduction, the female body becomes central to women’s subordination. Women’s bodies become their primary resource that can determine their social status in terms of reproduction as well as sexual availability. Also adolescent girls experience the pressure to be sexually active and available to their partners. Varga states that a girl’s respectability is dependent on her being sexually available and allowing her partner sexual decision-making authority (Varga 2003: 163). Furthermore, women’s lack of decision-making power when it comes to the use of contraceptives further undermines the status of women as they may be forced to engage in risky sexual behaviour to retain respectability. Unprotected sex may then lead to unwanted pregnancies which can pose a threat to the woman’s health.

Use of contraceptives that could reduce unwanted pregnancies and thus also maternal mortality might also be reduced by the emphasis on women’s reproductive role. Both men and women realise the importance of becoming pregnant at an early age in order to prove fertility and men may therefore object to using contraceptives as they also want to prove their fertility. Similarly, a woman may also refuse contraceptives so that she can maintain her status as a reproductive woman. Parenthood confirms the femininity or masculinity of men and women and childless people will face heavy stigma and discrimination (Albertyn 2003:...
Additionally, a woman’s use of contraceptives effectively challenges her role as a child bearer by removing the control over her fertility from her husband. By taking control over her body she challenges the patriarchal power structures which authorise men to make decisions concerning fertility. Men may therefore oppose the use of contraceptives as it will reduce their ability to make decisions and controlling a woman’s body (Walker 1996: 60-61). Similarly, abortion is another method that can be seen as giving women more power and challenging patriarchy, which will be discussed below.

These roles that women are given in society pose serious problems in terms of maternal mortality. A woman will be less inclined to use contraceptives or other forms of family planning if she is dependent on her ability to give birth to maintain her status. Additionally, it further reinforces male power as women are reduced socially and institutionally to their reproductive ability and their frequency of childbearing (Shen & Williamson 1999). Hence, women’s role therefore affects their access to services like family planning and abortion that could contribute to a reduction of maternal mortality levels. The structures of society which creates and reproduces this role is therefore also of utmost importance to this analysis.

1.3. Patriarchy

Societies dominated by patriarchal structures pose a great barrier to women’s empowerment. The structural relationships of power between males and females, where men hold the superior position cause a loss of freedom for women and may also increase the risk of violence against women (Bunch 1990). According to Einspahr patriarchy is a structure of domination, where the relationship between men and women need to be considered in terms of their relative position as members of a group. Thus, power relations and domination focuses “on the ability of some groups to systematically interfere in the lives of other groups, whether or not such power is exercised by all individuals so capable” (2010: 4). It is therefore important to recognise the differences between women and the intersections like class, race and age when discussing their role in a patriarchal society. Not all women are oppressed by men and some women have power over other women, or over men. However, as members of a group women face greater interference in their lives by men, compared to the ability women have to interfere in the lives of men. The individual woman may not face subordination by an individual male but nevertheless the freedom of women is hindered by the systematic domination by men in society.
Men take the role as decision makers in virtually every aspect of life, even issues concerning reproductive health and the female body. By denying women the right to control their own body, society restricts their access to basic needs that might risk their health as well as that of their children (Mirembe & Davies 2001: 407). Many societies in Africa, such as Ghana which will be discussed in chapter three, still adhere to traditional customs rather than national laws and regulations. These customs often subordinate women and girls and further reinforce men’s ability to make decisions and control women. Practises like early and forced marriage pose a danger for girls in terms of both physical and mental wellbeing. Outtara et al. argue that “equating a girl’s attainment of puberty with a husband’s license to seek and force sex upon her denies each girl control over her own body, including her control over whether, when, and with whom she has sexual relations” (1998: 32). This loss of control puts young girls at risk for sexually transmitted diseases and HIV as well as early pregnancy with a higher risk of suffering complications and even death. Early marriage has also shown to have detrimental effects on the education of both boys and girls, however girls tend to suffer more than boys and are also more likely to be illiterate which consequently further limits their independence (Outtara et al. 1998; Warner et al. 1997).

Furthermore, marriage as an institution also reinforces male power over women. Traditional views of women as wives and mothers held by both women and men, further entrenches gender inequalities as the patriarchal nature of a given society encourages women to hand over all assets and control to men. Besteman observes that women in a Somali community had strong cultural beliefs regarding their roles as wives and the extremely limited access to land and hence economic independence this entailed (1995: 201). Further, women are not only seen as the property of their husbands, but during most stages of their lives they are considered to be in a man’s possession. Before marriage a woman is in her father’s possession, at marriage in her husband’s and upon divorce or the death of her husband the woman becomes her brother’s responsibility (Besteman 1995: 201). The patriarchal power dominating society treats women as assets to the household controlled by a male, making a woman vulnerable and dependent on the decisions of men to ensure her wellbeing. The structural and systematic domination by men over women in patriarchal societies can therefore have serious implications for women’s access to vital health care as well as access to education and other services which could reduce women’s dependence on men.
1.4. Education

Women’s access to education is crucial if female empowerment is ever to be achieved. Education is an important tool that can be used to give women more power, improve gender equity and consequently also women’s health. Research by McTavish et al. in sub-Saharan Africa showed that mothers in countries with higher female literacy rates are more likely to use maternal health care than women living in countries where national levels of female literacy are low (2010: 1962). Furthermore, higher educated women will also have greater personal safety and access to resources and labour markets which may give them a greater freedom. Gender discrimination with regards to education often starts from childhood, where boys are given primary access to education. This problem links in to the role women have in society. As they are primarily viewed as child bearers and wives, society finds it unnecessary to invest money and resources into a girl’s education as she will not engage in any waged labour and the money invested will therefore not generate any return to the family (Okojie 1994: 1244). For boys, on the other hand, education is seen as an investment that will increase the likelihood of them obtaining higher-waged work later. Consequently, the gendered division of labour reinforces the discrimination of girls. If women would have more access to paid work the likelihood of families investing in their education would be higher as the girl would be able to pay back some of the money and support her parents when they get old. Because of this lack of education for girls, they often grow up to be illiterate hence further increasing their dependence on their husbands or other males for access to information (Sesay 2010: 6). A woman with none, or little, education will be less inclined to seek health care as she will lack the necessary information on how to access it or what kind of services that are being offered. Furthermore, rumours and prejudice regarding medical personnel and their treatment of pregnant women will also be more easily spread among uneducated women who do not have access to accurate information. When the status of women is high, they are more likely to have access to education and hence information, and will therefore be more inclined to seek care and to choose trained medical personnel over traditional birth attendants (Erdman 2012). Low levels of education therefore make women extremely vulnerable and dependent and pose a very real threat to women’s health.

However, education as a tool to empowerment also needs to be assessed in relation to the nature of the education provided. Simply improving the number of girls attending school will not necessarily improve their status, which can be seen in the MDGs discussed in chapter two. Education in itself is not always enough to empower girls if the available schooling
merely reproduces the patriarchal structures that subordinate them in the first place. The formal curriculum in sub-Saharan countries, such as Ghana which will be discussed in chapter three, is often inherited from the colonial powers and reflects the gender relations of that time. Girls were educated for domestic purposes while boys needed an education to find employment (Gordon 1998: 54). This gender stereotyping has largely remained in the current educational system and is reinforced by the teachers and in the textbooks used (Leach 1998: 14). Teacher normalising certain aspects of male and female behaviour including sexual harassment and abuse serves to further reproduce male domination leaving the girls vulnerable to violence and oppression (Dunne, Humphreys & Leach 2006: 80). Further, teachers often perceive boys as more intelligent and serious about school work compared to girls. This misconception means that teachers tend to be more submissive towards girls, hence denying them a chance to an education that could aid them in challenging gender inequalities (Kabeer 2005: 13; Leach 1998: 14). Education may thus reinforce the very norms, both feminine and masculine, and patriarchal hierarchies that it seeks to reduce. Although education is vital to equip girls with the knowledge necessary to reduce gender gaps, this will not be achieved until the schooling they receive is gender neutral. Without a gender sensitive curriculum girls will not be able to reach their full potential (Leach 1998) and their access to other services such as health care, including abortion, will remain limited.

1.5. Abortion

Abortion is a controversial topic in world politics and there are many different views and opinions on this issue. Abortion is closely related to reproductive health and rights of women, and it is central to any discussion concerning maternal mortality as unsafe abortion is one of the major causes to maternal deaths. However, the extremely divided opinions concerning abortion and whether it should be available to women have excluded it from many international documents and treaties, for example the MDGs which will be examined in chapter two. The exclusion of abortion from discussions on human rights and reproductive rights are problematic as it ignores the fact that unsafe abortion is a ‘major public health concern’, with women in the developing world suffering disproportionately (UN 1994: 8.25). Additionally, the patriarchal nature and male dominance of many international institutions further increases the neglect of questions concerning abortion as it is seen as an issue that only concerns women and is thus given lower priority (Peters & Wolper 1995).
Women’s role in society is also closely linked to abortion and the reason for it being such a contested issue. The importance of women’s fertility and their ability to reproduce reinforces the negative views on abortion. By seeking an abortion, a woman is challenging assumptions about the nature of women and their role as child bearers (Kumar et al. 2009: 628). Abortion thus becomes an issue of the very nature and position of women making it a much larger problem for society, especially patriarchal communities where women have inferior status to men. This inferiority also means that even if abortion is viewed as a female concern, decisions about the procedure and the legality or acceptability of it are still taken by men. By controlling abortion and surrounding it with stigma, society has taken control over women’s bodies and limited their reproductive rights. Patriarchal power is thus vital to understand abortion as a political and contested issue affecting women in more ways than purely physically (Braam & Hessini 2004). These societal structures and the customary laws and practices within them mean that women’s access to safe abortion is dependent on much more than simply state laws. Even where abortion is legal, such as in Ghana which will be discussed in chapter three, safe procedures are not always available. Again, the fact that the majority of higher level decision-makers are men contribute to this lack of available services as abortion is not a prioritised issue in many national health policies (Okojie 1994: 1243).

Women’s reproductive rights gained increased recognition in the 1990s with the Cairo and Beijing conferences. Abortion is also included in this much broader rhetoric that includes not only maternal health but women’s wider sexual rights (Petchesky & Judd 1998: 4). This rights-based perspective puts abortion in a much more positive light than previously, arguing that it is a woman’s right to make the choice to have an abortion without being condemned for it. However, despite the progress reached during these conferences, little has actually changed in the lives of the majority of women when it comes to access to abortion and the stigma surrounding it. Even in the developed world where abortion is largely accessible, abortion is still viewed as a necessary evil. For example, even in Scandinavia where anti-abortion views are relatively unaccepted by the society, women who have had an abortion are still expected to have feelings of doubt and sorrow (Lokeland 2004: 171). This victim-blaming rhetoric surrounding the procedure suggests that motherhood is the ideal condition women should strive for, and every unwanted, terminated pregnancy is a tragedy (Petchesky 1990). The idea of women as child bearers and mothers are thus strengthened, implying that a woman who chooses abortion has failed and should apologise for her actions.
Additionally, the Cairo conference was progressive in that it recognised the importance of abortion as a means to full reproductive rights. However, even in the plan of action emanating from the conference, abortion is still described as a kind of necessary evil which should be avoided if possible (UN 1994: 8.25). Increased levels of family planning are mentioned as a way to reduce abortions, and this would have beneficial effects on women’s health by reducing unwanted pregnancies. However, the fact that abortion is still only mentioned in relation to methods of reducing it implies that it is not a neutral, acceptable choice. While a reduction of unwanted pregnancies is indeed desirable, the rhetoric surrounding abortion nevertheless needs to be changed. Until abortion is morally accepted as a choice that does not need justification women will not enjoy full reproductive rights (Lokeland 2004: 172). Consequently, unless women’s role and position in society is changed abortion will remain a contested issue that poses a threat to women’s rights both in terms of freedom of choice as well as physical wellbeing.

1.6. Conclusion

In order to gain a full and accurate understanding of maternal mortality and its causes, it is crucial to include gender in the discussion. Gender issues lie at the core of women’s limited access to health services and hence the slow reduction of maternal mortality rates. The literature on gender discussed above recognises female subordination as a root cause of women’s limited decision making power and consequent lack of access to resources.

As outlined above, there are several underlying factors that contribute to women not accessing appropriate services that could reduce maternal mortality. Women’s role in society is the root cause of most of the other issues, as their subordinate position creates several problems in terms of access – to resources, information and health services. Allowing women a greater degree of self-determination would enable them to make informed decisions regarding their own health and reproductive life. Abortion is a particularly contested topic which nonetheless poses a great threat to women’s health. The reluctance of the international community to deal with this issue is seen in the outcomes of the Cairo conference discussed in the last section. Even a conference which is recognised specifically for its progressive ideas on reproductive rights fails to discuss abortion as a moral choice. Abortion is also left to the sovereign states to decide upon, reducing international pressure on states to make abortion services available to women (UNDP 1994: 8.25). Unsafe abortion will thus remain a concern for women of reproductive age, both in terms of physical health and because of the stigma.
they will face by accessing abortion. Accordingly, the importance of including gender in strategies aimed at reducing maternal mortality cannot be overemphasised. The varying experiences of different women also need to be properly acknowledged as one solution might not fit all. These issues will be further discussed in the next chapter which deals with the policy responses to maternal mortality.


2.1. Introduction
In 2000, 189 nations came together in an attempt to reduce poverty and help the poorest countries in the world. This pledge turned into a set of eight measurable, time-bound goals, addressing what is perceived to be the main obstacles to development (The Millennium Declaration 2000). These eight goals are measurable by a set of over 40 quantifiable indicators and the aim is to achieve them by 2015.

The United Nations Millennium Development Goals (MDGs) acknowledges the importance of reducing the high rates of maternal mortality around the world. MDG 5 focuses on improving maternal health through two targets. Target 5.A seeks to ‘reduce by three quarters the maternal mortality ratio’ and target 5.B to ‘achieve universal access to reproductive health’. These goals are measured by various indicators such as the proportion of women attended by skilled health personnel during pregnancy. Accordingly, like many other organisations and governments, the United Nations (UN) chooses to focus on the availability of health centres and skilled medical personnel. There is very little mentioning of other social and cultural factors that could be causing the slow improvements in maternal health over the last decade. Hence, the MDGs represent the approach commonly taken by many international organisations and by focusing on the goals this chapter aims to demonstrate the weaknesses of this approach as it fails to accurately include gender.

Moreover, most of the innovative strategies for improving the likelihood of reaching the health related MDGs also tend to focus on improving services and problems concerning transport and infrastructure (Altman et al. 2011). Even if these aspects are also important to improve in order to reach any lasting decrease in maternal deaths, a solution to such practical problems will not lead to any dramatic changes as the underlying social issues will still be present. Koblinsky et al. rightly asserts that “[b]ecause women’s health is a direct reflection
of their status, no strategy can be successful in the long-term unless women become equal partner in social development” (1993: 24). Based on these arguments this chapter will engage more closely with the structure and progress of the millennium development goals within the themes established in the first chapter: women’s role, patriarchy, education and abortion.

2.2. The Millennium Development Goals and Women’s Role

The past decades of increased focus on women’s rights and gender relations has resulted in growing recognition for the importance of improving women’s status and ensuring that their human rights are not being violated. The Millennium Development Goals have acknowledged this need for improving gender equality and empowering women. There is even a goal dedicated to achieving universal gender equality, and gender is also mentioned in several of the other seven goals. MDG 3 seeks to “promote gender equality and empower women” by eliminating gender disparity in education, increase women’s participation in waged, non-agricultural labour and increase the proportion of seats held by women in national parliament.

All of these three points are important in the process towards gender equality. However, simply focusing on the number of girls and women enrolled in school and waged work excludes many of the key obstacles to women’s empowerment (Heyzer, in Sweetman 2005). Societal norms and values that determine the role of women and can prevent them from improving their status relative to men are ignored. Further, progress towards this goal is only measured by education and literacy rates, thus failing to acknowledge the fact that even highly educated women can have very low personal status and limited ability to make reproductive decisions (Crossette 2005). In line with the argument of this essay, Heyzer (2005) states that the MDGs are lacking an analysis of basic power relations and do therefore not have the potential to fully achieve the goal of empowering women.

As discussed in chapter one, women are often viewed primarily as child bearers, with their role in in society being determined by their ability to reproduce. This role is central to the position of women in any given society and in order to ensure gender equality these assumptions about women’s role need to be challenged. Policies seeking to address gender relations hence need to include women’s existing roles and how they can be changed in order for policies to be effective. The weakness of the MDGs in this area is indicated in the stagnated decline of early child bearing as that may be viewed as an indicator of women’s lack reproductive autonomy. The 2012 Millennium Development Goals Report show that progress has slowed or even reversed since the goals were implemented in 2000 (UN 2012:
While the MDGs do emphasise the importance of education in changing women’s status and reduce their subordination to men, they do not discuss how existing perceptions of women affect their potential for empowerment (Ahmed et al. 2010: 5). With the lack of inclusion of women’s role and how it can be challenged the MDGs will not be able to achieve gender parity within the set time frame.

The importance of a woman’s fertility to her role in society makes control over the body a crucial factor to empower women (Braam & Hessini 2004). Reproductive and sexual health should be a priority for policy makers attempting to improve gender equality as well as maternal health. The fact that the MDGs do not mention reproductive health as such, but instead uses the much more narrow term maternal health, is a serious flaw. Even later reports on the MDGs conducted by the Millennium Project recommend that access to reproductive health services should be added to the MDG 5 (Bernstein & Hansen 2006) However, this recommendation has not been implemented. Childbearing comes with high health risks and maternal mortality is high in most areas of the developing world. MDG 5 which aims to improve maternal health therefore needs to be linked with MDG 3 to increase the possibility to achieve either of those goals. The focus on education and waged labour in the MDGs has led to some positive changes in terms of female participation in labour markets and parliaments as well as increased possibilities for women within these areas (UN 2012: 26). However, there has not been a corresponding increase in women’s freedom of sexual and reproductive choices (Braam & Hessini 2004). Gender divisions in society and the position of women have direct influence on maternal mortality as it affects women’s access to methods of family planning and thus birth rates (Petchevsky 1990). Women’s reproductive role has little value to societies that prioritise the importance of productive work, an area dominated by men. This partly explains the subordination of issues linked to women, like reproductive health, and accordingly the lack of commitment by international institutions leading to the exclusion of any explicit reference to sexual rights of women in the MDGs.

Additionally, there is an important difference between the condition of women and the position of women, with the former referring to a person’s material state while the latter refers to a person’s social, political or economic place in society (Johnson, in Sweetman 2005). The MDGs are mostly concerned with improving the condition of women such as levels of education and employment which is shown by the indicators of Goal 3. However, this focus on women’s poorer condition neglects the position of women and therefore fails to challenge the power relations that are causing women’s inferiority to men in society.
Focusing simply on empowerment through education and employment for women is thus not enough, but it is crucial to involve men in the process as well. Men play a large part in shaping and reproducing the subordinate position of women. Kabeer (2005) argues that empowerment is rooted in the perception people have of themselves and their sense of self-worth. The influence men have on women contributes to their sense of self-worth – a woman who is dependent on her husband to make any kind of decisions will not feel empowered regardless of her level of education. Again, the Millennium Project does recognise the significance of men in reproductive health. However, any mention of men in the actual MDGs is still lacking, preventing any substantial empowerment of women and consequently also any sustainable reduction of maternal mortality.

2.3. The Millennium Development Goals and Patriarchy

The social structures of society determine the way in which women are viewed, what rights they have and their ability to exercise those rights. Successful empowerment of women is therefore dependent on a change of these male-dominated, patriarchal structures. Gender roles are often deeply rooted in the culture and practices of a community, and may also be further reinforced by legal and institutional structures (Sweetman 2005). Hence, even if laws or regulations are imposed by the state or other institutions like the UN, it will not solve the initial problem that is preventing women from having a choice. It might also lead to further ignorance regarding gendered structures of power and might even reinforce the patriarchal nature of society. Power relations are most effective when not perceived as such (Kabeer 2005). The silence on aspects of patriarchy in the MDGs effectively means that the unequal power structures are allowed to remain. Further, it also depoliticises the issue by excluding patriarchal power and its consequences from both the gender and maternal health agenda.

Maternal death becomes a much more real threat in patriarchal societies where women are dependent on men to make decisions concerning reproduction and health care. However, the goal on maternal mortality is only concerned with reducing maternal mortality ratios by increasing the proportion of births attended by skilled health personnel. Although an increase in the number of births attended by skilled personnel will have a positive effect on maternal mortality, the mere existence of health workers at a clinic or hospital will not automatically mean that more women will have access to their services. Existing initiatives, including the MDGs, seeking to improve women’s access to services often confuse the immediate causes like the distance to, or availability of, the service with the ultimate causes (Senah 2003: 48;
Stromquist 1990). Further evidence of this approach can be seen in the World Health Organisations identification of areas that needs addressing to achieve MDG 5 (WHO 2013). Consequently, the MDGs fail to recognise the importance of gender as an expression of power in society which creates numerous obstacles to women’s access to health services. These obstacles are often closely related to the patriarchal nature of their communities, starting within the family where women may be treated as male property (Crossette 2005). Accordingly, women can only use the resources with their husband’s authorisation which effectively prevents them to even seek life-saving care, without the consent of the husband. Nnaemeka (1998) argues that women will continue to have less power relative to men as long as patriarchy dominates their communities. Even the practical issues, like transport to the clinic is thus very difficult to solve unless the woman is granted more decision-making power allowing her to depend less on her husband’s will.

Furthermore, the problems of patriarchal societies which enable men to control all resources and make all the decisions concerning the household and its members cannot be solved by simply imposing legal constraints either. Further, because of the patriarchal nature of society and higher level decision-making bodies, gender is often pushed off the agenda as political will tend to decrease when any improvement of women’s education or social status is seen as a challenge to patriarchy (Stromquist, 1990). An increase in the number of female policy makers may be part of a solution to this problem, however the very cause of this issue in the first place will inherently prevent women from reaching those positions. The MDG target of increasing the number of women in national parliament might therefore not lead to any dramatic changes in gender relations. The sources of women’s subordination must be challenged before any progress can be made (Petchevsky 1990).

2.4. The Millennium Development Goals and Education

Education is a central concern to much of the feminist debate on women’s empowerment, which was clearly shown in the policy suggestions emanating from the 1994 International Conference on Population and Development (ICPD) in Cairo. The programme of action states that education can help “reduce fertility, morbidity and mortality rates [and] empower women” (UN, 1994: ch. XI). Education does have the potential to equip women with greater knowledge and information regarding issues that can give them greater autonomy. Education is also one of few concepts for women’s empowerment identified in Cairo which has actually been adopted by large international organisations like the UN. The focus on education in
MDG 3 on gender equality is thus a step in the right direction. However, even though there are proved advantages of increased number of girls attending school, these benefits may not apply to all women in all contexts. Jeffery and Jeffery argue that the tendency to view education as the ‘silver bullet’ which will automatically lead to increased autonomy of women must be challenged (1998: 240). The indicators of MDG 3 that seeks to reduce gender inequalities are currently focused on the rate of girls enrolled in primary education and on the literacy rates of young women. However, these indicators as a way of measuring gender inequalities are problematic as they do not include any specifics about the education systems or the type of information that is being distributed. Furthermore, the Millennium Task Force 3 states that a key priority must be to strengthen opportunities for girls to complete secondary education (Grown 2005). Although this might lead to improved chances of the goal being met, it does not necessarily mean the gender inequalities have been reduced.

As discussed above, the patriarchal nature of many societies also affects the type of education available to girls. When women are being viewed primarily in terms of their reproductive abilities, education in the current system may not challenge this view but rather reinforce it. The potential education has to change gender roles and stereotypes also mean that it has the ability to further entrench gender stereotyping and hence women’s inferior status. Accordingly, education might be viewed as means of equipping girls to become better wives and hence more attractive in an increasingly competitive marriage market (Jeffery & Jeffery 1998; Kabeer 2005). School practices can further reinforce this gender division by emphasising that education is necessary because boys need a career whereas girls need a husband. Social inequalities between men and women are therefore entrenched from an early age. Even though targets and indicators of the MDG 3 might show that empowerment has occurred as more girls are enrolled in primary education, this does not mean that these girls have neither gained greater status or autonomy nor challenged their role as merely child bearers (Sweetman 2005).

Another weakness of the MDGs concerning education and gender is the fact that they fail to link the importance of education to the goal on maternal mortality. By reinforcing women’s role as wives and mothers who are subordinate to men, education does not contribute to any improvements of women’s reproductive health. Education may give women greater knowledge about issues like family planning and other types of maternal health care that is available to them. However, unless women gain greater autonomy they will still have limited ability to access these services contributing to continued high levels of maternal mortality.
(Bianco and Moore 2012: 13). In order to attain the goal on maternal health and reduce maternal mortality ratios it is therefore crucial to provide a more gender neutral education that will contribute to women’s sense of self-worth and independence. Girls also risk being exposed to sexual violence in school, both by male peers as well as teachers. This risk is also valid for female teachers who might suffer sexual, or other forms, of violence and abuse (Aikman et al. 2005). Consequently, their reproductive and sexual health is not only dependent on the school curriculum but also on the construction of the school environment as a whole.

Reduction of gender inequities can be partly achieved by increased education for women which in turn can lead to improved reproductive health and lower rates of maternal mortality. However, in order for any of these issues to be solved it is important to consider the nature of the education available and not simply enrolment rates. Neither empowerment nor reduced maternal mortality will be achieved as long as education systems continue to reinforce gendered roles that subordinate women to men.

2.5. The Millennium Development Goals and Abortion

Unsafe abortion is one of the main causes to the high levels of maternal deaths in the developing world, with 97% of unsafe abortions taking place there (WHO 2004). International institutions do recognise the implications unsafe abortion has on the lives of millions of women globally. This increased awareness is demonstrated in the outcomes of various global conferences, such as the ICDP in Cairo in 1994. The adoption of the Programme of Action of the 1994 ICDP was a great victory for women’s rights advocates everywhere as it recognised the importance of women’s sexual and reproductive health rights (Crane 2005). The liberal discourse in the programme gave new hope to feminists of a universal adoption of a women’s rights agenda with emphasis on reproductive and sexual health. However, this potential to create policies that could improve the situation for women has not been fully realised. The adoption of the universal MDGs could have provided a framework for further advancements of women’s rights, but instead only one goal deals with gender equality and the issue of reproductive health has vanished (Sweetman 2005). Further, the goals on gender and maternal health are very narrow and minimalistic, lacking much of the progressive ideas agreed upon in Cairo (Barton 2005). Most notably, the broad term reproductive and sexual health has been substituted for the much more narrow maternal health failing to include many important aspects which contribute to maternal deaths. There is
no mention of abortion rights in any of the goals or indicators, despite the fact that it is the second largest cause of maternal death (WHO 2013). Abortion has been identified as an issue in reports following the MDGs along with recommendations of the importance to include unsafe abortion as a target (Crane & Hord-Smith 2006). However, there have been very little efforts made to actually implement these recommendations and abortion remains a neglected issue. This neglect can largely be attributed to the role of the US in the creation of the MDGs. The Bush administration blocked the use of the term reproductive health as opposed to maternal health, because the broader term would then include right to abortion. The Bush administration strongly opposed abortion and American organisations were legally forbidden to engage in any projects which endorsed abortion (Crossette 2005). The US is the largest development aid donor and its refusal to even discuss abortion as a reproductive right places serious obstacle to improving the situation for women.

The exclusion of safe abortion in the MDGs will significantly reduce the possibility of achieving the aim of reducing maternal mortality ratio by 75% by 2015. Current estimates indicate that this goal will not be met. Thus, simply recognising that unsafe abortion is a major reason to the high level of maternal mortality will not lead to an improvement in the situation. Relevant strategies must not only be identified, but also implemented to save the lives of millions of women.

There is evidence that liberal abortion laws leads to lower levels of maternal mortality (Crane & Hord-Smith 2006). However, simply legalising abortion will not guarantee women’s access to it. As outlined above, patriarchal societies prevent women from making reproductive decisions, including that of having an abortion even if it is legally available. Gender power relations must be improved in order for women to attain a more equal position to men and hence be able to take the decision of having a safe abortion (Patel & Kooverjee 2009).

2.6. Conclusion
The failure of the goals to incorporate gender effectively means that the set targets to improve maternal health will not be achieved by 2015, which is also supported by the available statistics discussed above. Although there are other MDGs that focus on gender equality and women’s empowerment, these strategies are not fully incorporated into the efforts of trying to reduce maternal mortality. By achieving improved gender equality, maternal mortality will
most likely decrease as a consequence. It is therefore important to emphasise the goal focusing on equality and women’s status as this will contribute to the achievement of MDG 5 and may also lead to the improvement of child health (MDG 4). Thus, the failure of international policies to link issues like gender and women’s subordinate role to maternal mortality may be one reason to why the MDG 5 is still very far from being realised. Smaller non-governmental organisations (NGOs) and women’s rights initiatives, such as the Center for Reproductive Rights, have increasingly recognised the connection between female empowerment and improved maternal and child health (Center for Reproductive Rights 2012). However they lack much of the power and resources that organisations like the UN control and their efforts will therefore make a smaller impact. Increased commitment on a larger, international scale is therefore important in order to reach out to all women.

MDG 3 does acknowledge the need for women’s empowerment however as mentioned above this is limited to the inclusion of women in education and waged labour. Accordingly, even the goal that is specifically focused on gender equity fails to address the underlying causes of the inequalities. It also omits the fact that they might be further reinforced through the institutions, for example the education system as discussed previously. Aikman et al. (2005) identify the need to break down the hierarchies in education that excludes women and girls and prevent them from reaping the potential benefits education could provide them with. Without the acknowledgement of aspects of patriarchal structures such as reproductive rights and unjust laws, along with a strategy to challenge them the scope of success for the MDGs will be very limited as will be demonstrated in the following case study of Ghana.

3. Maternal Mortality: The Case of Ghana

3.1. Introduction

Every year 2700 women in Ghana die due to complications in child birth. Compared to developed countries, this number is extremely high as the number of annual maternal deaths in the UK is 92 and a mere 4 in Sweden (World Bank 2012). This high number of maternal deaths means that thousands of women each year do not receive the life-saving care they have a right to. Every woman has a right to a safe pregnancy and should have access to reproductive health care, yet many Ghanaian women die every day from obstetric complications and unsafe abortions. Despite these negative numbers, progress has been made in reducing maternal mortality towards the achievement of MDG 5. Maternal mortality rate
has been reduced from 740 deaths per 100,000 live births in 1999 to 451 in 2008 according to the Ghana 2008 MDG Report (UNDP 2010). However, progress has been too slow and if the current trend continues Ghana will not achieve the MDG of reducing maternal mortality by 75% (185 deaths per 100,000 live births) by 2015. This chapter will discuss the reasons to why maternal mortality in Ghana remains high, and why the efforts of reducing it have not been sufficient. A deeper understanding of gender inequalities is crucial in order to ensure the reproductive health of women and reduce maternal mortality.

Ghana is particularly interesting for a case study, as it has one of the most progressive abortion laws in sub-Saharan Africa (Guttmacher Institute, 2013). Abortion is largely legal in most circumstances due to the vague formulation of the law, which will be further discussed in the section on abortion. Nonetheless, maternal deaths caused by unsafe, illegal abortions remain high proving the initial hypothesis that the mere legality of reproductive services is not enough to reduce maternal mortality. This claim is supported by the evidence found in various studies conducted in Ghana as well as in statistics produced by international institutions and the Government of Ghana. These findings are discussed in four different sections, further exploring the themes of women’s role, patriarchy, education and abortion in the context of Ghana.

3.2. Women’s role in Ghana

Despite progress towards the achievement of the MDGs gender disparities remain large in Ghana and the division of labour and power between men and women are shown in both national decision making bodies as well as in local communities (UNDP 2010). Women, particularly in rural settings, are often confined to the private sphere where they are responsible for the reproductive labour. As outlined in the first chapter, women’s limited participation is largely due to the social constructions determining the role of women. Scholars, such as Warner et al. on the other hand, argue that it is labour constraints rather than social prescriptions that prevent women’s full participation in activities, and that these workloads differ between women (1997: 156-157). While it is vital to acknowledge the limitations of grouping all women together in one social category assuming that they all share the same obligations and amount of work, it is nevertheless crucial to look beyond these immediate obstacles. Labour constraints, such as childcare, may indeed prevent women from full participation in activities outside the compound. However the root cause of these labour constraints is the social prescriptions which give women the responsibility for that labour in
the first place. The role women have in Ghanaian society creates the heavy workload which in turn prevents their full participation and thus also affects their potential to change their situation.

Women in Ghana, particularly in rural settings, are viewed primarily in terms of their reproductive ability and their main role in life is to produce children for their husband and the lineage (Bawah et al. 1999). The importance of producing children for the lineage shows the significance of a community identity in Ghanaian society. This is especially valid for women’s identity, where the individual is merged with the community. The individual does not have an identity of its own and community values and interests are more important than individual preferences (Oye Lithur 2004). This shared identity makes it even more difficult for women to gain any sense of autonomy. Accordingly, reproduction becomes an important aspect of contributing to the needs of the community putting high pressure on women to live up to these expectations. The payment of bride wealth is seen as a way of acquiring a woman and hence also transferring her rights and decision making power to the husband. Research from rural communities in Northern Ghana revealed men’s strong opinions on the role women have in that community. A young man stated that “[w]e marry women to build our houses, therefore, women have no right to limit their births” (Bawah et al. 1999: 60). The practice of bride wealth payment and the consequent transfer of rights effectively diminish women’s reproductive rights and highlight the normative view of women as submissive wives (Adongo et al. 1997: 1793).

However, gender roles are not the only social construct that determine peoples status in rural communities. Warner et al. argue that other factors, for instance marital status or concepts of seniority, may be equally important in some societies (1997: 145). This claim is further supported by Besteman (1995) as mentioned in chapter one, who found that senior women in a patrilineal household may also gain rights over their daughters-in-law through the dowry payment. This intersectionality is important to recognise, not only important for the individual empowerment of women but also for national and international policies such as the MDGs to effectively address the root causes of inequalities which increase maternal mortality. Additionally, it is not only women’s status that is determined by the number of children they have, but a large number of children are also important for the men. Men want children, preferably boys, who can continue a strong lineage where male authority and respect are enhanced (Bawah et al. 1999). Consequently, the importance of children for the status of men places additional pressure on women and further entrenches their roles as child
bearers. Hence, the risks caused by high fertility rates in combination with little access to health care are increased.

3.3. Patriarchy in Ghana

The patrilineal nature of the majority of communities in Ghana also poses obstacles to women’s potential to exercise their full reproductive rights. Patriarchal structures create a hierarchy which puts men on top leaving women little decision making power. Even minor decisions about the basic necessities must be made by the men, along with reproductive decisions specifically affecting the female body (Ngom et al. 2003: 22). Women’s limited ability to make decisions is closely connected to the communal identity of society mentioned above, meaning that women are not just viewed as the property of their husbands but as the property of the patrilineal compound (Adongo et al. 1997: 1791). This dependence on men to make decisions, even those concerning the women’s own health can be problematic, and even fatal, in case of an emergency. If a pregnant woman is experiencing complications and her husband is not present to authorise her use of modern health care, she is unlikely to seek care on her own. Hence, the risk of maternal death is increased by women’s lack of decision making power and the patriarchal structures behind it (Senah 2003: 53). As discussed in chapter two, the mere availability of health services will therefore not be sufficient to reduce maternal mortality in Ghana as women will still be prevented from accessing the services without male authorisation. Accordingly, programs will only be successful if they are sanctioned by the decision makers, i.e. husbands and compound heads (Adongo et al. 1997: 1792).

Further, the introduction of modern means of controlling fertility in attempts to reduce maternal mortality may also have detrimental effects on the position of women in patriarchal societies. By providing women with means to control their reproduction and hence the possibility to increase their reproductive autonomy, patriarchal structures where men hold the ultimate decision are threatened. Male authority as well as the community identity is challenged as contraceptives allow women to “assert their individual preference above the interests of the group” (Bawah et al. 1999: 62). This in turn may lead to acts of violence or other forms of abuse or restricted freedom against the women who are perceived to challenge their reproductive obligations. Again, the root causes to Ghanaian women’s subordination relative to men need to be challenged before the introduction of reproductive health services can have a lasting effect on maternal mortality levels.
Although a majority of communities in Ghana are patrilineal, there are also several matrilineal peoples such as the Akan ethnic group. A comparative study between matrilineal and patrilineal groups in Ghana has showed that matrilineal women experience a greater level of autonomy than their patrilineal counterparts (Takyi & Dodoo 2005). The study showed that sociocultural processes affect fertility behaviour, with patriarchal structures impacting negatively on women’s independence. Matrilineal women who did not want more children were more likely to access and use contraception. Further, Takyi & Dodoo found that even when women are both educated and willing to use family planning, they often fail to practice contraception because of opposition from husbands and the general community (2005: 252). This finding further shows men’s strong influence on sexual and reproductive issues which may lead to continued high levels of gender inequality and hence maternal deaths.

The fact that even educated women are restricted in their ability to access reproductive health services is further supported by DeRose et al. who state that women do not expect reproductive autonomy even at higher parities (2002: 54). Educated women tend to have a preference for monogamous marriage and this may disadvantage them as their reproductive bargaining power can decrease as a consequence. As stated above, high fertility is important for men’s status as well and a man may therefore take another wife if the first decides to limit her fertility. As a result, women who wish to stay in a monogamous relationship will be reluctant to use contraceptives in an attempt to prevent the husband from taking on another wife (DeRose et al. 2002: 56). High fertility levels may reflect women’s attempt of improving their position relative to their husbands or other women rather than an actual desire to have many children. Increased gender equity and reduced patriarchal power may thus lead to fewer child births and consequently also reduced risks of maternal deaths.

3.4. Education in Ghana
Another area where gender disparities in Ghana are clearly visible is within the education system. Improvements have been made in order to achieve the MDG on education which is visible in the significantly lower numbers of children who do not enrol in school, but overall there are still fewer girls enrolled in school compared to boys in Ghana (Shabay & Konadu-Agyeamang 2004; UNESCO 2012). Further, it is not only enrolment rates that are lower for girls, but literacy remains lower for girls too with 77 per cent of girls and 84 per cent of boys (15-24 years old) being literate according to the 2008 Ghana Demographic and Health Survey (GDHS 2010). Efforts to increase the educational levels of females therefore need to be
focused on these aspects too, as high levels of enrolment do not necessarily mean that the girls will stay in school or learn as much as the boys. The same survey also showed that gender equality in education is on track to reach the MDG 3. These disparities between literacy levels and gender ratio in education indicate that simply increasing female enrolment will not necessarily lead to the same improvements in learning outcomes. Hence, a gender sensitive curriculum is crucial to ensure that girls receive the same resources and opportunities to improve their learning.

Most of the research presented in this chapter stems from poor, rural communities. Indeed, poverty is especially important when discussing female enrolment levels in school as reasons why girls are kept at home are often closely linked to poverty and the role females have in these contexts. Additionally, the patriarchal nature of many Ghanaian societies discussed above exacerbate the responsibilities that women, and girl children, take on in order to aid in household reproduction (Shabaya & Konadu-Agyeamang 2004). A study of Ghanaian home life showed that the children do on average about 18 hours of work within the home (Stephens, 2000: 34). As the household work is mainly carried out by girl children the opportunity cost of sending girls to school is higher compared to that of boys. Patrilineal systems, as mentioned above, also add to this cost as the family believe that they will not receive the benefits of the girl’s education as she will be joining her husband’s lineage upon marriage (Adongo et al. 1997: 1798). The payment of tuition fees thus represent an investment that will not be returned, posing a great obstacle to girl’s schooling, especially in contexts of extreme poverty (Stephens 2000: 38). Accordingly, Fentiman et al. argue that ‘gender sensitive programmes should be adapted to enable girls to combine schooling with their work responsibilities’ as a strategy to increase the amount of girls attending secondary school (1999: 346). While this claim is valid in the sense that gender issues need to gain greater recognition in the Ghanaian educational system, it also ignores the very issues it seeks to address. By enabling girls to combine school with their domestic workload, the gendered roles that place that responsibility on females in the first place are left unchallenged. Gender sensitive programmes therefore need to address the root causes to girl’s heavy workload and aim to reduce it, rather than simply sustain it.

Further, the gendered curriculum and nature of the education discussed in chapter one is very much present in Ghana as evidenced in several studies (Dunne 2007; Fentiman et al. 1999; Stephens 2000). Despite this evidence of the disadvantage girls suffer in school, the Ghana ministry of education still fail to mention gender (other than in relation to enrolment) in their
strategies for improvements (Government of Ghana 2013). The quantitative approach taken
by both the MDGs and the Government of Ghana fail to account for the gender inequities,
and the complex structures and practices which reproduce them, in the education system.
Lived gender experiences cannot be captured by these numerical measures, and studies
employing other types of methodology such as interviews and life history have shown a more
nuanced and accurate image of the existing gender issues (Dunne 2009: 509-510; Stephens

The failure to address gender inequities will result in further reinforcement of gender roles
and stereo-types which effectively subordinate women to men. Girls will be less likely to
change power relations, especially concerning reproductive rights, if they are continuously
exposed to gendered treatment from teachers as well as peers. For instance, male teachers in
one Ghanaian school attributed girl’s minimal classroom participation to shyness, a result of
the stereotypical view of girls and women’s roles. However, the girls themselves
acknowledged that the actual reason was the oppressive gender regime in the classroom
which prevented them from active participation (Dunne 2007: 509). Unless these attitudes are
recognised and challenged the increase of female enrolment levels will have little effect on
gender equality. This point is proven by Dunne who further states that “neither the presence
of a female head nor the predominance of female teachers … appeared to have an impact on
the gendered nature of the school” (2007: 504). In effect, this finding validates the claim that
the MDGs focus on increasing the numbers of females in schools as well as parliament is not
enough unless the underlying gendered power structures are challenged.

3.5. Abortion in Ghana
Ghana has a relatively liberal abortion law compared to other sub-Saharan countries. The law
permits abortion on ‘grounds of conception resulting from rape: defilement of a female idiot
or incest: when there is a risk to the life of the woman or likely injury to her mental or
physical health or where there is substantial risk or serious abnormality or disease with the
foetus’ (Government of Ghana 2012). The vague formulation of the law means that the law
can be interpreted liberally, allowing abortion on much broader grounds than most
practitioners think (Morhee & Morhee 2006). Despite this relatively liberal law, unsafe
abortion remains the second largest cause of maternal deaths in Ghana accounting for 11 per
cent of maternal deaths. Additionally, the provision of safe abortion is limited and almost half
(45 per cent) of abortions in Ghana are unsafe (Guttmacher Institute 2013). These statistics
show the importance of access to safe abortion as a measure to reduce maternal mortality. However, as discussed in the second chapter, the MDGs as well as other policies either fail to recognise the issue of abortion altogether, or they do not take all aspects into account. Policies addressing maternal mortality are “usually heavily skewed toward the medical explanatory model … [and] do not necessarily address the heartbeat of the problem” (Senah 2003: 48). Even though medical complications are what ultimately lead to maternal deaths, the underlying structures that initially caused these complications need to be considered.

The legal status of abortion, although important, may not be the most important factor determining the availability of safe abortion. Evidence from Ghana supports this claim as abortion is largely legal, but nevertheless in 2007 only 3 per cent of pregnant women were aware of this (Guttmacher Institute 2013). Socio-cultural norms, educational levels, national policy and attitude of health professionals all have significant impact on women’s access to safe abortion (Morhee & Morhee 2006: 82). The obstacles to family planning and contraception discussed previously in this chapter are valid for abortion too. The cost of abortion can vary significantly and women may lack the necessary resources to obtain an abortion without their husband’s consent.

Further, there is also heavy stigma surrounding abortion, a lot of which is linked to women’s reproductive role. Because of the importance of high fertility, abortion is viewed as a shameful act which affects not only the pregnant woman but the whole community due to the community identity discussed above (Oye Lithur 2004: 72). The customary laws of the community therefore have a strong influence on women’s decision to have an abortion as well as to their access to safe services. The stigma surrounding abortion can partly explain the high number of unsafe abortions in Ghana, as women may not want to be seen in a health facility and will hence not use the legal services available (Guttmacher Institute 2013). Abortion stigma also affects the provision of legal abortion services as health care practitioners also face heavy stigma from their surroundings if they perform abortions (IPAS 2011). Abortion may become more widely available if the stigma causing negative treatment of health professionals providing abortions were reduced. The large number of unsafe abortions illustrates the significance of addressing underlying social and cultural barriers to abortion rather than the mere existence of legal, professional health care.

Furthermore, for existing health services to be accessible to women, they need to be aware of the legality and existence of these services. That only 3 per cent of pregnant women know
that abortion is legal is problematic as it means that women desperate for an abortion, especially young unmarried girls with little social support, will resort to unsafe abortion which may cost them their life. Education and access to information is necessary to increase awareness of the legal status, as well as promoting gender equity and joint reproductive decision making (Guttmacher Institute 2013; Morhee & Morhee 2006).

3.6. Conclusion
The example of Ghana validates the argument that the mere legality or provision of health services is not sufficient to reduce the high rates of maternal mortality. Despite the fact that abortion is largely legal and services are available, many women do not access these services due to gender barriers and norms which limit their decision making power. The gendered nature of the educational system further reinforces these norms. Even though more girls are now enrolling in school, they still perform worse than boys indicating that school attendance alone does not always empower women. Both the MDGs and the Government of Ghana fail to address this situation and hence actions that could have improved the system are still absent. Furthermore, the narrow targets set in the goals make the inclusion of gender more difficult. As the target on achieving gender parity in schools most likely will be achieved by 2015, issues concerning girls’ disadvantages in school may consequently be disregarded. If gender equity is believed to be, at least statistically, achieved then resources may be reallocated to the detriment of the empowerment of girls and women.

The country specific focus of this chapter has aided an understanding of the implications gender has on maternal mortality. Although there may be variations within different countries, the issues shown in the research on Ghana are likely to be transferrable to other sub-Saharan countries with similar society structures. The inability of international policy responses such as the MDGs to achieve more rapid declines of maternal death in Ghana is true for other countries as well (Millennium Development Goals Report 2012). The gendered issues entrenched in women’s role, patriarchal structures, education and abortion in Ghana together create conditions which may have significant detrimental effects on the health of women. The MDGs as well as the Government of Ghana need to address these core causes of women’s relative subordination to guarantee their access to health services that could reduce the risk of maternal death.
4. **Final Conclusion**

The assumption that availability of health services and skilled personnel as the most effective way of improving maternal health has been challenged in this study. Although the increased provision of professional health personnel has indeed aided the falls in maternal mortality, the progress to reduce maternal deaths has slowed significantly in the past decade suggesting a need for alternative methods. This paper has therefore focused on gender inequalities, arguing that they are the underlying cause to the continued high levels of maternal deaths. The persisting gender inequalities and failure of current strategies to reduce maternal mortality rates makes the focus of this paper crucial. The fast approaching deadline for the MDGs and the fact that Goal 5 on maternal health will not be reached in time further emphasises the importance of looking beyond the immediate obstacles to women’s utilisation of health facilities. The post-2015 agenda needs to rectify the limitations of the MDGs by acknowledging the obstacles gender inequalities pose to development for women and girls.

Women’s role in society is highly relevant to maternal mortality as women’s limited decision-making power, resulting from their subordination, prevents access to health care. As outlined in the first chapter, there are several factors contributing to men’s domination over women in society. Women in patriarchal societies tend to be reduced to child bearers, with their primary responsibility being to reproduce for the continuation of the lineage. As such, they are denied their rights to self-determination particularly with regards to reproductive issues. Consequently, their utilisation of health services will be dependent on their husband’s authorisation. Education plays a large part in the exacerbation of gender roles and male superiority. There is evidence of the positive effects education can have on the status of girls and women which should be, and often are, recognised. However the gendered nature of educational systems tends to benefit boys more than girls, as well as entrenching assumptions about the roles of both sexes. The benefits of education therefore need to be assessed in relation to these negative aspects, as shown in the first chapter. Again, women’s access to education will also be dependent on male authorisation as women and girls may not have the resources to pursue an education themselves. Without access to education, and a more gender neutral curriculum, women will continue to face barriers to improve their status.

Abortion has been discussed in this paper as an issue which mirrors the extent of women’s reproductive freedom. Even documents regarded as progressive in advancing women’s reproductive rights, such as the 1994 ICPD Plan of Action places a (im)moral value on abortion implying that it is a necessary evil. While a reduction of abortions would be
desirable as it may lead to fewer maternal deaths, abortion nevertheless should be recognised as a right without any moral values attached to it. The three different sections on abortion in this paper have proved the importance of access to abortion as a means to reduce maternal mortality, and post-2015 policies should acknowledge this issue.

As the 2015 deadline for the MDGs is rapidly approaching, strategies for post-2015 need to be developed as some of the goals are not likely to be achieved. To avoid another decade of slow improvements in maternal health, gender issues need to be included in any new goals or policies. These claims are recognised by initiatives such as the Association for Women’s Rights in Development (AWID) who cautions “against developing another set of reductive goals, targets and indicators that ignore the transformational changes required to address the failure of the current development model” (AWID 2013). This statement agrees with the argument of this paper, highlighting the limited scope of the current goals. Further, as discussed throughout the paper the fact that a non-state actor like AWID has acknowledged these weaknesses also supports the claim that government regulations may not be the most appropriate solution. Rather, change needs to be initiated from a bottom-up approach in order to ensure the inclusion of the most vulnerable, which in terms of maternal mortality are girls and women.

In order for these global efforts to be effective, the four aspects of gender inequalities analysed in this paper need to be included. Women’s role, patriarchy, education and abortion are all interrelated and affect each other. Consequently, they also affect maternal health, which is why these four themes were chosen for the analysis. They all contribute to the structure and norms of society and as such also the role of women in relation to men. The gender inequalities reproduced in patriarchal societies and gender biased education systems emphasise the normative views of women as child bearers, as well as the view of the man as decision maker. By reinforcing the roles of both women and men, improvements towards gender equality are hindered due to the constructed notions of what constitutes acceptable female, and male, behaviour. By reducing women’s decision making power, society effectively limits the options available to women seeking to exercise their reproductive rights. Hence, this paper finally concludes that women’s role in society can have detrimental effects on their access to health services which could reduce maternal mortality.
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